DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR

2010

General Departmental Management
Office of Medicare Hearings and Appeals
National Coordinator for Health Information Technology
Prevention and Wellness Fund
Service and Supply Fund
Retirement Pay & Medical Benefits for Commissioned Officers
HHS General Provisions

Justification of Estimates for
Appropriations Committees

Introduction

This FY 2010 Congressional Justification is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 (GPRA) and with Office of Management and Budget Circulars A-11 and A-136, through the HHS agencies' FY 2010 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Citizens' Report. These documents are available at http://www.hhs.gov/asrt/ob/docbudget/index.html.

The FY 2010 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2008 Annual Performance Report and FY 2010 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Citizens' Report summarizes key past and planned performance and financial information.

Message from the Acting Assistant Secretary for Resources and Technology

I am pleased to present the Congressional Justification for Departmental Management (DM) activities within the Office of the Secretary. This budget request represents the Administration's priorities for guiding the Department of Health and Human Services (HHS) to fulfill the President's vision of improving the affordability and quality of health care for all Americans, investing in science and research, supporting human service programs that serve the most vulnerable Americans, and preparing for and combating pandemic flu.

The DM budget request supports the Secretary in her role as chief policy officer and general manager of HHS. The request totals $523 million and 3,470 full-time equivalent (FTE) staff in FY 2010. These levels will ensure the Secretary's ability to successfully manage the Department in these challenging times, while increasing accountability in oversight functions and improving the transparency of information and decision making. It also includes resources needed to guide nationwide implementation of interoperable health IT, including secure electronic health records.

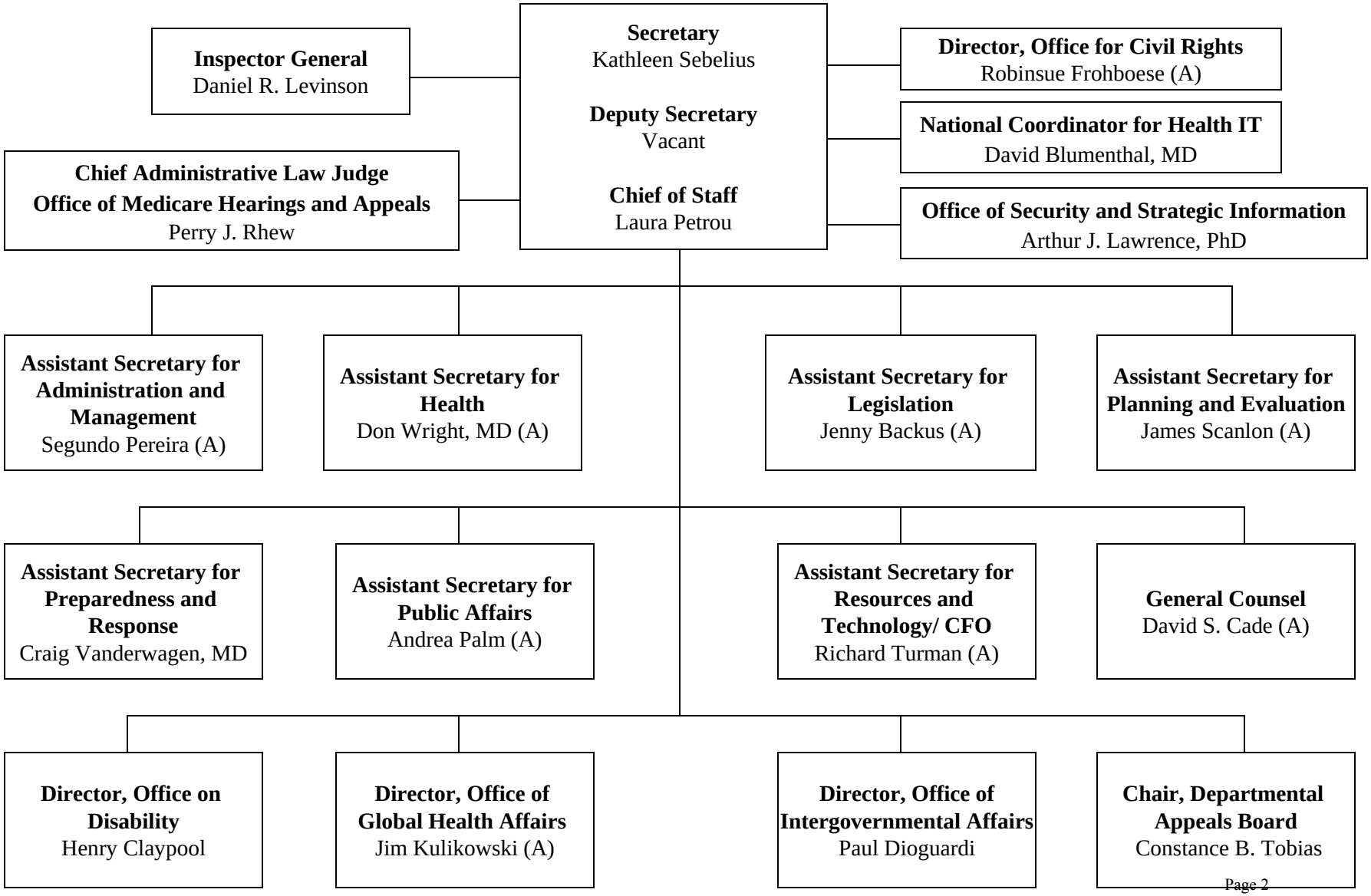
The FY 2010 Budget for DM includes funding increases for reducing health disparities among minority populations. In addition, the Request increases funding for the Office of Medicare Hearings and Appeals, to ensure its continued ability to provide full access to claimants while also processing cases within legally mandated timeframes. Finally, we are proposing to more effectively target teen pregnancy prevention funds, utilizing evidence-based models and promising practices.

The Secretary looks forward to working with the Congress toward the enactment and implementation of a 2010 Budget that advances the Nation's health and supports families.

_____/s/_____
Richard J. Turman
Acting Assistant Secretary for
Resources and Technology

Departmental Management Overview

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY



DEPARTMENTAL MANAGEMENT

OVERVIEW

Departmental Management (DM) is a consolidated display that includes the Office of the Secretary (OS) activities funded under the following accounts:

- General Departmental Management (appropriation);
- Office of Medicare Hearings and Appeals (appropriation);
- Office of the National Coordinator for Health Information Technology (appropriation); and
- Service and Supply Fund (revolving fund).

The **mission** of OS is to provide support and assistance to the Secretary in administering and overseeing the organization, programs, and activities of the Department of Health and Human Services.

The FY 2010 budget request for DM totals $523,027,000 in appropriated budget authority, and 3,470 full-time equivalent (FTE) positions – an increase of $18,095,000 (or 3.6 percent) above the comparable FY 2009 Enacted level (i.e., excluding the Prevention and Wellness Fund). Please see the DM Budget by Appropriation table on the following pages.

The **General Departmental Management** (GDM) appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department in administering and overseeing the organization, programs, and activities of HHS. These activities are carried out through twelve Staff Divisions (STAFFDIVs), including the Immediate Office of the Secretary, the Departmental Appeals Board, and the Offices of: Public Affairs; Legislation; Planning and Evaluation; Resources and Technology; Administration and Management; Intergovernmental Affairs; General Counsel; Global Health Affairs; Disability; and Public Health and Science. For FY 2010, GDM is requesting a total of $409,549,000 and 1,630 FTE.

The **Office of Medicare Hearings and Appeals** (OMHA) was created in response to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). As mandated by MMA, OMHA opened its doors on July 1, 2005, to hear Medicare appeals at the Administrative Law Judge level, for cases under titles XVIII and XI of the Social Security Act. OMHA is funded entirely from the Medicare Hospital Insurance and Supplemental Medical Insurance Trust Funds, and requests $71,147,000 and 378 FTE in FY 2010.

The **Office of the National Coordinator for Health Information Technology** (ONC) was authorized by the Health Information Technology for Economic and Clinical Health Act, signed by President Obama on February 17, 2009. ONC initially became operational on August 19, 2005, in response to Executive Order 13335, signed on April 27, 2004. For FY 2010, HHS requests budget authority of $42,331,000 (program level of $61,342,000) and 65 FTE, to coordinate national efforts related to the implementation and use of electronic health information

exchange. By encouraging providers to adopt health information technology, both the quality of care and the efficiency with which health IT is delivered can be improved.

The **Service and Supply Fund** (SSF) is now shown as a single, consolidated submission within this DM justification. Previously, the Program Support Center (PSC) portion of the SSF submitted its own separate justification document, while the Non-PSC portion of the SSF was included in the DM justification. Presenting the two parts together in a single submission will allow greater understanding and transparency of the Fund's overall operations. For FY 2010, the SSF is projecting revenue of $837,971,000 and 1,376 FTE.

NOTES:

The justification for the **Public Health and Social Services Emergency Fund** (PHSSEF) appropriation, which in previous years was included as a tab in the DM justification, is now a separate, stand-alone document.

Note: The HHS Nonrecurring Expenses Fund (NEF) was established by the Consolidated Appropriations Act, 2008 (P.L. 110-161) in the Office of the Secretary. This authority permits *expired unobligated balances from discretionary accounts in* FY 2008 (and later) funds to be transferred into a no-year account (the NEF) prior to cancellation. Since FY 2008 funds will not be cancelled until the end of FY 2013, funding is not expected to be available until just prior to September 30, 2013. These funds may be used only for nonrecurring capital acquisitions (facilities infrastructure and information technology infrastructure) that have a broad value to the Department. *Advance notification of the proposed use of the Unobligated Balance Fund would be submitted to the relevant Appropriations Committee, and apportionment of the funds would be submitted to OMB.*

DEPARTMENTAL MANAGEMENT

BUDGET BY APPROPRIATION
(Dollars in thousands)

	FY 2008 Enacted		FY 2009 Omnibus		FY 2010 Request	
	FTE	Amount	FTE	Amount	FTE	Amount
General Departmental Management	1,351	$354,998	1,527	$396,776	1,630	$409,549
Office of Medicare Hearings and Appeals	366	$63,864	366	$64,604	378	$71,147
Office of the National Coordinator for Health Information Technology	28	$41,661	30	$43,552	65	$42,331
Prevention and Wellness Fund 1/	0	–	21	$700,000	21	–
Subtotal, Budget Authority	**1,735**	**$460,523**	**1,944**	**$1,204,932**	**2,094**	**$523,027**
Service and Supply Fund	1,218	–	1,376	–	1,376	–
TOTAL, Budget Authority	**2,953**	**$460,523**	**3,320**	**$1,204,932**	**3,470**	**$523,027**
[Trust Fund transfers included above, GDM + OMHA]		[$69,555]		[$70,455]		[$76,998]
PHS Evaluation Funds (GDM + ONC)		*$65,656*		*$64,435*		*$78,767*
HCFAC Funds (GDM)		*$5,714*		*$5,714*		*$5,714*
TOTAL, Program Level		***$531,893***		***$575,081***		***$607,508***

[1] Two-year appropriation, FYs 2009-2010.

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General Departmental Management

APPROPRIATIONS LANGUAGE

GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management, including hire of six sedans, and for carrying out titles III, XVII, XX, XXI and XXIX of the Public Health Service Act ("PHS Act"), the United States-Mexico Border Health Commission Act, and research studies under section 1110 of the Social Security Act, [$389,925,000] *$403,698,000,* together with $5,851,000 to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, and **[**$46,756,000**]** *$59,756,000* from the amounts available under section 241 of the PHS Act to carry out national health or human services research and evaluation activities: *Provided,* That of this amount, $51,891,000 shall be for minority AIDS prevention and treatment activities; $5,789,000 shall be to assist Afghanistan in the development of maternal and child health clinics, consistent with section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002; and $1,000,000 shall be transferred, not later than 30 days after enactment of this Act, to the National Institute of Mental Health to administer the Interagency Autism Coordinating Committee: *Provided further,* That of the funds made available under this heading for carrying out title XX of the Public Health Service Act, $13,120,000 shall be for activities specified under section 2003(b)(2), **[**all of which shall be for prevention service demonstration grants under section 510(b)(2) of title V of the Social Security Act**]** *of which $9,840,000 shall be for programs that replicate the elements of one or more teenage pregnancy prevention programs that have been proven through rigorous evaluation to delay sexual activity, increase contraceptive use (without increasing sexual activity), or reduce teenage pregnancy, and of which $3,280,000 shall be available for research and demonstration*

grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teen pregnancy, without application of the limitation of section 2010(c) of said title XX: *Provided further,* That funds provided in this Act for embryo adoption activities may be used to provide, to individuals adopting embryos, through grants and other mechanisms, medical and administrative services deemed necessary for such adoptions: *Provided further,* That such services shall be provided consistent with 42 CFR 59.5(a)(4)**[**: *Provided further,* That $2,854,000 shall be used for the projects, and in the amounts, specified under the heading "General Departmental Management" in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act): *Provided further,* That specific information requests from the chairmen and ranking members of the Subcommittees on Labor, Health and Human Services, and Education, and Related Agencies, on scientific research or any other matter, shall be transmitted to the Committees on Appropriations of the House of Representatives and the Senate ("Committees on Appropriations") in a prompt, professional manner and within the time frame specified in the request: *Provided further,* That scientific information, including such information provided in congressional testimony, requested by the Committees on Appropriations and prepared by government researchers and scientists shall be transmitted to the Committees on Appropriations, uncensored and without delay**]**. *(Department of Health and Human Services Appropriations Act, 2009.)*

LANGUAGE ANALYSIS

Language Provision	Explanation
"all of which shall be for prevention service demonstration grants under section 510(b)(2) of title V of the Social Security Act"	This change is necessary because the current language restricts the use of these funds too narrowly. Deleting this language will permit teen pregnancy prevention funds to be targeted more effectively, utilizing evidence-based models and promising practices.
"of which $9,840,000 shall be for programs that replicate the elements of one or more teenage pregnancy prevention programs that have been proven through rigorous evaluation to delay sexual activity, increase contraceptive use (without increasing sexual activity), or reduce teenage pregnancy, and of which $3,280,000 shall be available for research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teen pregnancy,"	This language is necessary to permit teen pregnancy prevention funds to be targeted more effectively, utilizing evidence-based models and promising practices.
"*Provided further*, That $2,854,000 shall be available for the projects, and in the amounts, specified under the heading "General Departmental Management" in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act)"	This language was for a one-time-only action and is no longer needed.
"*Provided further*, That specific information requests from the chairmen and ranking members of the Subcommittees on Labor, Health and Human Services, and Education, and Related Agencies, on scientific research or any other matter, shall be transmitted to the Committees on Appropriations of the House of Representatives and the Senate ("Committees on Appropriations") in a prompt, professional manner and within the time frame specified in the request: *Provided further*, That scientific information, including such information	This language is no longer needed.

provided in congressional testimony, requested by the Committees on Appropriations and prepared by government researchers and scientists shall be transmitted to the Committees on Appropriations, uncensored and without delay

AMOUNTS AVAILABLE FOR OBLIGATION[1]

	FY 2008 Enacted	FY 2009 Omnibus	FY 2010 Request
General funds:			
Annual appropriation	$355,518,000	$389,925,000	$403,698,000
Rescission pursuant to PL 110-161	-6,211,000	–	–
Subtotal	349,307,000	389,925,000	403,698,000
Actual transfer from:			
State Dept/USAID for Bio-Technology Engagement Program (BTEP)	+1,500,000	–	–
Actual transfer to:			
NIMH for Interagency Autism Coordinating Cmte	-983,000	-1,000,000	-1,000,000
Subtotal, adjusted general funds	349,824,000	388,925,000	402,698,000
Trust funds:			
Annual appropriation	5,792,000	5,851,000	5,851,000
Rescission pursuant to PL 110-161	-101,000	–	–
Subtotal, adjusted trust funds	5,691,000	5,851,000	5,851,000
Subtotal, adjusted budget authority	355,515,000	394,776,000	408,549,000
Unobligated balance lapsing	-5,831,000	–	–
Total obligations	$349,684,000	$394,776,000	$408,549,000

[1] Excludes the following amounts for reimbursable activities carried out by this account: FY 2008 – $210,000,000; FY 2009 – $225,000,000; FY 2010 – $225,000,000.

SUMMARY OF CHANGES

2009	General funds appropriation	$389,925,000
	HI/ SMI trust funds transfer	5,851,000
	Total adjusted budget authority	395,776,000
2010	Request – General funds	403,698,000
	Request – HI/SMI trust funds transfer	5,851,000
	Total estimated budget authority	409,549,000
	Net change	+13,773,000

	2009 Estimate (FTE)	2009 Estimate Budget Authority	Change from Base (FTE)	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. Anualization of January 2009 pay raise (3.9%)	(1,527)	$156,591,000	(--)	+1,527,000
2. Effect of January 2010 pay raise (2.0% civilian, 2.9% military)	(1,527)	156,591,000	(--)	+2,561,000
3. Within-grade increases and career ladder promotions	(1,527)	156,591,000	(--)	+1,566,000
4. Total Common Expenses/ Service and Supply Fund payments	(--)	12,570,000	(--)	+1,950,000
Subtotal, Built-In Increases			(--)	+7,604,000
B. Program:				
1. Departmental Accountability	(--)	0	(+76)	+7,600,000
2. Secretarial Initiatives and Flexibility	(--)	0	(+27)	+6,500,000
3. OPHS: Office of Minority Health	(62)	5,296,000	(+1)	+3,000,000
4. Web Communications	(--)	0	(--)	+2,000,000
5. ASRT: Office of Recovery Act Coordination	(9)	1,265,000	(+9)	+1,785,000
Subtotal, Program Increases			(+113)	+20,885,000
Total Increases			(+113)	+28,489,000

Decreases:

B. Program:

1. OGHA: Health Diplomacy Initiative.....	(--)	7,000,000	(--)	-5,000,000
2. One-time Congressional projects included in FY 2009 GDM appropriation.....	(--)	2,854,000	(--)	-2,854,000
3. Interagency Working Group on Youth Programs.....	(--)	1,000,000	(--)	-1,000,000
4. Net decrease in Advisory and Assistance Services.....	(--)	27,601,000	(--)	-4,839,000
5. Net decrease in Operation & Maintenance of Equipment.....	(--)	3,411,000	(--)	-1,023,000
6. President's Council on Bioethics (reimbursable authority).....	(10)	0	(-10)	0
Total Decreases.....			(-10)	-14,716,000
Net Change.....			(+103)	+13,773,000

BUDGET AUTHORITY BY ACTIVITY
(Dollars in Thousands)

	FY 2008 Enacted		FY 2009 Omnibus		FY 2010 Request	
	FTE	Amount	FTE	Amount	FTE	Amount
Immediate Office of the Secretary	67	$ 10,728	73	$ 11,073	73	$ 11,245
Public Affairs	27	4,453	32	4,432	38	5,492
Legislation	26	3,379	27	3,430	30	3,978
Planning and Evaluation	120	-	128	-	137	-
Resources and Technology	149	23,162	166	25,781	193	29,705
Administration and Management	114	16,855	125	17,390	134	18,411
Intergovernmental Affairs	33	5,978	36	6,244	39	6,338
General Counsel	389	36,617	397	37,581	414	40,110
Departmental Appeals Board	65	9,641	70	9,981	74	11,457
Disability	4	779	5	805	6	814
Secretarial Initiatives and Flexibility	-	-	-	-	27	6,500
Global Health Affairs	30	9,610	32	16,740	32	11,741
Public Health and Science	301	145,138	411	163,791	418	167,365
President's Council on Bioethics	10	-	10	-	-	-
Center for Faith-Based Initiatives	6	-	7	-	7	-
Embryo Adoption Awareness Campaign	-	3,930	-	4,200	-	4,200
Minority HIV/AIDS Initiative	-	50,984	-	51,891	-	51,891
Rent/ Operations & Maintenance 1/	-	17,112	-	17,001	-	16,935
Common Expenses/ SSF Payment 1/	-	11,301	-	12,692	-	14,520
Enterprise IT	-	347	-	347	-	347
Interagency Autism Coordinating Commmittee	-	983	-	1,000	-	1,000
Natl Commission on Children & Disasters	-	500	-	43	-	-
Healthcare-Associated Infections activities	-	-	-	5,000		5,000
Lifespan Respite Care Act	-	-	-	2,500	-	2,500
Congressional Projects	-	3,501	-	3,854	-	-
Subtotal GDM budget authority	1,341	354,998	1,519	395,776	1,622	409,549
Trust Fund transfers, included above	-	(5,691)	-	(5,851)	-	(5,851)
CHIPRA & FMAP, not included above	-	-	8	10,000	8	10,000
Total Budget Authority, less Trust Funds	**1,341**	**$ 349,307**	**1,527**	**$ 399,925**	**1,630**	**$ 413,698**
PHS Evaluation Funds; non-add		*46,756*		*46,756*		*59,756*

1/ Excludes OGC, OGHA, IGA, DAB and OPHS shares; see narrative for Rent and Common Expenses.

BUDGET AUTHORITY BY OBJECT

	2009 Estimate	2010 Estimate	Increase or Decrease
Personnel Compensation:			
Full-time permanent (FTP)	108,523	114,580	+6,057
Other than FTP	9,601	11,523	+1,922
Other personnel compensation	4,977	5,776	+799
Military personnel compensation	5,989	6,849	+860
Subtotal	129,090	138,728	+9,638
Civilian personnel benefits	24,478	25,422	+944
Military personnel benefits	3,009	4,407	+1,398
Benefits to former personnel	14	17	+3
Subtotal, Pay Cost	156,591	168,574	+11,983
Travel	2,499	2,044	-455
Transportation of things	262	271	+9
Rental payments to GSA	18,787	20,814	+2,027
Rental payments to others	156	175	+19
Communications, utilities, misc. charges	4,953	4,747	-206
Printing and reproduction	3,705	3,589	-116
Other contractual services:			
Advisory and assistance services	27,601	22,762	-4,839
Other services	20,514	19,533	-981
Purchase of goods and services from government accounts	43,726	43,870	+144
Operation and maintenance of facilities	5,908	5,324	-584
Research and Development Contracts	255	261	+6
Medical Care	0	0	-
Operation and maintenance of equipment	3,411	2,388	-1,023
Subsistence and support of persons	0	0	-
Subtotal Other Contractual Services	101,415	94,138	-7,277
Supplies and materials	2,582	3,459	+877
Equipment	2,371	1,365	-1,006
Grants, subsidies, and contributions	106,604	114,522	+7,918
Subtotal, Non-pay costs	243,334	245,124	+1,790
Total Budget Authority	399,925	413,698	+13,773
CHIPRA & FMAP, included above	10,000	10,000	-

SALARIES AND EXPENSES
(Budget Authority)

	2009 Estimate	2010 Estimate	Increase or Decrease
Personnel Compensation:			
Full-time permanent (FTP)	108,523	114,580	+6,057
Other than FTP	9,601	11,523	+1,922
Other personnel compensation	4,977	5,776	+799
Military personnel compensation	5,989	6,849	+860
Special personnel services	-	-	-
Subtotal	**129,090**	**138,728**	+9,638
Civilian personnel benefits	24,478	25,422	+944
Military personnel benefits	3,009	4,407	+1,398
Benefits to former personnel	14	17	+3
Subtotal, Pay Cost	**156,591**	**168,574**	+11,983
Travel	2,499	2,044	-455
Transportation of things	262	271	+9
Rental payments to others	156	175	+19
Communications, utilities, misc. charges	4,953	4,747	-206
Printing and reproduction	3,705	3,589	-116
Other contractual services:			
Advisory and assistance services	27,601	22,762	-4,839
Other services	20,514	19,533	-981
Purchase of goods and services from government accounts	43,726	43,870	+144
Operation and maintenance of facilities	5,908	5,324	-584
Research and Development contracts	255	261	+6
Operation and maintenance of equipment	3,411	2,388	-1,023
Subsistence and support of persons	-	-	-
Subtotal Other Contractual Services	**101,415**	**94,138**	-7,277
Supplies and Materials	2,582	3,459	+877
Total, Salaries and Expenses	**272,163**	**276,997**	+4,834

AUTHORIZING LEGISLATION

	2009 Amount Authorized	2009 Enacted	2010 Amount Authorized	2010 Budget Request
General Departmental Management, except accounts below:				
Reorganization Plan No. 1 of 1953	Indefinite	$231,985,000	Indefinite	$242,154,000
Office of Public Health and Science:				
Public Health Service Act,				
Title III, Section 301	Indefinite	66,946,000	Indefinite	81,988,000
Title XVII, Section 1701 (ODPHP)	[1]	7,232,000	[1]	7,232,000
Title XVII, Section 1707 (OMH)	[2]	52,956,000	[2]	55,965,000
Title XX, Section 2010 (AFL)	[3]	29,778,000	[3]	29,778,000
Title XXI (NVPO)	[4]	6,879,000	[4]	6,896,000
Subtotal		163,791,000		167,395,000
Total appropriation		$395,776,000		$409,549,000

[1] Authorizing legislation under Section 1701(b) of the PHS Act expired September 30, 2002. Reauthorization will be proposed.

[2] Authorizing legislation under Section 1707 of the PHS Act expired September 30, 2002. Reauthorization will be proposed.

[3] Authorizing legislation under Section 2010 of the PHS Act expired September 30, 1985. Reauthorization will be proposed.

[4] Authorizing legislation under Title XXI, Subtitle1, of the PHS Act expired September 30, 1995. Reauthorization will be proposed.

APPROPRIATIONS HISTORY TABLE

(Non-Comparable)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2001				
Appropriation	$223,741,000	$206,780,000	$204,266,000	$285,224,000
Rescission	–	–	–	-438,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
FY 2002				
Appropriation	415,348,000	333,036,000	416,361,000	341,703,000
Rescissions	–	–	–	-1,667,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
FY 2003				
Appropriation	387,880,000	352,600,000	368,535,000	361,364,000
Rescission	–	–	–	-2,349,000
OER Transfer	–	–	–	-13,856,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
Rescission	–	–	–	-38,000
FY 2004				
Appropriation	348,100,000	343,284,000	344,808,000	357,358,000
Rescissions	–	–	–	-3,174,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
Rescission	–	–	–	-35,000
FY 2005				
Appropriation	431,971,000	349,298,000	376,704,000	371,975,000
Rescissions	–	–	–	-3,530,000
Trust Funds	5,851,000	5,851,000	5,851,000	55,851,000
Rescission	–	–	–	-447,000
SSA Transfer	–	–	–	-49,600,000
FY 2006				
Appropriation	353,325,000	338,695,000	353,614,000	352,703,000
Rescission	–	–	–	-3,527,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
Rescission	–	–	–	-58,000

APPROPRIATIONS HISTORY TABLE
(Cont.)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2007				
Appropriation	$362,568,000	–	–	$350,945,000
Rescission	–	–	–	-500,000
KLL Supplemental	13,512,000	–	–	–
Trust Funds	5,851,000	–	–	5,793,000
FY 2008				
Appropriation	386,705,000	342,224,000	386,053,000	355,518,000
Rescission	–	–	–	-6,211,000
NIMH Transfer	–	–	–	-983,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,792,000
Rescission	–	–	–	-101,000
FY 2009				
Appropriation	374,013,000	366,825,000	361,764,000	389,925,000
NIMH Transfer	–	–	–	-1,000,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
CHIPRA (PL 111-3)	–	–	–	5,000,000
ARRA (PL 111-5)	–	–	–	5,000,000
FY 2010				
Appropriation	403,698,000			
Trust Funds	5,851,000			

GENERAL DEPARTMENTAL MANAGEMENT

	FY 2008 Enacted	FY 2009 Omnibus	FY 2010 Request	FY 2010 +/- FY 2009
Budget Authority	$354,998,000	$395,776,000	$409,549,000	+$13,773,000
FTE (including reimbursables)	1,391	1,527	1,630	+103

FY 2010 Authorization .....Indefinite
Allocation Method .....Direct Federal

Overview of Budget Request

The FY 2010 budget request for General Departmental Management (GDM) includes $409,549,000 in appropriated funds and 1,630 full-time equivalent (FTE) positions. This request is $13,773,000 (3.5 percent) and 103 FTE higher than the comparable FY 2009 Omnibus level.

The GDM appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department. These activities are carried out through twelve Staff Divisions (STAFFDIVs), including the Immediate Office of the Secretary, the Departmental Appeals Board, and the Offices of: Public Affairs; Legislation; Planning and Evaluation; Resources and Technology; Administration and Management; Intergovernmental Affairs; General Counsel; Global Health Affairs; Disability; and Public Health and Science.

The largest single STAFFDIV within GDM is the Office of Public Health and Science (OPHS). OPHS serves as the focal point for leadership and coordination across the Department in public health and science, and provides advice and counsel to the Secretary on public health and science issues. OPHS also exercises management responsibility for twelve cross-cutting program offices, including: Surgeon General, HIV/AIDS Policy, Adolescent Family Life, Disease Prevention and Health Promotion, President's Council on Physical Fitness and Sports, Minority Health, Women's Health, Human Research Protections, Commissioned Corps Initiatives, National Vaccine Program Office, Public Health Reports, and Research Integrity.

This justification includes narrative sections describing the activities of each STAFFDIV funded under the GDM account, plus the Rent and Common Expenses accounts. (Resource tables reflect only funding provided from the GDM appropriation. FTE figures include full-time, part-time, and temporary employees.) This justification also includes selected performance information; however, the majority of performance-related information for GDM can be found in the On-line Performance Appendix at http://www.hhs.gov/asrt/ob/docbudget/2010gdmopa.pdf and the Annual Performance Report at http://www.hhs.gov/budget/GeneralDepartmentalManagementAPR.pdf.

The FY 2010 request for GDM reflects the following significant changes from previous years:

- Accountability (+$7,600,000 in Budget Authority) – Targeted funding increases to support Office of the Secretary (OS) functions and activities in several Staff Divisions are included to ensure that key offices have the necessary resources to support risk mitigation efforts for ongoing HHS activities. This request reflects an increased need for additional resources to support those offices which are responsible for creating and implementing guidance, policies, and controls crucial to the effective management of HHS programs. Growth of HHS programs has resulted in increased demands on these offices. As a result, OS intends to be responsive by providing oversight to programs critical to the safety and well being of the American public. As OS responds to the Administration's priorities to employ rigorous standards of accountability and transparency throughout the Federal government, this funding will allow responsible offices to: enhance oversight of and policy guidance for acquisitions; strengthen legal review and oversight; improve financial reporting and financial controls; and implement robust budgetary oversight execution controls and performance tracking. In support of these efforts, this request includes salaries and expenses to employ the necessary staff with the distinctive skill-sets required to execute these functions. This request also includes funding to support a portion of other inflationary costs for all Staff Divisions. Details supporting the overall budget request can be found in the individual FY 2010 budget requests of each affected office.

- Secretarial Initiatives and Flexibility (+$6,500,000) – This funding is needed to provide the Secretary with the flexibility necessary to respond quickly to unanticipated issues and opportunities.

- Office of Minority Health in OPHS (+$3,000,000) – This increase is requested specifically to address health disparities in minority populations. This increase is for the Comparative Health Disparities Demonstration that is intended to develop and assess more effective and efficient national and regional models for eliminating health disparities.

Non-comparable appropriated funding for GDM during the last five years, including amounts available for obligation from both general funds and trust fund transfers, has been as follows:

Fiscal Year	Funds	FTE
2005	$423,849,000	1,499
2006	$354,725,000	1,335
2007	$355,764,000	1,297
2008	$354,015,000	1,391
2009	$395,776,000	1,527

In addition to appropriated funds, the GDM budget uses other sources and types of funding, including: transfers from the federal Health Insurance and Supplementary Medical Insurance trust funds; inter-departmental delegations of authority; inter-agency reimbursements; and funds from the Health Care Fraud and Abuse Control (HCFAC) account. GDM also conducts centrally-managed projects which benefit the Department's OPDIVs and STAFFDIVs, under the authority of the Economy Act (31 USC 1535) or other specific statutes. Costs for these activities

are distributed among the OPDIVs and STAFFDIVs on a proportional basis, using established cost distribution formulas.

The President's FY 2010 appropriation request of $409,549,000 for the GDM account represents current law requirements. No proposed law amounts or program eliminations are included.

IMMEDIATE OFFICE OF THE SECRETARY

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
BA	$10,728,000	$11,073,000	$11,245,000	+$172,000
FTE	67	73	73	--

FY 2010 Authorization .....Indefinite
Allocation Method .....Direct federal

Program Description and Accomplishments

The Immediate Office of the Secretary (IOS) provides leadership, direction, policy, and management guidance to the Department, and supports the Secretary and Deputy Secretary in their roles as representatives of both the Administration and the Department of Health and Human Services (HHS). IOS serves as the nucleus for all HHS activities and shepherds the Department's mission of enhancing the health and well being of Americans.

The Immediate Office serves to advocate the Administration's health and human services agenda and drives the Department's formulation of policy. The mission of the office involves coordinating all Departmental documents, issues and regulations requiring Secretarial action; mediating the resolution of differences between Departmental components; communicating Secretarial decisions; and ensuring the implementation of those decisions. IOS achieves this objective by ensuring key issues are brought to leaderships' attention in a timely manner, facilitating discussions on policy issues, reviewing documents requiring Secretarial action for policy consistent with that of the Secretary and the Administration, and coordinating the appropriate release of regulatory documents. IOS works with other Departments to coordinate analysis of and input on policy decisions impacting activities within their purview. IOS also ensures White House policymakers are afforded a timely opportunity to participate in policy decisions impacting high-profile issues.

IOS activities include:

- Leading efforts to reform health care across all HHS programs by improving the quality of the health care system and lowering its costs, computerizing all medical records, and protecting the privacy of patients. Direct activities that increase the delivery of quality care to all Americans by instituting temporary provisions to make health care coverage more affordable.

- Providing advisory management and executive leadership essential for the Secretary to manage and direct the numerous programs in the Department. This includes, the Executive Secretariat which coordinates and facilitates policy decisions within the Department by ensuring that the relevant decision makers provide input into the decision

making process and policy implementation. The Executive Secretariat works with pertinent components to develop comprehensive briefing documents, facilitate discussions among staff and operating divisions, and ensures final products reflect policy decisions.

- Providing assistance, guidance and coordination to the White House and other Cabinet agencies on HHS issues.

- Setting the Department's regulatory agenda and review of all new regulations and regulatory changes to be issued by the Secretary; performing an on-going review of regulations which have already been published, with particular emphasis on reducing the regulatory burden.

- Responsible for Departmental direction for strengthening program integrity by reducing waste, fraud, and abuse and holding programs accountable.

Funding History

FY 2005	$ 7,872,000
FY 2006	$ 8,728,000
FY 2007	$ 9,959,000
FY 2008	$10,728,000
FY 2009	$11,073,000

Budget Request

The FY 2010 request for IOS is $11,245,000, an increase of $172,000 above the FY 2009 Omnibus. This amount will partially cover increased personnel costs, such as the annualization of the January 2009 pay raise and the anticipated January 2010 pay raise.

The budget request for IOS will be used to support agency policy direction, effective oversight and management on issues that the Secretary and HHS confront daily on more than 300 programs, covering a wide spectrum of activities. The budget also supports overseeing the operations and functions of IOS entities including: Deputy Secretary's Office, Scheduling and Advance, the Executive Secretariat and the White House Liaison.

ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$4,453,000	$4,432,000	$5,492,000	+1,060,000
FTE	27	32	38	+6

FY 2010 Authorization .....Indefinite
Allocation Method .....Direct federal

Program Description and Accomplishments

The Assistant Secretary for Public Affairs (ASPA) serves as the Department's principal public affairs office, communicating information on the Secretary's initiatives and HHS's mission and activities to the general public. ASPA plays an important role by:

- Serving the Secretary in advising and preparing public communications.
- Providing timely, accurate, consistent and comprehensive public health information to the public.
- Coordinating public health and medical communications across all levels of government and with international and domestic partners.
- Providing public affairs counsel in the HHS policymaking process.
- Acting as the central HHS press office handling media requests, clearing all press releases and interviews, and managing news issues that cut across Agencies; produce electronic clips for the Secretary and senior staff; and compile a Department-wide report on each day's media affairs.
- Managing and maintaining the content of the HHS Web site and counsel on outreach utilization of New Media and the Web.
- Overseeing the extensive daily public affairs activities that take place throughout the Department.
- Supporting the Secretary's television and radio appearances; manage the HHS studio, producing and distributing radio and television outreach materials and monitoring television news; and provide HHS photographer.
- Producing speeches, statements, articles, and related material for the Secretary, Deputy Secretary and Chief of Staff and other top Departmental officials; researches and prepares op-ed pieces, features, articles, and stories for the media.
- Maintaining HHS FOIA/Privacy Act operations and activities.

ASPA also continues to lead the development of a consolidated, U.S. government-wide public Web portal to provide citizens with access to timely information on how to prepare for a possible outbreak of avian influenza. In addition, Web staff are upgrading, modernizing, and enhancing the Department's internal and external Web presence, to allow Web access to the vital health and

human service programs that reside within HHS. Funds to address Web improvements are requested in the Rent and Common Expenses. This has necessitated establishing a governance organization to evaluate the content and timeliness of agency Websites, and to coordinate them with the Department's Website.

In FY 2007, ASPA organized, convened and coordinated more than two dozen briefings for the media to gain support of the Secretary's initiatives; created reports, postcards, brochures and other leave-behind tools written and produced to complement the Secretary's Initiatives; published and distributed "Public Health Emergency Response: A Guide for Leaders and Responders," a reference guide designed to inform elected officials (e.g., mayors, county executives, governors) and first responders (e.g. police, fire, EMS, etc.) about the role of public health in emergency response; and conducted tabletop exercises on pandemic flu response in six U.S. cities with media representatives and senior Federal, State and local officials.

In FY 2008, ASPA developed more than a dozen new public service announcements for local media to use during emergency and disaster response or to heighten awareness of pressing health care issues; redesign the HHS Newsroom site with more interactive and comprehensive features such as web videos, promoted awareness of the Secretary's blog, and conducted a pandemic flu response tabletop exercise with bloggers and senior Federal, State and local officials.

In FY 2009, ASPA continued to work on several key areas including: improving the effectiveness of Departmental education and marketing campaigns, producing and distributing health messages to television and radio station outlets, and improving the efficiency of processing Freedom of Information Act (FOIA) requests based on current laws.

Funding History

FY 2005	$3,929,000
FY 2006	$3,931,000
FY 2007	$4,008,000
FY 2008	$4,453,000
FY 2009	$4,432,000

Budget Request

The FY 2010 request for ASPA is $5,492,000, an increase of $1,060,000 above the FY 2009 levels.

We are in the midst of a communications revolution, one that for the first time allows direct public interaction in the shaping and implementation of policy, even as it exponentially increases the platforms from which we communicate. It is critical that Americans have the tools they need to hold their government accountable and be able to witness firsthand critical policy decisions and actions in the public sphere. These platforms include New Media applications that allow the Department to reach new and often underserved audiences, harness "viral" messaging whereby individuals rebroadcast health messages in ever-expanding personal networks, and to engage people in nearly infinite national discussions. And capitalizing on these new platforms requires new resources and capabilities.

This budget request will support the annualization of the January 2009 pay raise and the anticipated January 2010 pay raise. It will also allow ASPA to conduct Department-wide public affairs programs; synchronize Departmental policy and activities with communications; oversee the planning, management and execution of communication activities throughout HHS, and administer the Freedom of Information Act (FOIA) and Privacy Act programs on behalf of the Department.

Additionally, the increase will fund six additional FTEs. ASPA needs new staff that is comfortable with New Media, who *blog* and *twitter*, who understand the convergence of video, Web and social networking, who can bring the American people to the table as participants in the policy process, and who know that writing and communicating via these new platforms requires new and different talents. Specifically, ASPA needs the following positions to build an integrated collaborative team:

- *Studio TV Producer* capable of producing live and Web events both in-house and in the field;
- *New Media TV Producer* who integrates traditional with social media for Webcasting and other interactive formats;
- *Speechwriter* who crafts messages equally effective delivered in the virtual medium and from the podium;
- *Blog Writer* who is capable of communicating critical messages in a personal and engaging manner and responding directly to citizens' questions and concerns;
- *Outreach Specialist* who is capable of traditional marketing and New Media messaging;
- *Graphic Designer* who is capable of illustrating complex concepts across a spectrum of media; and
- *FOIA Executive Staff Analyst* who will assist FOIA staff in redesign of HHS-wide FOIA processes and help utilize technology to expedite FOIA requests.

In addition to these staffing needs, ASPA also needs to make some important investments in making the Department more accountable and transparent and to expedite the process for getting critical information to Congress and the American people. ASPA would like to hire an outside consulting firm with experience in technology and databases to conduct an audit on our FOIA systems and suggest potential upgrades and changes to make the information available faster and more efficiently.

ASSISTANT SECRETARY FOR LEGISLATION

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$3,379,000	$3,430,000	$3,978,000	+548,000
FTE	26	27	30	+3

FY 2010 Authorization .....Indefinite
Allocation Method .....Direct federal

Program Description and Accomplishments

The Office of the Assistant Secretary for Legislation (ASL) serves as the principal advocate before Congress for the Administration's health and human services initiatives; serves as chief HHS legislative liaison and principal advisor to the Secretary and the Department on Congressional activities; and maintains communications with executive officials of the White House, OMB, other Executive Branch Departments, Members of the Congress and their staffs, GAO, non-governmental organizations and associations.

ASL informs the Congress of the Department's views, priorities, actions, grants and contracts and provides information and briefings that support the new Administration's priorities and the substantive informational needs of the Congress. The mission of the office also includes coordinating all Departmental documents, issues and regulations requiring Secretarial action; mediating the resolution of differences between Departmental components; communicating Secretarial decisions; and ensuring the implementation of those decisions.

ASL is organized into six divisions:

- Immediate Office of the Assistant Secretary for Legislation;
- Office of the Deputy Assistant Secretary for Discretionary Health Programs;
- Office of the Deputy Assistant Secretary for Mandatory Health Programs;
- Office of the Deputy Assistant Secretary for Human Services;
- Office of the Deputy Assistant Secretary for Congressional Liaison; and
- Office of Oversight and Investigations.

Immediate Office of the Assistant Secretary for Legislation -The Assistant Secretary for Legislation serves as principal advisor to the Secretary with respect to all aspects of the Department's legislative agenda and Congressional liaison activities. Examples of ASL activities are:

- working closely with the White House to advance Presidential initiatives relating to health and human services;
- managing the Senate confirmation process for the Secretary and the 19 other Presidential appointees requiring Senate confirmation;
- transmitting the Administration's proposed legislation to the Congress; and

- working with Members of Congress and staff on legislation for consideration by appropriate Committees and by the full House and Senate.

Office of the Deputy Assistant Secretary for Discretionary Health Programs - The Deputy Assistant Secretary for Legislation for Discretionary Health Programs assists in the legislative agenda and liaison for discretionary health programs. This portfolio includes:

- Health-science-oriented operating divisions
- Health IT
- Private-sector health insurance
- Medical literacy, quality and patient safety, and
- Bio-defense

Office of the Deputy Assistant Secretary for Legislation for Mandatory Health Programs - The Deputy Assistant Secretary for Legislation for Mandatory Health Programs assists in the legislative agenda and liaison for health services and health care financing operating divisions.

Office of the Deputy Assistant Secretary for Legislation for Human Services - The Deputy Assistant Secretary for Legislation for Human Services assists in the legislative agenda and liaison for human services and income security policy.

These three offices carry out activities such as developing, transmitting, providing information about, and working to enact the Department's legislative and administrative agenda; coordinating meetings and communications of the Secretary and other Department officials with Members of Congress; notifying and coordinating with Congress regarding the Secretary's travel and event schedule; and preparing witnesses and testimony for Congressional hearings.

The Office of the Deputy Assistant Secretary for Congressional Liaison (CLO) maintains the Department's program grant notification system to Members of Congress (public access at: *GrantsNet* and *TAGGS*), and is responsible for notifying and coordinating with Congress regarding the Secretary's travel and events schedule. In addition, CLO provides staff support for the Assistant Secretary for Legislation coordinating responsibilities to the HHS regional offices, and coordinates the Continuity of Operations Plan (COOP). Activities include:

- responding to Congressional inquiries and notifying Congressional offices of grant awards (via Econosys) made by the Department;
- providing technical assistance regarding grants to Members of Congress and their staff; and
- facilitating informational briefings relating to Department programs and priorities.

The Office of Oversight and Investigations has responsibility for all matters related to Congressional oversight and investigations, including those performed by the Government Accountability Office (GAO), and assists in the legislative agenda and liaison for special projects. This includes coordinating Department response to Congressional oversight and investigations; and acting as Departmental liaison with the GAO and coordinating responses to GAO inquiries.

ASL successfully advocates the Administration’s health and human services legislative agenda before the Congress. ASL works to secure the necessary legislative support for the Department’s

initiatives and provides guidance on the development and analysis of Departmental legislation and policy.

Funding History

FY 2005	$2,732,000
FY 2006	$3,110,000
FY 2007	$3,187,000
FY 2008	$3,379,000
FY 2009	$3,430,000

Budget Request

The FY 2010 request for ASL is $3,978,000, a net increase of $548,000 above the FY 2009 President's budget level. This increased funding will allow ASL to carry out critical activities to support the President's legislative healthcare agenda that, among others, include fundamental reforms to the healthcare system that expand health insurance coverage to millions of uninsured and underinsured Americans, lower the cost of healthcare for America's families, businesses and government, and improve the quality or care patients receive.

In FY 2010, ASL will use this increased budget amount to support the President's commitment to strengthen the systems that protect our food and medical products supply and to provide the FDA with the authority to regulate tobacco. In addition, ASL will support a critical part of the President's agenda to reduce healthcare costs through an expedited pathway for the approval by FDA of follow-on biologic medicines. ASL will also support efforts to reauthorize the Temporary Assistance to Needy Families (TANF) program, the Ryan White Care Act, the HRSA health professions programs and others.

ASL will continue to work on several mission critical areas with Members of Congress, Congressional Committees and staff including: managing the Senate confirmation process for Department nominees; preparing witnesses and testimony for Congressional hearings; improving Congressional awareness of issues relating to the programs and priorities of the Administration and advising Congress on the status of key HHS priority areas. Additionally, ASL will support increased activity as a result of the implementation of the American Recovery and Reinvestment Act (Recovery Act), including health information technology, comparative effectiveness research, prevention funding, and other components of the Act.

This budget request will support ASL in facilitating increased communication between the Department and Congress; support ASL's responsibilities to monitor, coordinate and respond to the increasing oversight and accountability activities of the Government Accountability Office (GAO); and cover funding for increased personnel costs to include six FTEs, which will enable ASL to continue carrying out mission critical activities to support the President's legislative healthcare agenda. Additionally, increased funding will support annualization of the January 2009 pay raise and the anticipated January 2010 pay raise.

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
Budget Authority	0	0	0	0
PHS Evaluation	$41,243,000	$41,243,000	$41,243,000	0
Reforming Health Care	0	$1,000,000	$12,500,000	+$11,500,000
CHIPRA	0	$5,000,000	$10,000,000	+$5,000,000
PHS Evaluation FTE	120	118	119	+1
Reforming Health Care FTE	0	10	18	+8

Authorizing Legislation:……42 U.S.C. 241 Public Health Service Act
FY 2010 Authorization……...Indefinite
Allocation Method: Direct federal/intramural; Contracts; Competitive grants/Cooperative agreement; Other (Salaries and Expenses, etc.)

Program Description and Accomplishments

The Assistant Secretary for Planning and Evaluation (ASPE) serves as the principal policy advisor to the Secretary of HHS on issues related to health, disability, aging, human services, and science. ASPE conducts research and evaluation studies; provides critical policy analysis, development, and advice; provides policy planning, coordination, and management; conducts research, evaluation, and data collection; and estimates the costs and benefits of policies and programs under consideration by HHS or the Congress. ASPE has a long history of leading special initiatives on behalf of the Secretary (e.g., health care and welfare reform), and provides direction for HHS-wide strategic, evaluation, legislative and policy planning.

Four policy offices within ASPE (Health Policy, Science and Data Policy, Human Services Policy, and Disability and Long Term Care Policy) perform these functions with a focus on their primary population or issue of interest. ASPE develops and reviews issues with a perspective that is broader in scope than that of any one Operating Division (OPDIV) or Staff Division (STAFFDIV). When appropriate, ASPE divisions collaborate with HHS OPDIVs and STAFFDIVs, as well as other federal agencies, state and local partners, and non-governmental groups, in performing these functions. Working with these partners enables ASPE to leverage available resources more effectively, achieve efficiencies, and assist the translation of research into practice. ASPE also coordinates and manages data and information policy within HHS, and coordinates crosscutting policy-related activities within, and sometimes outside, HHS.

ASPE's contributions provide objective and reliable information for policy development and program decision-making. ASPE's policy analysis, evaluation and policy development activities

in health, long-term care, science, and human services have contributed substantial information to senior policy makers in HHS and throughout the federal government.

ASPE continues to build a strong analytical capacity, including making substantial investments in the creation and analysis of nationally representative data to inform critical policy issues. Policy support services provided include micro simulation modeling, statistical analysis, actuarial support and other technical and analytic services. These services support internal HHS-wide coordination in data policy, including interagency data collection and data standards, and collaborative efforts between HHS, the health industry, and the non-profit and philanthropic sectors.

In addition to the activities of the four policy offices, ASPE also performs the following primary activities:

- Data Collection Coordination – ASPE leads the coordination of data collection and statistical policy across HHS. To promote HHS-wide planning and coordination for data collection investments, ASPE co-chairs the HHS Data Council that is comprised of senior executives and managers from all HHS OPDIVs and STAFFDIVs. The Council promotes HHS-wide communication and planning for data collection from a collective, HHS-wide perspective, assures coordination and cost efficiencies in addressing interagency data needs and issues, stresses efficient and effective approaches to data collection, and serves as a forum to address priority interagency, HHSal and national data needs in a coordinated fashion.

- Research Coordination – ASPE also has the lead role in ensuring that the HHS' investment in health and human services research supports the Secretary's priorities in the most efficient and effective manner. ASPE continues to work to achieve efficient leveraging of the HHS' health and human services research portfolio by identifying areas where efficiencies could be achieved through collaboration, and by identifying better ways to translate the findings of research into practice.

- Research and Evaluation – ASPE's policy research and evaluation program has a significant impact on the improvement of policies, programs and services of the HHS, through the systematic collection of information on program performance; gauging program effectiveness, improving performance measurement, performing environmental scans and assessments, and providing program management.

In FY 2008 and FY 2009 ASPE supported HHS' mission and works to implement the Strategic Goals from the FY 2007-2012 HHS Strategic Plan, as described below.

Goal 1: Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care through:

- Providing policy research, economic, actuarial and technical analyses in support of the President's health reform and health policy initiatives.
- Conducting policy analyses used in developing the President's proposal to expand health care access to every American through a national health insurance exchange and potentially a

public plan. ASPE conducted research and analysis that examined how to measure efficiency within a public insurance program.

- Leading and conducting policy research and economic analyses to promote and accelerate the adoption of Electronic Health Record (EHR) systems, and to support the President's associated health information technology initiatives to transform health care. This work has resulted in acceptance of new health information technology standards, demonstrations and evaluations of EHRs and PHRs, and frameworks for incentives for EHR adoption.
- Conducting research and policy analyses of Medicare payment issues such as the Sustainable Growth Rate (SGR) for physicians' services, payment options for Medicare Advantage plans, and the market dynamics for these plans.
- Leading analyses in support of the implementation of the recently passed Medicare mental health parity provision for outpatient psychiatric services.
- Conducting research and analysis that resulted in a modification of the Medicaid law to provide all states with the option to implement the Long-Term Care Partnership. ASPE completed and issued the federal guidance and regulations implementing the Partnership. More than half the states have modified their Medicaid plans to include Partnership programs. ASPE provides ongoing support and technical assistance to these programs.
- Leading the implementation of the Long-Term Care Awareness Campaign. The campaigns in 17 states have led to significant increases in planning activities related to long-term care, such as the purchase of the long-term care insurance, with a 15% increase in policies purchased in the campaign states.
- Co-chairing the HHS Data Council that has coordinated HHS data activities and has developed the web-based Gateway to HHS Statistics and Data on the Web, an integrated, one-stop HHS-wide website that provides user-friendly access to the wide range of statistics and data developed by HHS agencies. The Gateway is designed to provide information for policy development and decision making in health and human services and has been expanded to include minority data and health insurance data websites.

Goal 2: Prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats by:

- Conducting studies related to national vaccine policy and economics, including cost-benefit analysis of influenza vaccine; a study to better understand vaccine shortages; a series of analyses relating to the demand, supply and economics of the vaccine production and distribution in the U.S.; and a project with FDA to develop and evaluate a system for the rapid post-approval assessment of the safety of a pandemic vaccine.
- Conducting cost-benefit analyses of clinical and community-based preventive services.
- Conducting evaluation and policy development efforts in chronic disease prevention and health promotion, with a focus on increasing physical activity and preventing obesity.
- Conducting rigorous research on the cost-effectiveness of preventing falls among the elderly. Falls are a leading cause of disability, death and decreased quality of life for seniors.
- Co-sponsoring a research synthesis at the National Academies on Nutritional Risk Assessment.
- Developing, funding and implementing with CMS and FDA the Sentinel drug safety initiative, a national, integrated, electronic system for monitoring drug safety after market approval based upon Medicare Part D data and other health plan data.

- Conducting research to strengthen FDA's import safety and food safety risk assessment and management.

- Providing support for the HHS' efforts to improve public health and emergency preparedness efforts.
- Developing cost-benefit analyses comparing screening and treating refugees for communicable diseases prior to or after entry into the U.S.

Goal 3: Promote the economic and social well-being of individuals, families and communities by:

- Providing policy research and analysis to inform and support legislative proposals, regulations, reauthorization and implementation changes in TANF, Head Start, the Child Abuse and Neglect Prevention Act, and other programs. ASPE developed a model to estimate eligibility for the TANF Contingency Fund and which is used to estimate outlays from the Fund. ASPE analyses of various Head Start funding proposals contributed to estimates of the effect of changes on enrollment and funding allocation across grantees. ASPE's sponsorship of data collection and analysis of resulting data on health and employment of TANF recipients contributed to policies that were incorporated in interim final regulations.
- Conducting research on family processes, family structure, and the economic, social, and physical well-being of children and families. ASPE analysis found that family relationships matter for adolescents and young adults and that parent-marital quality and parent-adolescent relationship quality are related to physical health, mental health, substance use, and other outcomes.
- Leading the Interagency Working Group of Youth Programs, which has created FindYouthInfo.gov, a web-based resource that assists citizens and decision makers to plan, implement, and participate in effective programs for at-risk youth. The Working Group's membership includes twelve federal HHSs that focus on youth. Through the Working Group, ASPE works to enhance collaboration among these HHSs and other existing interagency workgroups and to improve the effectiveness of youth programs
- Conducting research on child welfare practices and collaborating to create and analyze the first national database on adoptive families. Results of projects are being used extensively by state and local agencies to change policies and practices.

Funding History

GDM

FY 2005	$6,851,000
FY 2006	$6,726,000
FY 2007	$6,787,000
FY 2008 *	$0
FY 2009	$0

PHS Evaluation

FY 2005	$35,000,000
FY 2006	$35,000,000
FY 2007	$34,500,000
FY 2008 *	$41,243,000
FY 2009	$42,243,000

* FY 2008 reflects the shift of all GDM funding for ASPE into PHS Evaluation funds.

Budget Request

The FY 2010 request for ASPE is $53,743,000 (excluding the Children's Health Insurance Program discussed below) an increase of $11,500,000 over the FY 2009 level. This increase will provide funds to support the President's Reforming Health Care initiatives, including policy research, analysis, micro simulation modeling, actuarial, public health, and economic analyses, and to fund an additional ten FTE on-board in FY 2009. The FY 2010 funding level will also allow ASPE to continue a variety of independent policy research and evaluation activities across the spectrum of the HHS's programs, with particular attention to crosscutting initiatives.

ASPE's Research and Evaluation program, funded under section 241 of the U.S. Public Health Service Act, has a significant impact on the improvement of HHS policies, programs and services. Set-aside funds are used to conduct research and evaluation studies; collect data; and estimate the costs, benefits and impacts of policies and programs under consideration by HHS or the Congress. ASPE's work directly supports the HHS's mission and achievement of the Strategic Goals. In FY 2010 ASPE will conduct the following activities in support of HHS's four Strategic Goals.

Goal 1: Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care. Priority projects for FY 2010 under this goal include health care reform initiatives, promoting health information technology; modernizing Medicaid; and strengthening and improving Medicare.

- Health Reform. Provide policy research, economic, actuarial and technical analyses in support of the President's health reform and health policy initiatives.
- Improve health care quality. Continue to research, develop, and analyze policy options to improve the quality of health care for all Americans. Conduct an assessment of the methodology used to develop estimates of the number of medical errors and preventable deaths that occur each year.
- Quality Measurement. Work with internal partners to foster the use of Medicare data to support efforts of local quality measurement.
- Health information technology. Continue policy analysis and evaluation efforts for improving the effectiveness and efficiency of the health system through the accelerated adoption of health information technology. Continue ASPE's leadership role in evaluating activities to support the President's priority to accelerate the development and use of

information technology in health care, long-term care, and public health. Areas of focus include developing a framework and pathway for Medicare EHR incentives, safety net providers, physician adoption, personal health records demonstrations and evaluations, Health IT for public health and improving the tools for communicating patient information during transitions from hospitals to nursing homes and post-acute care settings.

- Health care marketplace competition. Investigate the impacts of health care marketplace competition, and research the effects of health care spending on the economy.
- Long-term care needs and services. Continue research efforts to study, analyze, and evaluate consumer-driven options for organizing, delivering, and financing home- and community-based support for people who use long-term care services. Develop and analyze policy options and identify barriers, with the goal of expanding long-term care planning opportunities for individuals.
- Strengthen health professions workforce. Support new and ongoing research activities to address the recruitment and retention of a qualified, stable frontline workforce to provide long-term supports in institutional and community settings, including strengthening the basic data infrastructure and partnering with the HHS of Labor to promote career ladders for paraprofessional workers in long-term care settings.
- HIV/AIDS prevention and treatment. Continue to work on issues related to the implementation of the Ryan White HIV/AIDS Modernization Act of 2006, and work with HRSA and ASL to respond to inquiries from Congress about progress implementing new provisions of the Act.
- Independent living supports. Support survey research and analysis on home modifications that enable older individuals with disabilities to live in their homes more safely for longer periods of time.
- Advance directives and hospice services. Continue to support research on advance directives and hospice services, to provide policymakers with sound information on death-and dying-related issues, and to promote awareness and planning by consumers.
- Disability in the aging population. Develop and analyze policy options and data sources for measuring and describing the aging of the population and the incidence and prevalence of disability in the aging population.

Goal 2: Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats. Priority projects for FY 2010 under this goal include improving food and medical product safety, promoting emergency preparedness, response and recovery planning efforts; preventing chronic disease and promoting healthy behaviors; and reducing health disparities.

- Improve Food and Medical Product Safety. Conduct research and analyses to strengthen FDA's food safety capacity, and post market drug and medical product surveillance.
- Chronic Disease Prevention and Health Promotion. Conduct cost-benefit analyses of a variety of evidence-based clinical and community-based preventive services. Conduct evaluation and policy development efforts in chronic disease prevention and health promotion, with a focus on increasing physical activity, preventing obesity, preventing costly falls among the elderly, and addressing the long-term care needs of chronically ill individuals with impairments.
- Retail clinic industry. Conduct an assessment of the policy implications of continued

expansion of the retail clinic industry. This includes an assessment of applicability of this service delivery site for the Medicare population.

- HIV/AIDS prevention and treatment. Examine HIV disease management programs that serve Medicaid enrollees and other low-income populations.
- Performance measurement. Conduct research to develop measures and metrics for assessing the performance of the health system at national, state and local levels.
- Public Health and Emergency preparedness. Work closely with other agencies on the implementation of the Emergency Preparedness Plan and Pandemic Flu Plan, with special attention to evaluation, data and policy analysis.
- Conduct policy research, evaluation and data development for assuring and assessing prevention, preparedness, and response capabilities for planning, preparing, and responding to a variety of public health threats, such as bioterrorism, natural disasters, and a potential disease pandemic. Conduct research to understand how states and localities plan for the needs of vulnerable populations in their emergency preparedness plans.
- Mental health and substance abuse programs. Conduct evaluation efforts targeted at the effectiveness of mental health and substance abuse programs.
- Assessing and addressing disparities in health. Continue to research, develop and analyze policy options to identify, assess and reduce racial and ethnic health disparities.

Goal 3: Promote the economic and social well-being of individuals, families and communities. Priority projects for FY 2010 under this goal include promoting economic independence and social well-being of individuals and families; protecting the safety and fostering the well-being of children and youth; and addressing the needs of other vulnerable populations, including human trafficking victims.

- Economic Opportunity and Support. Conduct research, evaluation and analyses on poverty; low-wage workers; welfare; and child support enforcement. Continue research on policies to help low-income Americans succeed in the workforce, ensure access to other safety net programs such as TANF, enhance the well-being of vulnerable families and their children, foster self-reliance and reward work, support capacities for ownership, and improve strategies for helping the hard-to-employ. Continue support for the Poverty Research Centers to examine causes, consequences, and remedies of poverty.
- Fathers and families. Conduct research on healthy families and responsible fatherhood to promote economic security, family stability, child well-being, and public health. Continue to build the knowledge base about family structure and function, the contributions of fathers, and effective family strengthening services by specific subgroups. Continue to analyze child support enforcement, including ARRA investments, and its contribution to child health and economic wellbeing. Continue to evaluate programs for incarcerated and re-entering fathers and their partners.
- Healthy youth development. Promote healthy youth development through research and data on positive youth development and risk-based adolescent behaviors, support interdepartmental collaborations to assist at-risk youth, and continue to build evaluation capacity to assess effectiveness and improve programs.
- Early childhood development and child well-being. Continue to examine programs and policies that affect child well-being, early childhood development, early childhood education, and coordination across programs. Continue to model eligibility for and use of child care

subsidies.
- Child Welfare. Examine ways to improve permanency planning for at-risk children and assess child welfare financing issues.
- Homelessness. Continue to coordinate the HHS' activities related to homelessness, including chairing the HHS' internal Homelessness Work Group and serving as the liaison between the HHS and the U.S. Interagency Council on Homelessness. Continue to support research and evaluation to improve programs and services for homeless persons, with a special focus on the impact of homelessness on children.
- Vulnerable Populations. Continue research and analysis on policies and strategies for vulnerable populations including Native Americans and immigrant and refugee families.
- Faith-Based and Neighborhood Partnerships. Conduct analysis in support of the President's initiative to maximize effective partnerships, and contribute to overall understanding of the role these organizations play in social services delivery.
- Worksite wellness. Explore the types and comprehensiveness of worksite wellness programs. Examine the effectiveness and cost benefit of these types of programs.

Goal 4: Advance scientific and biomedical research and development related to health and human services. Priority projects for FY 2010 under this goal include conducting research and evaluation efforts and translating them into practice, especially in the areas of food, drug and medical product safety, and personalized health care.

- Innovation. Conduct policy analysis and research relating to the research, development, adoption and technology innovation cycle in health care, including genomics, drugs, biologics and devices in support of prevention and treatment.
- Genomics and health care. Support policy research and analytical efforts to further the concept of personalized health care by building upon existing efforts, providing leadership and program and policy coordination across HHS, and carrying out a program of policy research, analysis and evaluation.
- Food, drug, and medical product safety. Conduct evaluation and analytical efforts and support policy research and analytical efforts in issues related to national vaccine policy; food, drug, and medical product safety; national prescription drug policy including pharmaceutical economic, drug cost, and utilization studies; international drug studies; and pharmaceutical research and development issues.
- Risk assessment and management. Conduct evaluation and analytical efforts in risk assessment, risk management, risk communication, regulatory science, and the impact of biomedical investment and related issues in science and technology policy.

HHS Evaluations of the Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires the Secretary of HHS to conduct two separate program evaluations of CHIP:

- Section 203(b) directs the Secretary to conduct a comprehensive, independent evaluation of a new option provided in CHIPRA for States to use Express Lane agencies to conduct simplified eligibility determinations. Section 203(b) also appropriates $5,000,000 for the period of FYs 2009-2012 to carry out this evaluation, including an analysis of the

effectiveness of the option, together with recommendations for legislative or administrative changes. A final report on the results of this evaluation is due to Congress no later than September 30, 2012.

- Section 603 directs the Secretary to conduct an independent evaluation of ten States with approved child care plans, and to submit a report to Congress on the results of the evaluation by December 31, 2011. Section 603 also appropriates $10,000,000 in FY 2010 for this evaluation, with funds remaining available through FY 2012.

ASPE will be responsible for both of these evaluations. CHIPRA funds are reflected in the other funding source table.

ASPE Grant Awards Table:

ASPE maintains a grants program to support academically based research centers. ASPE has a long history of supporting research and evaluation of important and emerging social policy issues associated with income dynamics, poverty, individual and family functioning, marriage and family structure, transitions from welfare to work, child well-being, and special populations. Federal support for the poverty center program has been continuous since 1968. Federal support for a marriage research center was instituted by ASPE in FY 2007.

ASPE's academic research center grants provide funding for five research institutes with funding levels ranging from $350,000 per year to $850,000 per year. The national poverty center conducts a broad program of policy research to describe and analyze national, regional and state environments (e.g., economics, demographics) and policies affecting the poor, particularly those families with children who are poor or at-risk of being poor. In addition, grants support three smaller research centers that maintain a more focused agenda on expanding our understanding of the causes, consequences and effects of poverty in local geographic areas, especially in states or regional areas of high concentrations of poverty. The national marriage research center works to improve our understanding of how family structure and function affect the health and well-being of children, adults, families and communities. All these centers develop and mentor social science researchers whose work focuses on these issues.

Description	FY 2008	FY 2009	FY 2010
Number of Awards	5	5	5
Average Award	$555,000	$550,00	$565,000
Range of Awards	$350,000 - $800,000	$350,000 - $789,000	$350,000 - $850,000

ASSISTANT SECRETARY FOR RESOURCES AND TECHNOLOGY

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 President's Budget	FY 2010 +/- FY 2009 Appropriation
BA	$23,162,000	$25,781,000	$29,705,000	+$3,924,000
FTE	149	166	191	+25

*Note: FTE levels include reimbursable FTE in all years funded via PHS Evaluation and Grants.gov.

FY 2010 Authorization .....Indefinite
Allocation Method .....Direct federal; Contracts

Program Description and Accomplishments

The Assistant Secretary for Resources and Technology (ASRT) advises the Secretary on all aspects of budget, grants, financial management and information technology, and provides for the direction of these activities throughout the Department of Health and Human Services (HHS). In carrying out these functions, the Assistant Secretary has several formal and informal roles, including Chief Financial Officer (CFO), Chief Infrastructure Assurance Officer, HHS audit follow-up official, and lead official for budget and grants. The Assistant Secretary is also a close advisor to the Secretary on all policy issues. Beginning in FY 2009, ASRT is also responsible for overseeing the implementation and reporting of all activities for HHS under the American Recovery and Reinvestment Act of 2009. ASRT accomplishes its work through its component offices:

Office of Recovery Act Coordination – The Recovery Act Office is responsible for meeting performance goals and objectives related to the timely and effective implementation of the American Recovery and Reinvestment Act of 2009 (Recovery Act), and related Executive Orders and Presidential Memoranda. The Recovery Act provided an estimated $166 billion to HHS to support approximately 40 programs managed by 8 Operating Divisions, the Office of the Secretary (OS), and the Office of the Inspector General (OIG). The Office of Recovery Act Coordination was created in March 2009 using a small cadre of staff detailed from within HHS. This allowed the Office to begin functioning immediately. Over time, the Office will recruit more full-time staff for continuity and stability in operations.

The Recovery Act Office is the central HHS office responsible for addressing the emphasis on transparency and accountability required by the Recovery Act and subsequent Office of Management and Budget (OMB) guidance. The Recovery Act Office collaborates with the various major business functions across HHS -- grants, contracts, budget, finance, information technology, personnel, facilities and environmental quality standards compliance as well as offices such as the Office of General Counsel, and the Office for Civil Rights – to develop special guidance as necessary to meet these new requirements. The Recovery Act Office provides leadership for the establishment and reporting of financial and program performance

objectives for each supported program grant and contract; the design and operation of risk management strategies to prevent fraud, abuse, and waste. The Recovery Act Office will also work to develop new procedures to achieve transparency and accountability in the award of Recovery Act funds to States, communities, universities, institutions and individuals and in the use of funds by award recipients. The Office is also responsible for ensuring that HHS meets the requirements and deadlines established by the Recovery Act in accordance with the guidelines and schedules prepared by OMB and the Accountability and Transparency Board.

Office of Budget (OB) – The OB manages the preparation of the HHS' annual performance budget, and prepares the Secretary to present and defend the budget to the public, the media, and Congressional committees. The OB serves as the HHS appropriations liaison. In addition, the OB manages the HHS' apportionment activities, which provide funding to the OPDIVs and Staff Divisions (STAFFDIV). The OB prepares analyses, options, and recommendations on all budget and management issues for the HHS and works with OMB and the Congress to accomplish the Secretary's priorities. The OB also manages the budget process for the OS and the Service and Supply Fund. In 2008, the OB provided budget guidance to the HHS OPDIVs in a timely manner and successfully submitted the FY 2009 Congressional Justifications and performance related material on time. In addition, the OB successfully managed the major workload required in support of the annual performance budget and other program budget analysis and estimates that occurred throughout the year. Guidance and technical assistance were provided in a timely manner. Budget and performance justifications were carefully reviewed and distributed in a timely manner prior to hearings. In 2009, prior to the establishment of the Recovery Act Office, the OB also played a pivotal role in the implementation of the Recovery Act at HHS by working with the OPDIVs and STAFFDIVs funded by the Recovery Act to develop spend plans and successfully implement new activities and provisions.

The OB also manages the implementation of the Government Performance and Results Act (GPRA) and the performance improvement activities. This involved preparing HHS Performance Highlights and On-line Performance Appendix; working on the Performance and Accountability Reports; managing OPDIV development of integrated performance budgets; establishing and coordinating quarterly senior manager meetings on performance; and coordinating performance measurement information as well as additional performance management products. The FY 2009 HHS Performance Highlights, On-line Performance Appendix and Congressional Justifications were submitted on time.

Office of Finance (OF) – The OF provides financial management leadership to the Secretary through the CFO and the OPDIV CFOs. In accordance with the CFO Act, OMB Circulars, the Federal Accounting Standards Advisory Board (FASAB) and other federal financial management legislation, OF manages and directs work in the development and implementation of financial policies, standards and internal control practices (as required by FMFIA and OMB Circular A-123). The OF prepares HHS' annual consolidated financial statements and coordinates the HHS' financial statement audit. The OF oversees HHS' financial management systems portfolio, and also has business ownership responsibilities for the Unified Financial Management System (UFMS). In addition, the OF has HHS-wide responsibility for ensuring that grantee audit findings (under OMB Circular A-133) are resolved in a timely and appropriate manner. The OF also has responsibility for overseeing the progress in managing the elimination

of improper payments (as required by IPIA). OF works with the CFO Community, throughout OS and with OIG to carry out its mission and drive results in these business areas.

Consistent with the Reports Consolidation Act and GPRA, federal agencies prepare an annual Performance and Accountability Report (PAR), or its alternative, which includes consolidated financial statements, the auditor's opinion and other statutorily required annual reporting. In FY2008, the OF and OB worked together to complete the second PAR pilot including the Agency Financial Report, the Agency Performance Report included in the Congressional Budget Justification, and the Citizen's Report on HHS' performance and financial information. For the tenth consecutive year, HHS earned an unqualified or "clean" opinion on the HHS' audited financial statements. In our efforts to achieve a "clean" opinion in FY2008, the OF developed a working model, which united the CFO community in the development and implementation of corrective action plans. This HHS-wide coordination enabled HHS to eliminate two material weaknesses (Budgetary Accounting and Medicare Claims Processing) in the Auditor's Report on Internal Control for FY 2008. Another result of this unity was that the OF and the OPDIV CFOs developed an HHS CFO Community Strategic Plan. Several of the corrective action initiatives started in FY 2008 are continuing in FY 2009, and some have been completed. Continuing FY 2009 activities include: working to systemically consolidate financial reporting; developing new and improving existing financial management and systems policies; and improving our information technology systems and security. These efforts support the HHS' management strategy towards HHS-wide improved financial management.

The OF develops HHS-wide policies and standards for financial and mixed financial system portfolios, including the development and business management of UFMS. UFMS is an integrated financial management system that operates across HHS' Operating Divisions and six HHS accounting centers. In FY 2008, HHS successfully executed its annual financial reporting closing across all HHS OPDIVs. A major contributor to this effort was the successful implementation of the Indian Health Service accounting center. HHS continues its UFMS stabilization efforts and is focusing significant resources to improve the financial management and reporting services across the HHS. The OF is currently working on the development of a Consolidated Reporting tool that will enable the OF to consolidate all reporting from UFMS, Healthcare Integrated General Ledger Accounting System (HIGLAS), and the National Institutes of Health National Business System (NBS)more effectively and efficiently. The HIGLAS implementation continues on schedule and HHS is working toward the incorporation of Medicare Parts C and D financial accounting into the system. As one of HHS' six accounting centers, NBS continues its integration of accounting and legacy systems to ensure comprehensive financial management practices. In connection with its financial management responsibilities, OF coordinates the HHS activities related to management initiatives to Improve Financial Management and Eliminate Improper Payments in Federal programs. The OF, in collaboration with the OPDIVs, continues progress toward meeting the criteria for improved financial management.

Further, HHS continues its progress in managing the elimination of improper payments in FY 2008. No new high-risk programs have been identified, and in FY 2008, HHS reported at least one component of an error rate for all nine HHS high-risk programs.

Office of the Chief Information Officer (OCIO) – OCIO, led by the HHS Chief Information Officer, is the primary Information Technology (IT) office for HHS. OCIO is responsible for IT security and policy, capital planning and investment control (CPIC), enterprise architecture, enterprise project management activities, and information collections and HHS-wide oversight of records management. In FY 2009, OCIO with National Archives and Records Administration (NARA) and OMB kicked off an integrated project team (IPT) to coordinate records management activities within HHS. The IPT will work with clear goals and objectives towards establishing the enterprise segment architecture for records management at HHS. OCIO coordinates activities throughout HHS to implement requirements under the Paperwork Reduction Act (PRA) and the Clinger-and Cohen Act and ensures compliance as HHS implements the Recovery Act. OCIO continues to promulgate HHS IT policies supporting security and enterprise project lifecycle management. HHS did not have any PRA violations in FY 2008.

OCIO leads the HHS IT CPIC process with an approximate annual portfolio of $6 billion: $3 billion in direct IT expenditures and $3 billion in IT grants to state and local entities. In its leadership role, OCIO coordinates the implementation of CPIC guidance from OMB and the Government Accountability Office (GAO) throughout HHS OPDIVs and ensures the IT investments remain aligned with HHS' strategic goals and objectives and the Enterprise Architecture.

OCIO leads the HHS-wide program for transitioning long distance telecommunications services from FTS2001, an expiring contract, to Networx. Under the Networx contract, OCIO will manage the complete portfolio of telecommunications services across HHS. OCIO will be responsible for ensuring compliance, service level agreement management, delivery of services, service and access optimization, technology refreshment, interoperability and migration of new services. This will reduce redundant OPDIV level functions and obtain economy of scale thru pooling and managing HHS requirements, usage volumes, and quantity discounts to manage and control prices and cost.

OCIO represents HHS in support of GSA through membership and participation in the Interagency Management Council. Additionally, OCIO staff act as co-chairs of the OMB-mandated Trusted Internet Connection (TIC) Initiative working group with the intent to bolster IT security across the federal government. OCIO staff also represents HHS at the Council of Principles (COP) in support of maintaining critical infrastructure and in support of the Government Emergency Telecommunications System, Telecommunications Service Priority.

Office of Information Technology Security (OITS) within the OCIO is responsible for management and oversight of the HHS' IT Security Program. OITS coordinates the efforts of OPDIV IT security programs in order to ensure compliance with the requirements of the Federal Information Security Management Act (FISMA) and compliance with OMB and guidance issued by the National Institute of Standards and Technology guidance. OITS performs HHS-wide coordination of all security performance measure implementation and reporting, including IT systems security certification and accreditation, security controls testing, risk assessments, contingency plan testing, and security training. OITS also coordinates activities to prevent,

mitigate, and detect computer security attacks against all IT systems at HHS, to also include the coordination of all security incident reporting to US CERT.

Office of Grants (OG) – The OG advises the Secretary on all aspects of grants administration. As HHS is the largest grant-making entity in the federal government, the OG continues to play a leadership role regarding assistance awarding programs (grants, grant payments, and cooperative agreements programs) government-wide. To accomplish management and oversight of HHS award policies, business processes and related systems, the OG maintains an expert, senior staff. The OG also convenes the Executive Committee for Grants Administration Policy comprised of high level grants policy and grants management experts from the HHS OPDIVs and STAFFDIVs, representing some 55 operational entities. In addition, the OG also operates two grants administrations systems, the Tracking Accountability in Government Grants System (TAGGS) award reporting system and the new HHS Forecast of Grant Opportunities. The OG also houses the government-wide Grants.gov Program Management Office and facilitates resolution of all related issues across agencies and awarding communities related to its functions.

The OG provides leadership in developing the award closeout process, which is a challenge government-wide, ultimately resulting in changes to HHS grants policy, business models, and the HHS' payment management system. In addition, the OG plays a critical role in the government-wide implementation of the Recovery Act. The OG assisted OMB in developing standard grant award terms and conditions; definition of terms: and HHS' Quarterly Recipient Reporting in consultation with the Recovery Act Office. In addition, the OG provides leadership in the grant-making process from program development, to application review and selection, award and post-award management and oversight, and award closeout.

The OG continues to provide leadership to government-wide and HHS communities. The OG has taken a leadership role with the Office of Personnel Management in the government-wide effort to develop a Grants Manager competency model as part of the greater commitment to human capital management. During FY 2009, the OG convened its first annual Cost Policy Forum, with internal and external experts. The goal of the Forum was to ensure that the revised Hospital Cost Principles maintained by the OG were adequate for government-wide use. FY 2009 oversight and evaluation activities have included the streamlining of funding models and processes related to administration of the President's Emergency Program for Aids Relief to African nations. In addition, the OG continues to focus on the development of modern policy guidance to drive modern business models and the functional requirements for the electronic systems that centralize information about HHS grants.

History

FY2005	$18,961,000*
FY2006	$18,943,000
FY2007	$20,662,000
FY2008	$23,162,000
FY2009	$25,781,000**

* The Office of Grants joined ASRT in FY 2005.
**The Office of Recovery Act Coordination created in FY 2009.

Budget Request

The FY 2010 request for the Office of the Assistant Secretary for Resources and Technology is $29,705,000 and 191 FTE. This is an increase of $3,924,000 and 25 FTE. The request will allow ASRT to address increasing responsibilities associated with improving financial management, expanding electronic government, improving budget and performance integration, improving grants management and operations oversight, and eliminating improper payments. As part of the HHS' efforts to support risk mitigation efforts for ongoing HHS activities, these additional resources will also help ASRT keep pace with the increased demands that have been placed upon it by the growth in HHS programs, allowing it to create guidance, policies, and controls crucial to the effective management of HHS programs, and achieve the Administration's accountability and transparency goals. These include improved support for financial reporting and financial controls, more robust budgetary execution controls and performance tracking. The Budget increase also provides critical staff and resources to undertake the pivotal responsibility of overseeing and coordinating the implementation of the Recovery Act in HHS. Specific information is included in the sections below.

Office of Recovery Act Coordination – The Recovery Act Office was established on March 12, 2009, midway in the fiscal year, in response to the enactment of the Recovery Act on February 17, 2009. The FY 2010 increase for ASRT includes the annualized level of resources necessary for the Office of Recovery Act Coordination to conduct the coordination, oversight, and reporting activities across HHS to ensure HHS meets the goals and requirements set forth under the Recovery Act.

Office of Budget (OB) – The OB will continue to manage the preparation of HHS' annual performance budget, and prepare the Secretary to support the budget to the public, the media, and Congressional committees. The OB will also continue its efforts to prepare analyses, options, and recommendations on all management issues related to budget for HHS and work with OMB and Congress to accomplish HHS priorities. The request will also allow the OB to continue its other responsibilities associated with the GPRA as well as support the Program Performance and Tracking System. In addition, the request provides additional funding for staff to address increased workload requirements and responsibilities as well as increasing requirements related to the Administration's priorities to employ rigorous standards of accountability and transparency throughout the federal government. The request provides funding for staff to address increased workload requirements and responsibilities associated with Recovery Act Activities and support for the Recovery Act Office, including reviewing spend plans, processing apportionments, and reviewing performance measures.

Office of Finance (OF) – The Office of Finance's FY 2010 request will provide continued support for financial management and reporting needs under the management initiatives for Improving Financial Management and Eliminating Improper Payments, with specific efforts to resolve outstanding financial statement audit findings, and auditor reported material weaknesses and significant deficiencies. The request will also sustain the implementation of the OMB Revised Circular A-123, *Management's Responsibility for Internal Control*. In response to the IPIA, OF continues to support HHS efforts to develop comprehensive error rates for all program components under the Eliminating Improper Payments initiative. Using an HHS-wide CFO Community Strategic Plan, the OF will continue to work across HHS to address outstanding management and auditor identified significant deficiencies and material weaknesses. The FY 2010 request also supports the extension of the OF role as the HHS central audit liaison and enables OF to lead the CFO community through the implementation and execution of the requirements of Recovery Act reporting. The OF continues its leadership role for reporting by managing and evaluating new and expanded reporting requirements to be implemented throughout HHS. OF staff will also participate as key members of Recovery Act implementation and execution teams as subject matter experts.

Within the construct of the CFO Community Strategic Planning activities, OF will develop updated financial policies and procedures to standardize HHS' approach to financial management across HHS. Additionally, OF will lead the efforts of the CFO Community to maximize the UFMS' technical capabilities and utilize its financial data for decision-making.

Office of the Chief Information Officer (OCIO) – The request will allow the OCIO to provide leadership and oversight in all of its responsibilities by enhancing the quality, availability, and delivery of HHS information and services to citizens, employees, businesses, and governments. OCIO will utilize FY 2010 funding to meet the current and pending legislative, statutory and regulatory requirements that will inherently impact resources within for the Office of the CIO as it participates in activities to ensure compliance throughout HHS. OCIO Records Management IPT will work with the OPDIVs to provide a transition plan from a paper based records management system to an electronic records management system. The request will support activities as the OCIO leads HHS Networx transition and TIC Initiative, which is on target to transition HHS' long distance telecommunications services from FTS2001 (an expiring contract) to Networx.

OCIO staff oversees the HHS-wide IT Security Program and its activities funded through the Public Health and Social Services Emergency Fund (PHSSEF). These activities include the monitoring and mitigation of any IT security incidents involving the loss of personally identifiable information. The IT Security Program ensures that HHS' IT security and privacy programs are in full compliance with the requirements of FISMA and the Privacy Act. As a result of ongoing efforts, the OIG provided a passing grade in its most recent annual review of HHS' compliance with FISMA. Continued strengthening of the enterprise computing infrastructure will be required HHS-wide to proactively identify and mitigate security risks introduced by the continuing attacks against IT systems across the federal government, including systems at HHS. Therefore, HHS is also requesting an increase for Cyber-Security through the PHSSEF in FY 2010. The increase for Cyber-Security in FY 2010 will enable HHS to

implement security architecture initiatives that will result in the re-design of the computing network infrastructures at several OPDIVs. This will provide for multiple layers of security controls to protect our most critical HHS information, while also enabling HHS to securely conduct scientific research with our partners. HHS will also pursue the secure use of evolving social networking technologies to enhance our health information sharing responsibilities with the general public. (See section on Public Health and Social Service Emergency Fund/Cyber Security).

Office of Grants (OG) – This request maintains and enhances the results in the projects and activity areas related to HHS grants administration from policy-making to business modeling and development of supporting system applications HHS-wide. In addition, OG will continue to contribute expertise and advise in the development of government-wide grant-making enterprise activities. This request also supports increased training requirements related to both grant administration and the intensified grant reporting requirements required by statute and regulation. In addition, this request supports increased OG activities to assist a larger number of recipients in their understanding of grant transparency and accountability requirements, including additional staff to support the increased policy-making and general assistance support requirements related to Transparency Act and recipient reporting.

ASSISTANT SECRETARY FOR ADMINISTRATION AND MANAGEMENT

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
Budget Authority	$16,855,000	$17,390,000 ,418,000	$18,411,000	+$1,021,0000
FTE (including reimbursables)	114	125	134	+9

FY 2010 Authorization.....Indefinite
Allocation Method.....Direct federal

Program Description and Accomplishments

The Assistant Secretary for Administration and Management (ASAM) advises the Department of Health and Human Services (HHS) Secretary on all aspects of administration; provides leadership, policy, oversight, supervision, and coordination of long and short-range planning for HHS; and supports the agency's strategic goals and objectives. This includes the successful implementation of the American Recovery and Reinvestment Act (Recovery Act). The ASAM provides critical Departmental policy and oversight in the following major areas: Office of Acquisition Management and Policy, Office of Human Resources, Office of Facilities Management and Policy, Office of Small and Disadvantaged Business Utilization, Office of Business Transformation, Office of Diversity Management & Equal Employment Opportunity, and the Office of the Secretary Executive Office. The ASAM also provides operational support for the Program Support Center (PSC), which is funded through other sources.

- **Office of Acquisition Management and Policy (OAMP)** – Provides performance leadership for HHS business practices through policy development and oversight of HHS contracts and logistics. In FY 2009, OAMP led the successful implementation of the HHS Consolidated Acquisition Solution (HCAS) system across the Department, further improving the integration of the organization's acquisition and financial management business processes. Also in FY 2009 OAMP issued HHS Acquisition Workforce guidance implementing the Federal Acquisition Certification program for Contracting Officers' Technical Representatives across the agency. OAMP has taken great strides in improving the Department's acquisition systems, standardizing training to further develop the agency's acquisition workforce, and developing performance measures to track and improve competition, performance-based contracts, and past performance assessments. In FY 2010, OAMP will continue to focus on enhancing its oversight and accountability function by improving the agency's systems, workforce, and business processes.

- **Office of Facilities Management and Policy (OFMP**) – Provides mission-enabling facilities and a safe, secure and healthy work environment for all HHS employees. OFMP is charged with effectively managing the Department's international real property portfolio. In FY 2008, 100 percent of HHS' real property acquisitions and disposals were executed in accordance with regulations. OFMP is also focusing on reducing energy consumption at

HHS facilities as mandated by the Executive Order (EO) 13423.

In FY2008, OFMP awarded a contract to improve the lighting throughout the HHH Building using a Utility Energy Savings Contract (UESC). The energy savings have already begun; the dollar savings per year will equate to $360,000 once the 5 year capital payback is completed. A new chiller was installed for hot weather load. HHS avoided the capital cost of $1M by negotiating the action with GSA. There will be a recurring savings of $10,000-$15,000 per year depending on usage during the summer. Improvements to the HHH building air handlers (installation of cogged drive belts) will yield an annual 3% savings in energy usage for that equipment.

- **Office of Small and Disadvantaged Business Utilization (OSDBU)** – Advises the Secretary and the Deputy Secretary on services and practices to foster the use of small and disadvantaged businesses as Federal contractors pursuant to Public Law 95-507. OSDBU's goal is to provide guidance to the small business community on Federal contracting processes and contracting opportunities available within HHS. OSDBU continues to monitor the performance of all acquisition activities exceeding $100,000 by Operating Divisions (OPDIVs) regardless of funds type to ensure they are structured to attain the Department's small business goals and drives process improvements.

- **Office of Business Transformation (OBT)** – Provides results-oriented analytical management oversight and policy support for key management efforts. OBT also oversees the implementation of special projects, strategic initiatives and commercial services activities, including insourcing on a Department-wide basis. These efforts are often designed to improve levels of service, create efficiencies, avoid costs and generate savings. To date, HHS has conducted multiple studies and has successfully implemented many improved or higher performing organizations.

- **Office of Human Resources (OHR)** – Provides leadership in the development and assessment of the Department's human resources programs and policies that support and advance the HHS mission. OHR also serves as the Department liaison to central management agencies exercising jurisdiction over personnel matters. The scope of OHR's activities is Department-wide, covering all statutes and regulations relating to human resources, including those under 5 USC and Title 5 CFR. This includes assigning responsibility to develop and implement methodologies to measure, evaluate, and improve human capital results to ensure mission alignment, effective HR management programs, efficient business processes and merit-based decision-making in compliance with laws and regulations. In FY2008, OHR worked as a strategic partner with the Food and Drug Administration to meet the goals for the FY08 hiring surge. As a result, FDA was able to successfully fill more than 1,400 positions prior to the September 30, 2008 deadline.

- **Office of Diversity Management and Equal Employment Opportunity (ODME)** Provides Departmental leadership in creating and sustaining a diverse workforce and promoting a workplace free of discrimination by establishing Departmental policy, conducting program evaluations, ensuring Equal Employment Opportunity (EEO) compliance, strengthening diversity through outreach, recruitment, and special employment initiatives. In FY 2008, ODME formed relationships with external affinity groups and

organizations to promote HHS job opportunities. As a result of the organization's efforts, Hispanic workforce representation increased 13% across HHS.

- **OS Executive Office (OSEO)** – Provides administrative management support and oversight to General Departmental Management-funded Staff Divisions within the Office of the Secretary in the areas of budget and financial management, strategic human capital planning, asset management, internal controls, travel, records and information management. OSEO provides centralized, cost-effective service delivery that enables the OS staff divisions to execute key functions for the Secretary and the Department. In addition, OSEO manages the OS EEO program.

Funding History

FY 2005	$15,298,000*
FY 2006	$15,644,000
FY 2007	$15,458,000
FY 2008	$16,855,000
FY 2009	$17,390,000

*Note: The Office of Grants Moved to the Assistant Secretary for Resources and Technology (ASRT) in FY 2005.

Budget Request

The FY 2010 request for ASAM is $18,411,000, an increase of $1,021,000 above the FY 2009 enacted appropriation. The increase is needed to cover the mandatory costs of annualization for the January 2009 pay raise and the anticipated January 2010 pay raise. Additionally, the increase will allow for additional resources to support stronger oversight and accountability of the Department's procurement and acquisition activities. With approval of the funding request in FY 2010, the ASAM will improve operations utilizing the following strategies.

Office of Acquisition Management and Policy (OAMP) will continue to standardize and modernize HHS' acquisition processes and expand its oversight and accountability role. Additionally OAMP will:

- Increase the use of full and open competition and increase the appropriate use of performance-based contracts and performance specifications.
- Manage the direction of acquisition and logistics policy (including travel policies) for the Department. Manage and monitor the travel card and e-travel systems, and providing direct travel support staff offices.
- Develop and maintain an acquisition career management program, in concert with Government-wide initiatives.

The additional funding for six OAMP positions will enhance the Department's accountability, performance and ability to:

- **Improve Program Performance**: Integrate capital planning, investment control, acquisition planning, program execution, earned-value and performance-based methodologies, and executive decision-making for improved program cost, schedule and

performance.

- **Strengthen Financial Stewardship:** Perform quality assurance, data validation, and performance measurement of acquisition functions and systems to: foster financial stewardship; identify and manage risks to successful acquisition and program performance, including potential organizational conflicts of interest; increase efficiency and cost saving; strengthen the implementation of audit recommendations; and promote accountability.
- **Enhance Transparency at all Levels**: Validate the soundness of acquisition decisions and processes. Through enhanced knowledge management, report on outcomes, best practices, and lessons learned to increase visibility into acquisition decision-making and operations. Strengthen communications with OMB, GAO, Congress, OIG, industry and other stakeholders to ensure the highest levels of procurement integrity and public trust.

Office of Facilities Management and Policy (**OFMP)** will develop policies and monitor HHS Occupational Safety, Health and Environmental Programs and provide technical assistance for OPDIV's in accordance with applicable Executive Orders (EO) and Federal, State and local laws and regulations.

The additional funding for two OFMP positions to the existing OFMP FTE totals will improve the Department's accountability and ability to:

- Continue the implementation of Environmental Management Systems across the Department (per EO 13423).
- Provide Departmental oversight for all HHS real property assets and the facilities capital budget planning and delivery process (per EO 13327).
- Lead the Comprehensive Historic Preservation Program to protect and preserve properties in accordance with the National Historic Preservation Act of 1996, as amended.
- Provide effective oversight of all construction projects including environmental and energy savings analysis to ensure compliance with all National Environmental Policy Act (NEPA) requirements in addition to other appropriate laws and regulations.

Office of Human Resources (OHR) will continue to provide Strategic Human Capital Planning guidance and policy for HHS' 65,000 plus workforce as well as overseeing enterprise-wide recruitment, retention, and succession programs by:

- Providing effective human resource services via consolidated Human Resource Centers.
- Evaluating and refining workforce planning processes to ensure they are integrated with agency budget proposals, employee performance contracts, and organizational restructuring plans.
- Identifying business process improvements to support accelerated hiring timeframes.
- Partnering with collective bargaining members to effectively manage the new consolidated bargaining agreement.

Office of Small and Disadvantaged Business Utilization (OSDBU) will continue to increase the use of mechanisms and programs which maximize opportunities for small businesses. It will work to disseminate best practices and policy that insures sufficient numbers of small businesses are considered during the procurement process including those needs as necessary to meet contract needs under the American Recovery and Investment Act (Recovery Act).

Office of Business Transformation (OBT) will perform management and administrative analysis and develop policy and guidelines for proposed or ongoing management initiatives to improve effectiveness and gain efficiencies by:

- Leading HHS development of High Performing Organizations (HPOs).
- Coordinating HHS' response to statutorily-imposed commercial services management requirements and related activities. These include the Department's requirements for: the Federal Activities Inventory Reform Act of 1998 (P.L.105-270), Section 647 (b) of Division F of the Consolidated Appropriations Act, FY 2004, P.L. 108-109, which requires annual commercial services management reports to Congress; and, Insourcing, Section 735 of Title VII of the Omnibus Appropriations Act, 2009, P.L. 111-8.
- Providing centralized coordination of all ASAM Recovery Act activities including drafting Recovery Act-related human resource, financial management, and facility construction management guidance.
- Facilitating strategic and tactical planning for organizations, including mission definition, goal and objective setting, and establishment of meaningful metrics and successful data collection.
- Documenting and disseminating best practices, including private sector innovations, that move the Department forward as an integrated whole, and developing strategic communications designed to facilitate organizational perception and change.
- Fostering communication across organizational boundaries to identify opportunities for savings/cost avoidances that can be redirected to HHS mission accomplishment.

Office of Diversity Management and Equal Employment Opportunity (ODME) will continue to establish policy and conduct program evaluations to ensure Diversity and EEO efforts are integrated, standardized and compliant throughout the Department with regard to legislative and regulatory requirements through:

- Providing technical assistance and coordination with the OHR on management and recruitment initiatives, assessment reviews and OPDIVs review process related to improving Diversity and EEO programs.
- Serving as the Departmental contact in the provision of assistive technology, devices and services to HHS employees with disabilities via the HHS partnership with the DoD Computer/Electronic Assistance Program.
- Reviewing, analyzing and adjudicate complaints of discrimination for purposes of issuing Final Agency Decisions on behalf of the Secretary.
- Providing oversight/technical assistance in connection with Alternate Dispute Resolution (ADR)-EEO programs and collaborating with the Departmental Appeals Board and others to facilitate the use of ADR techniques in the resolution of EEO complaints.

OSEO will continue to oversee the full complement of administrative management functions to the General Departmental Management-funded Staff Divisions within the Office of Secretary with an emphasis on procedures and systems that result in higher economies of scale and administrative efficiencies. Services will include:

- Ensuring the appropriate policies, standard operating procedures, and training programs are in place for across the various administrative program areas (travel, asset management, purchase card management, etc.).
- Providing budgetary and financial management services in support of its client base.
- Ensuring the appropriate internal controls are in place across all OS administrative management programs.

OFFICE OF INTERGOVERNMENTAL AFFAIRS

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
BA	$5,978,000	$6,244,000	$6,338,000	+94,000
FTE	33	36	39	+3

FY 2010 Authorization .....Indefinite
Allocation Method .....Direct federal

Program Description and Accomplishments

The Office of Intergovernmental Affairs (IGA) is composed of a headquarters office and the ten offices of the Regional Directors. The headquarters office advises Departmental officials on the intergovernmental aspects of HHS policies, programs and initiatives. The headquarters office also coordinates the Department's strategies to strengthen intergovernmental relationships and implement Administration and Secretarial initiatives at various levels of government. The Regional Directors represent the Department in direct official dealings with state, local, and tribal governmental officials and offices, as well as non-government organizations. In addition to helping implement Department of Health and Human Services (HHS) initiatives and programs, IGA undertakes a variety of assignments for the White House, the Secretary, and the Deputy Secretary related to the Department's intergovernmental partners. IGA also works closely with individual States, local and tribal officials, and the local and national organizations that represent them, ensuring that lines of communication are maintained among all levels of government.

The IGA advocates and facilitates the communication of the Administration's health and human services agenda with State, local and tribal governments and outreach to external organizations. IGA consistently does this by serving as chief HHS liaison and principal advisor to the Secretary and the Department on state, local, and tribal activities. IGA establishes and maintains effective communications with Governors, mayors and tribal governments, and selected external organizations. IGA effectively provides guidance on the development and analysis of Departmental policy as it relates to state, local and tribal governments.

IGA activities include:

- Providing advice to State and local entities about the potential impact of proposed HHS legislative, regulatory, and administrative decisions. This includes working with the HHS Operating Divisions as well as with State local and tribal officials in the development and implementation of Federal legislation and regulations on subjects ranging from health reform, welfare, American Recovery and Reinvestment Act implementation, Tribal consultation, Medicare and Medicaid, emergency preparedness, to bioterrorism and other important departmental activities.
- Promoting general public understanding of programs, policies, and objectives of HHS through meetings, conferences, informational sessions, and through the dissemination of Departmental materials.

- Designing and implementing an outreach plan for communication with key external groups, such as business advocacy groups, healthcare organizations and other private sector entities impacted by the Secretary's priorities and initiatives.
- Coordinating the Department's tribal consultation responsibilities, pursuant to the Indian Self-Determination and Education Assistance Act (PL 93-638) and presidential Executive Orders on tribal consultation; to provide a single point of contact for nearly 700 American Indian/Alaska Native (AI/AN) tribes to access HHS program information and assistance. IGA also provides general management and supervision of the Secretary's Intradepartmental Council on Native American Affairs and reviews policy and actions to ensure program objectives are achieved.

Funding History

FY 2005	$5,787,000
FY 2006	$5,931,000
FY 2007	$5,762,000
FY 2008	$5,978,000
FY 2009	$6,244,000

Budget Request

The FY 2010 request for IGA is $6,338,000, an increase of $94,000. This will partially cover increased personnel costs such as the annualization of the January 2009 pay raise, and the anticipated January 2010 pay raise.

The budget request for IGA will be used to coordinate a range of outreach activities and facilitate cross-cutting initiatives in the field. IGA develops close relationships with, and is the Secretary's representative to, governors, State legislators, mayors, tribal leaders, other elected and appointed officials, and their constituencies. In 2010, IGA will work extensively to convene multi-stakeholder forums with state, local and tribal governments to advance and support health reform activities across the country. IGA will continue to build on their participation in the White House Regional Forums on health reform which were held in Michigan, Vermont, Iowa, North Carolina and California to discuss what must be done to change our health care system. IGA also responds with outreach and communication with key external groups, such as business advocacy groups, healthcare organizations and other private sector entities impacted by Departmental Initiatives. In IGA's role the office tracks HHS region-specific, Federal and State legislative actions, and serves as a surrogate for the Secretary and Deputy Secretary in the regions, informing State, local and tribal officials, the media and public of the Administration's and Department's program initiatives and priorities. IGA provides Departmental leadership in the field in several areas, including all top Secretarial priorities and initiatives. IGA also represents the Secretary and the Deputy Secretary in contacts with officials from other Federal agencies, the White House, State, local, and tribal governments, their representative organizations, and other outside parties. IGA solicits a full range of viewpoints from stakeholders, including State, local and tribal officials, district Congressional staffs, business coalitions, interest groups, advocacy groups, the media and other regional constituents to be shared with headquarters and the Office of the Secretary.

OFFICE OF THE GENERAL COUNSEL

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
BA	$36,617,000	$37,581,000	$40,110,000	+2,529,000
FTE	362	363	380	+17
HCFAC	$5,752,000	$5,714,000	$5,714,000	--
FTE	27	34	34	--

FY 2010 Authorization .....Indefinite
Allocation Method .....Direct federal

Program Description and Accomplishments

The Office of the General Counsel (OGC) litigates cases while providing advice and counsel to its client agencies throughout the Department. OGC reviews proposed regulations and legislative drafting, and provides other legal work that emerges from the policies and programs of the Department, Administration, and the Congress. OGC is the legal team of HHS, providing quality representation and legal advice on a wide range of highly visible national issues. OGC supports the development and implementation of the Department's programs by providing the highest quality legal services to the Secretary of HHS, the Operating Divisions (OPDIVs), and the Staff Divisions (STAFFDIVs).

With a team of over 400 attorneys and a comprehensive support staff, OGC is one of the largest, most diverse and talented law offices in the country. Many OGC lawyers are heavily involved in administrative and Federal court litigation. The OGC team also reviews proposed regulations and legislation affecting significant issues of health and human services.

OGC's long-term goal is to provide effective and efficient legal support to the Department. OGC's performance measure for this goal is to support the Office of the Secretary and program client operations, initiatives, and requests by providing high quality legal services, including sound and timely legal advice and counsel. In FY 2009, OGC provided exceptional legal services in a timely manner in support of the Department's Strategic Plan.

OGC continues to provide extensive advisory and litigation support to CMS to ensure that nursing homes and other entities participating in Medicare and Medicaid comply with Federal health and safety requirements. OGC anticipates a continuous and heavy workload involving legal defense of State appeals or disallowances of Federal Financial Participation, primarily involving the Medicaid program. OGC continually works with The Centers for Medicare & Medicaid Services (CMS), Department of Justice (DOJ) and OIG to investigate and litigate False Claims Act actions against Medicare and Medicaid providers and suppliers. OGC provides critical advice to CMS on nursing home inspection findings, deficiency citations, plans of correction, and imposition of sanctions. OGC works closely with CMS to craft innovative settlements in major products liability cases.

OGC leads the efforts to recover conditional payments under the Medicare Secondary Payer (MSP) in various class action cases filed nationwide. OGC has provided legal advice and support to ACF in its administration of over $50 billion. OGC works closely with DOJ in Federal Court cases, and independently handles proceedings where the Departmental Appeals Board (DAB) has jurisdiction.

OGC also advises ACF and AoA about the propriety of claims for Federal funding and proposed disallowances, and then defends the agency's disallowance actions in administrative and court proceedings. OGC devotes extensive resources to this activity and has prevented millions of dollars from being improperly expended. OGC has defended ACF against a series of aggressive challenges to the Office of Refugee Resettlement's operation of the Unaccompanied Alien Children Program.

Funding History

FY 2005	$37,413,000
FY 2006	$36,729,000
FY 2007	$37,347,000
FY 2008	$36,617,000
FY 2009	$37,581,000

Budget Request

The FY 2010 request for the Office of the General Counsel (OGC) is $40,110,000; an increase of $2,529,000 above the FY 2009 Omnibus. In FY 2010, OGC will continue to provide effective and efficient legal support to the Department. OGC will continue to support HHS Strategic Goals. OGC's goal is to support the Office of the Secretary and the Department by providing high quality legal services, including sound and timely legal advice and counsel. The budget request for OGC will be used to continue to effectively manage the legal challenges and provide support for the Secretary and Department's initiatives and programs. In addition to the activities financed through the General Departmental Management appropriation, the Office of the General Counsel also provides reimbursable services to HHS components.

This request contains an increase for mandatory, pay raise and inflationary increases for FY 2010. It also includes a program increase request for funding additional resources in the area of procurement and grants administration. These additional resources will fund 17 positions (9 FTE) in OGC and will necessitate an estimated additional $1,420,000 for the annualization of these positions in FY 2011. The justification for this increase is summarized below:

Procurement and Grants Administration

Additional resources in the procurement and contract administration area would allow HHS to conduct a more systematic review of procurement actions at various dollar thresholds, and would allow OGC to add value at every stage of the acquisition process, including the planning and selection phase, where most legal issues can be addressed and resolved. These resources would also facilitate more frequent one-on-one counseling sessions with acquisition staff. Such

individualized attention will reduce legal risk on procurement actions, and will also provide opportunities for OGC to educate and inform acquisition staff regarding various procurement-related legal issues.

These resources would also improve the Department's ability to defend bid protests and contract claims. At present, because of the limited staff, OGC is often limited to assigning one primary attorney (excluding reviewers) to a litigation matter, rather than two or more. On one recent protest matter, OGC assigned two attorneys, where twenty-three attorneys were listed as opposing counsel on the matter. These resources would help OGC to more efficiently litigate claims, and would help free up attorneys to better balance litigation and advice workloads.

Additional resources in the OGC Grants Administration area are necessary to assist in issues that arise under the massive increase in grant funding by HHS under ARRA and under other program expansions. HHS Operating Divisions have appropriately relied upon OGC to assist in the full range of legal services appropriate to grant administration. These services range from assistance in statutory interpretation, design of funding announcements, review of legal issues related to eligibility and program conditions, and the analysis of very complex legal questions regarding the interaction of ARRA and other statutory grant authorities with other statutes, including civil rights laws, Paperwork Reduction Act, anti-lobbying requirements, and fiscal accountability statutes, as well as compliance with OMB guidance.

In some cases, program regulations and other Federal Register publications are needed, and lawyers play a key role in reviewing such documents. Furthermore, while OGC works to avoid litigation, some litigation can be expected as numerous applicants compete for limited funds. Administrative litigation is often required to recover grant funds that are misspent or to force compliance with grant terms and conditions. OGC handles such matters for HHS. This legal assistance is essential to enable the Operating Divisions to fund complex programs under applicable deadlines, with all elements of accountability and oversight (including transparency) fully addressed.

In FY 2010, OGC will continue to focus on supporting the Department's highest priorities. Select OGC initiatives and programs are outlined below:

- *Physician Quality Reporting Initiative.* OGC continues to counsel CMS in the implementation and expansion of the Physician Quality Reporting Initiative (PQRI).
- *Health Information Technology*. OGC plays a critical role in the Department's health information technology initiatives, specifically: (i) working with CMS on transparency initiatives; (ii) working with CMS on the rules effectuating the e-prescribing provisions for the Part D program under the Medicare Modernization Act (MMA); and (iii) working with ONC on the development of the Nationwide Health Information Network.
- *Ensuring Access to Quality Services for Medicare Beneficiaries.* Assist CMS efforts to ensure quality in the Medicare Advantage program. OGC has addressed numerous legal issues involving Medicare Advantage Private Fee-for-Service plans.
- *Maintaining Financial Integrity of Medicare and Medicaid Programs.* OGC will continue the enormous amount of work involved in advising CMS with respect to payment system changes, anti-fraud initiatives, implementation of the Medicaid Integrity

Program, and other efforts to protect the financial integrity of the Medicare and Medicaid programs.

- *Medicare Modernization Act (MMA) and the Part D Benefit.* OGC expects that the implementation of the Medicare Part D benefit and the Regional Medicare Advantage program, both enacted into law with the MMA, will continue to generate a significant amount of litigation challenging various aspects of these programs. OGC continues to defend lawsuits challenging CMS's implementation of Part D, and we expect to continue in the upcoming years. More important, OGC's experience now shows that the enactment of Part D will give rise to future, predictable litigation. Prescription Drug Plans' (PDPs) and MA-PDs' bids are submitted on a yearly cycle, and OGC fully expects that subsequent years will bring additional legal challenges by unsuccessful bidders.
- *Public Health Emergency Preparedness.* OGC will help prepare the nation for public health emergencies through legal preparedness activities, including drafting international cooperation agreements and assisting HHS officials in advising federal, state, local and tribal officials on legal authorities (e.g., for quarantine or emergency declarations).
- *Pandemic Influenza Preparedness.* OGC will advise relevant HHS agencies in their discussions with the World Health Organization and member countries regarding access to pandemic influenza strains originating from developing countries.
- *Expanding Global and Domestic HIV/AIDS and Emerging Infections Programs.* OGC advises both CDC and HRSA on the numerous legal issues associated with HHS's expanding international programs including those focused on emerging infections and those focused on HIV/AIDS and tuberculosis. OGC will work with key personnel implementing the reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. In addition, OGC will work with the Department of State to provide advice on the development of bilateral agreements with host countries.
- *Strategic National Stockpile.* OGC will assist the Centers for Disease Control and Prevention with its efforts to expand and maintain the Strategic National Stockpile, providing legal assistance and advice regarding a number of significant issues involving the purchase, stockpiling, and deployment of vital vaccines, drugs, and other medical supplies, including negotiation of deployment agreements, and the management and contracts administration of current and new contracts.
- *The Pandemic and All-Hazards Preparedness Act (PAHPA), P.L. 190-417.* OGC has provided and continues to provide extensive advice on the implementation of this act to ASPR and other HHS agencies. OGC advised ASPR on a myriad of issues regarding the return of the NDMS to HHS, employment issues, licensing and credentialing issues, ability of team members to provide support to states or private entities and use of Federal property when NDMS teams have not been activated by the Federal government and storage of pharmaceuticals and other equipment.
- *PHS Commissioned Corps Transformation.* The Secretary's initiative on the Commissioned Corps seeks to ensure Corps readiness to respond to urgent or emergency public health care needs at the national, state, or local level. OGC has drafted the HHS proposal for legislation, of which the core force management provisions were enacted in 2007. Through technical assistance (including legislative drafting), OGC continues to assist HHS to advance additional proposed authorities needed for broad-based transformation of the Corps.

- *Patient Safety and Quality Improvement Act of 2005 (Medical Malpractice).* OGC will continue to advise and assist AHRQ, OCR, and HHS clients in connection with drafting of regulations and other tasks connected with implementation of the recently enacted patient safety legislation, designed to encourage reporting of medical errors in order to facilitate correction of systemic problems, by ensuring that such reports cannot be used in adversarial proceedings.
- *Indian Health Care Improvement Act Reauthorization.* OGC will assist ASL and IHS in providing technical assistance to the Congress (including legislative drafting assistance) on Congressional bills to update IHS program authorities to respond to changing health care needs of the American Indian/Alaska Native population.
- *Indian Self-Determination Act.* OGC reviews hundreds of proposed contracts under this Act, transferring over $2 billion on an annual basis to nearly 300 tribes through these agreements. OGC reviews these tribal proposals, advises the federal negotiation team, and ensures that the agreements are within the agency's statutory authority.
- *President's Health Centers Initiative, and Tort Claims and Tort Litigation.* OGC expects an increase in tort claims and litigation under the Federal Tort Claims Act (FTCA). OGC has issued legal opinions about tort coverage to various clients and has provided assistance to IHS and HRSA especially in the area of "risk management" activities designed to prevent, respond to, or minimize the effects of any alleged medical malpractice in Federally-funded facilities. This nationwide workload involves medical malpractice actions relating to care provided at IHS-funded facilities and HRSA-funded Community Health Centers. OGC projects a significant growth in tort claims and tort litigation, especially regarding claims arising from the expansion in the number of HRSA-funded Community Health Centers.
- *TANF Reauthorization.* OGC assisted ACF in reviewing and clearing final regulations, answering multiple questions concerning implementation issues, and will defend challenges to penalty impositions.
- *Improving Head Start Grantee Performance.* OGC is working closely to assist ACF implement changes to the Head Start Act resulting from legislation reauthorizing the program which was enacted in December 2007. Final regulations are expected to be issued in FY 2010 and OGC will assist ACF in their development and clearance.
- *William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008.* OGC is working closely with ACF in interpreting provisions of this legislation which reauthorizes the Trafficking Victims Protection program and also transfers new responsibilities for the care and custody of Unaccompanied Alien Children who may be victims of Trafficking from DHS to HHS.
- *Development and Implementation of the Medicare Clinical Research Policy.* OGC has assisted CMS and AHRQ in developing a new national coverage determination that will enable the Medicare program to expand the current clinical trial policy and support research that is particularly beneficial to the Medicare population. OGC has been involved from the outset of this initiative and have been instrumental in developing the legal theories to support expanded coverage under two provisions of the Social Security Act while ensuring compliance with Departmental rules on the protection of human subjects.
- *Oversight of Biomedical and Behavioral Research and Research Misconduct.* OGC

assists the Office for Human Research Protections (OHRP) and the Office of Research Integrity (ORI) within the Office of Public Health and Science in their oversight of HHS-conducted or supported biomedical and behavioral research and research misconduct. OGC also assists NIH to carry out its own intramural programs to ensure research integrity and appropriate human subject protection in research.

- *Personnel Legal Activities.* OGC attorneys support the Department's managers who take action against employee misconduct, and make efforts to improve employee performance and, where necessary, take performance-based adverse actions. OGC attorneys defend management decisions with respect to employee misconduct, poor performance or claims of unlawful discrimination before various arbitrators, the MSPB, the EEOC, and the FLRA, and assist DOJ with personnel litigation. OGC attorneys also advise management in the area of labor relations and assist in negotiating collective bargaining agreements.
- *Ethics Redesign Initiative.* OGC administers the Department's ethics program. This includes the public and confidential financial disclosure systems. OGC will focus on completion of ongoing program reviews and implementing enforcement and compliance systems. OGC will also reinitiate audits after an appropriate interval to measure improvement.
- *American Recovery and Reinvestment Act of 2009 (ARRA).* OGC will continue to play a critical role in helping HHS Operating and Staff Divisions implement ARRA, which funds a myriad of programs throughout HHS. OGC will provide interpretations of statutory provisions and OMB guidance, will advise workgroups, clear language for grant and contract awards, and work to assure appropriate adherence to statutory requirements.

DEPARTMENTAL APPEALS BOARD

	FY 2008 Enacted	FY 2009 Omnibus	FY 2010 Request	FY 2010 +/- FY 2009
BA	$9,641,000	$9,981,000	$11,457,000	+1,476,000
FTE	65	70	74	+4

FY 2010 Authorization .....Indefinite
Allocation Method .....Direct Federal

Program Description and Accomplishments

The Departmental Appeals Board (DAB) provides impartial, independent hearings and appellate reviews, and issues Federal agency decisions under more than 60 statutory provisions governing HHS programs. Unlike most other Staff Divisions (STAFFDIVs) in the Office of the Secretary, DAB performs functions that are mandated by statute or regulation. Cases are initiated by outside parties who disagree with a determination made by an HHS agency or its contractor. Outside parties include States, universities, Head Start grantees, nursing homes, clinical laboratories, doctors, and Medicare beneficiaries. Disputes heard by the DAB may involve over $1 billion in Federal funds in a single year. DAB decisions have nation-wide impact. In addition, DAB decisions on certain cost allocation issues in grant programs have government-wide impact, since HHS is the agency whose decisions in this area legally bind other Federal agencies.

In general, DAB contributes to the improved management and integrity of HHS programs, and to the quality of health care, by:

- Ensuring compliance with program requirements;
- Promoting consistency in decision-making across HHS;
- Issuing timely decisions that are well-founded, well-reasoned, and clearly communicated;
- Resolving disputes administratively, thereby avoiding costly court proceedings.

DAB has made progress in the strategic management of human capital by re-engineering its operations and improving its case management techniques. DAB shifts resources across its Divisions as needed to meet changing caseloads, where feasible, and targets mediation services to reduce pending workloads.

DAB is organized into four Divisions:

- the Appellate Division supports the Board Members, who preside in various types of cases;
- the Civil Remedies Division supports DAB Administrative Law Judges (ALJs), who conduct evidentiary hearings;

- the Medicare Operations Division supports DAB Administrative Appeals Judges, who review decisions by ALJs from the HHS Office of Medicare Hearings and Appeals (OMHA) or (in some older cases) by Social Security Administration ALJs; and
- the Alternate Dispute Resolution Division, which provides mediation services in DAB cases and provides policy guidance and information on the use of dispute resolution methods throughout HHS to reduce administrative and management costs.

Performance analyses for each Division are based on FY 2008 data. Workload assumptions are explained in the charts under the section "Budget Request."

Board Members – Appellate Division

DAB Board Members are appointed by the Secretary, and the Board Chair is also the STAFFDIV Head of DAB. All Board Members are judges with considerable experience who, acting in panels of three, issue decisions with the support of Appellate Division staff. In some cases (such as Head Start terminations and Medicaid disallowances), Board Members conduct *de novo* reviews and hold evidentiary hearings if needed. In other cases, Board Members provide appellate review of decisions by DAB ALJs or other ALJs. Board review ensures consistency of administrative decisions, as well as adequacy of the record and legal analysis before court review. For example, Board decisions in grant cases promote uniform application of OMB cost principles. Board decisions are posted on the DAB Website and provide precedential guidance on ambiguous or complex requirements.

Board jurisdiction affecting Medicare and Medicaid includes:

- Appellate review of DAB ALJ decisions in cases for which a healthcare provider or supplier has a hearing right under section 1866(h)(1) of the Social Security Act and/or 42 C.F.R. Part 498, including cases that raise important quality of care issues such as nursing home enforcement and Clinical Laboratory Improvement Amendments (CLIA) cases.
- Review of Medicare National Coverage Determination policies and review of DAB ALJ decisions on Local Coverage Determinations that may affect whether Medicare beneficiaries get timely access to new medical technology/procedures, without jeopardizing safety or wasting funds.
- Appellate review of DAB ALJ decisions in civil money penalty and exclusion cases brought by the HHS Office of Inspector General (OIG) or Centers for Medicare & Medicaid Services (CMS) to improve program integrity.
- Review of DAB ALJ decisions in cases involving the imposition of CMPs on covered entities that violate standards adopted by the Secretary to implement the Administrative Simplification provisions of HIPAA.
- *De novo* review of Medicaid disallowances (i.e., the loss of Medicaid funding) appealed by States pursuant to statute.

States may also request Board review of TANF (welfare) penalties, penalties based on ACF child and family welfare and services reviews, foster care eligibility disallowances, and some other determinations related to financial or program management.

Performance Analysis: In FY 2008 the Appellate Division issued decisions in 100 cases and closed an additional 82 cases**.** The Appellate Division exceeded its timeliness standard of 50% in FY 2008 (Long-term Performance Objective 1, hereafter "Objective" 1). This objective measures the percentage of total Board decisions issued in cases with a net age of six months or less. In FY 2008, 76% of the decisions issued had a net case age of six months or less. The Board has set new timeliness targets of 76% for both FY 2009 and FY 2010. The Board anticipates being able to meet these new targets because of the significant reduction of its case backlog as of the end of FY 2008. However, due to the overall increasing complexity of the matters in dispute in the cases before the Board, a significant number of cases will still require a longer processing time than six months. Objective 2 for the Appellate Division measures the number of Board decisions reversed or remanded in Federal court, as a percentage of all Board decisions. During 2008, Federal courts reviewed 13 Board decisions. All of those decisions were affirmed. In one case, the court of appeals reversed a district court decision that had reversed the underlying Board decision. The Appellate Division met its target of 2% for FY 2008, and will maintain this extraordinary low reversal rate in FY 2009 and FY 2010.

Administrative Law Judges – Civil Remedies Division (CRD)

DAB ALJs are supported by staff in CRD. These ALJs conduct adversarial hearings in proceedings that are critical to HHS healthcare program integrity efforts, as well as quality of care concerns. Hearings in these cases may last a week or more. Cases may raise complex medical or clinical issues. Some cases require presentation of evidence to prove allegations of complicated fraudulent schemes. Cases may also raise legal issues of first impression. For example, appeals of enforcement cases brought under the Health Insurance Portability and Accountability Act (HIPAA) are likely to raise new issues.

DAB ALJs hear cases brought by CMS or OIG to exclude providers, suppliers, or other healthcare practitioners from participating in Medicare, Medicaid and other federal healthcare programs or to impose civil money penalties for fraud and abuse in such programs. CRD's jurisdiction also includes appeals from Medicare providers or suppliers, including cases under CLIA and provider/supplier enrollment cases. Expedited hearings are provided when requested, in some proceedings, such as provider terminations and certain nursing home penalty cases. These cases typically involve important quality of care issues. DAB ALJs also hear cases which may require challenging testimony from independent medical/scientific experts, for example, in appeals regarding Medicare Local Coverage Determinations or issues of research misconduct.

Based on current receipts, we project that CRD will receive 790 new appeals in FY2009. Heightened enforcement and oversight efforts by HHS OIG, CMS, and the HHS Office for Civil Rights (OCR) will result in an increase in the number of appeals again in FY 2010. In addition, a growing number of appeals are subject to regulatory deadlines. ALJs must decide HHS OIG enforcement, fraud, and exclusion cases within 60 days of the close of the record. This 60-day time limit also applies to SSA OIG civil monetary penalty cases, as well as other enforcement cases. CMS provider or supplier enrollment appeals must be decided within 180 days of the filing of the case.

In FY 2009, one DAB ALJ left to take a Senior ALJ position with SSA, and one senior attorney retired. DAB is unable to backfill these positions. Two CRD attorneys were reassigned to another Division, in an effort to eliminate a backlog of statutory deadline cases. In FY 2008, CRD had 6 ALJs and 10 CRD attorneys; in FY 2009, there are 5 ALJs and 7 attorneys in CRD.

As a result of the loss of an ALJ, the number of cases assigned to the remaining ALJs has increased by 15 percent. Case processing time has increased. Moreover, staffing losses have made meeting regulatory deadlines for deciding appeals particularly challenging. The proposed budget for FY 2010 will permit DAB to replace the ALJ position and to fill vacant staff positions.

Performance Analysis: By the end of FY 2008, CRD had eliminated a backlog of cases that had been pending for more than one year from the date of the close of the record. CRD also closed 870 cases in FY 2008 (195 by decision) and exceeded its two timeliness goals (Objectives 3 and 4). Objective 3 relates to OIG actions to impose civil money penalties or to exclude individuals from participating in Federal programs. The measure for this goal is the percentage of OIG cases in which DAB ALJs issue decisions within 60 days of the close of the record. The target was increased from 97% in FY 2008 to 100% for FY 2009 and FY 2010. Objective 4 ensures that increases in case receipts do not result in a greater number of aged cases. The measure is the number of cases open at the end of the year that had been received in prior years. For FY 2008, CRD greatly exceeded its target (by more than 50%), despite reduced staff. In FY 2009, meeting timeliness goals will be a challenge, but with new staff in FY 2010, CRD will meet both Objective 3 and 4. Also, for FY 2010, CRD has introduced two new timeliness measures and, with the assistance of new staff, will meet these targets.

Medicare Appeals Council – Medicare Operations Division (MOD)

With support from MOD attorneys and staff, Administrative Appeals Judges (AAJs) on the Medicare Appeals Council review decisions involving Medicare coverage or entitlement issued primarily by ALJs in OMHA. Medicare Appeals Council review strengthens Medicare management by:

- Improving patient access to health services by ensuring that Medicare requirements are applied correctly nationwide;
- Protecting parties' due process rights;
- Ensuring that interpretations applied to individual claims conform to the statute, regulations, and policy guidance; and
- Avoiding costly court review by ensuring that the administrative record is complete and that the administrative decision is sound and is clearly communicated.

MOD has increased both the quality and rate of its case dispositions. Productivity gains substantially reduced the number of pending cases, despite receiving an ever-larger number of cases each year (increasing about ten-fold in the last ten years). MOD enhanced overall output by temporarily transferring attorneys from other DAB Divisions to work on older appeals, by hiring contract legal staff to focus on the most complex and aged cases, and by using unpaid law student interns to screen new cases so MOD's existing attorneys could focus on writing

decisions. The MOD also increased efficiency in case intake and processing by ensuring that claims that arise from the same ALJ hearing are bundled together, instead of tracking appeals by the number of ALJ decisions that are issued.

With this increased productivity, however, MOD has had to devote significantly more resources to preparing certified court records for Federal district courts. While the percentage of cases appealed to Federal court has not increased, the overall number and complexity of the cases have, resulting in an increase from 22,000 pages of document certification for Federal court appeals in FY 2007 to 187,000 pages in FY 2008. This trend continues into FY 2009 (currently projecting 224,000 pages for appeals in FY 2009) and will continue in FY 2010. MOD will need additional administrative staff to meet this Federal court requirement.

Performance Analysis: In FY 2008, MOD focused its efforts primarily on reducing its backlog of older cases and decreased the number of pre-calendar 2006 cases from 356 to 20. In FY 2009, MOD will completely eliminate its backlog of older cases.

MOD exceeded its FY 2008 target for Objective 7, to increase the number of decisions to 1,800, from 1,511 cases in FY 2007. In fact MOD closed 2,689 cases, a 78% increase. In FY 2009, productivity will fall off somewhat from this FY 2008 high, due to the departure of contract legal staff. But with the shift of two attorneys from CRD to MOD and with further management attention to individual productivity, MOD will meet its new targets of 2,200 cases for FY 2009 and FY 2010. MOD did not meet the target for Objective 6, constraining the growth in case age by reducing the average time to complete action on Medicare Part B cases to 160 days (as measured from the date MOD received the case folder). The FY 2008 result, 185 days, is directly attributable to the fact that MOD had to focus on meeting the mandatory statutory deadline of 90-days for resolution of new appeals (while also reducing the backlog of older appeals). At the beginning of FY 2008, MOD was deciding cases on average more than 3 months past the deadline. At the end of FY 2008, MOD was deciding nearly all of its cases within two weeks of the 90-day deadline. Currently in FY 2009, MOD is issuing the majority of cases prior to the 90-day deadline. MOD should meet the Objective 6 targets of 160 days for FY 2009 and 155 days for FY 2010. Nevertheless, current levels of staffing will not allow MOD to meet both the Objective 6 target and the 90-day deadline in all cases, particularly large DME appeals involving hundreds of claims.

Alternative Dispute Resolution (ADR) Division

Under the Administrative Dispute Resolution Act, each Federal agency must appoint a dispute resolution specialist and must engage in certain activities to resolve disputes by informal methods, such as mediation, that are alternatives to adjudication or litigation. Using ADR techniques saves costs and improves program management by reducing conflict and preserving relationships that serve program goals (e.g., between program offices and grantees, or among program staff).

The DAB Chair is the Dispute Resolution Specialist for HHS and oversees ADR activities under the HHS policy issued under the Act. ADR Division staff provide mediation services in DAB cases, provide or arrange for mediation services in other HHS cases (including workplace

disputes and claims of employment discrimination filed under the HHS Equal Employment Opportunity program), and provide training and information on ADR techniques (including negotiated rulemaking – a collaborative process for developing regulations with interested stakeholders).

DAB has only a small ADR staff, and leverages its reach through a variety of innovative programs. For example, DAB's Sharing Neutrals Program won an award from the Office of Personnel Management for the innovative use of collateral duty mediators to resolve workplace disputes. (The Shared Neutrals Program is designed so that Federal employees who are already trained mediators can occasionally mediate disputes for Federal agencies other than their home agency, in exchange for similar services to their home agency from mediators employed by other Federal agencies.) DAB also partners with the ADR office at the Department of Transportation (DOT) to provide conflict management seminars to HHS and DOT staff. DAB attorneys encourage parties to mediate DAB cases, and many staff members are trained mediators.

Performance Analysis: In FY 2008, the ADR Division exceeded its goal of providing 8 conflict resolution seminars to HHS employees and providing ADR services in 55 DAB cases. Objective 5 is a consolidation of previous ADR performance goals. It measures the new core ADR objective of enhancing ADR capacity, such that ADR is used whenever appropriate in disputes involving HHS. This objective measures capacity as a function of training opportunities (which assure sufficient ADR information and skills in the HHS population) and ADR interventions in DAB cases (which measures actual use in a significant subset of HHS conflicts). ADR performance targets will increase for FY 2009 and FY 2010, because ADR resources increased slightly during that period with the net addition of one-half FTE (resulting from staff transfers between Divisions) and the use of unpaid legal interns who are trained in ADR.

Funding History

FY 2005	$8,853,000
FY 2006	$8,691,000
FY 2007	$9,600,000
FY 2008	$9,641,000
FY 2009	$9,981,000

Budget Request

DAB's FY 2010 request is $11,457,000, an increase of $1,476,000 over the FY 2009 comparable enacted level. The increases in resources will be used to offset increases for pay and inflation. In addition, this amount should allow the DAB to add one ALJ for the Civil Remedies Division, and to backfill attorney vacancies. This will help DAB offset the loss of one senior ALJ and three attorneys, to more equitably distribute the existing caseload, and to handle the anticipated increase in cases resulting from heightened enforcement efforts by HHS and SSA. DAB may also be able to hire staff in other divisions to address their increasing workloads and the increased burdens of preparing more certified administrative records for Federal courts.

The funding request for DAB is fully justified by the increasing Medicare and other workloads, workload statistics for each Division (see below), increased personnel and other costs (such as IT costs and rent), DAB e-Government needs, and the potential fiscal and legal consequences of not meeting statutory and regulatory deadlines for hearings and appeals.

Board Members – Appellate Division

Chart A shows total caseload data for this Division. FY 2008 data is based on actual case receipts, and FY 2009 and 2010 data is based on certain assumptions, including:

- Nationwide Federal pay raise of 2% in January 2010 and non-pay inflation factor of 1% for FY 2010;
- Continued increases in Medicaid disallowance appeals due to stepped-up enforcement;
- Relatively high levels of non-CMS public assistance program appeals from disallowances or penalties resulting from program reviews;
- Some appeals of ALJ decisions involving civil money penalties imposed pursuant to the HIPAA provisions.

Chart A
APPELLATE DIVISION CASES

	FY 2008	FY 2009	FY 2010
Open/start of FY	126	79	75
Received	135	140	145
Decisions	100	75	80
Total Closed	182	144	149
Open/end of FY	79	75	71

Administrative Law Judges – Civil Remedies Division

Caseload data for CRD is shown in Chart B. The caseload data and projections for FY 2008 were modified from prior budget charts to reflect more recent data, as well as updated information from HHS agencies. Assumptions include the following:

- Nationwide Federal pay raise of 2% in January 2010 and non-pay inflation factor of 1% for FY 2010;
- No new resources for this division during FY 2009, but a new ALJ and legal support staff for FY 2010;
- A continued upward trend in certain case types, due to heightened enforcement and oversight efforts by HHS OIG, CMS, and OCR; and
- Meeting new regulatory processing deadlines in FY 2009 with fewer staff.

Chart B
CIVIL REMEDIES DIVISION CASES

	FY 2008	FY 2009	FY 2010
Open/start of FY	417	330	320
Received	783	790	830
Decisions	195	160	185
Total Closed	870	800	830
Open/end of FY	330	320	320

Medicare Appeals Council – Medicare Operations Division

By strategic management of human capital and improved management generally, MOD has dramatically improved staff productivity and achieved greater control over a caseload that has increased significantly. With the addition of attorneys detailed from other Divisions and contract legal staff, MOD increased dispositions to 2,689 (18,219 claims) by the end of FY 2008.

Individual cases take more time to complete because the Medicare Appeals Council must now perform *de novo* review and, in general, cases under the current regulations are raising more complex issues than in the past. Under the prior standard, the Council reviewed appeals based on a substantial evidence standard, under which not all appeals required full decisions. Under current regulations, the Council must conduct a review of the complete evidentiary record for all requests for review, and issue an order within a 90-day statutory timeframe for appeals arising from ALJ decisions in Part A and Part B cases. In order to address MOD's large caseload, DAB shifted two attorneys from other Divisions to MOD.

Chart C contains case data for this Division, based on actual numbers for FY 2008 and trends in case receipts at lower levels of appeals. DAB is reporting data about those cases requiring individual determinations, while noting the associated individual claims. (A single case may represent hundreds of Medicare claims and more than one Medicare contractor denial.)

Assumptions on which the data are based include:

- Nationwide Federal pay raise of 2% in January 2010 and non-pay inflation factor of 1% for FY 2010, and
- Increased receipts of appealed and referred cases in FY 2009 and FY 2010, as OMHA's disposition rate increases.

Chart C
MEDICARE OPERATIONS DIVISION CASES

	FY 2008	FY 2009	FY 2010
Open/start of FY	1,471	761	761
Received	1,979	2,200	2,400
Cases Closed (claims closed)	2,689 (18,219 claims)	2,200 (22,000 claims)	2,200 (24,000 claims)
Open/end of FY	761	761	961

Alternative Dispute Resolution Division

In FY 2009 and FY 20010, ADR will strive to meet the following goals:

- Enhance ADR capacity at HHS, such that ADR is used whenever appropriate in disputes involving HHS;
- Use ADR in HHS cases, so as to increase cost savings and decrease contentiousness in case resolution;
- Leverage limited resources for HHS cases and advance interagency ADR goals though efficient management of OPM award winning Sharing Neutrals Program; and
- Collaborate with other HHS staff and the federal ADR community in general to advance joint ADR goals.

CJ Outcome/Outputs Table

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.1.1: Percentage of Board decisions with net case age of six months or less.	FY 2008: 76% (Target Exceeded)	76%	76%	Maintain
1.2.1: Number of decisions reversed or remanded on appeals to Federal court as a percentage of all Board decisions issued.	FY 2008: 2% (Target Met)	2%	2%	Maintain
1.3.1: Percentage of decisions issued within 60 days of the close of the record.[1]	FY 2008: 100% (Target Met)			

CRD proposes the following revision to Objective 3

1.3.1(revised): Percentage of decisions issued within 60 days of the close of the record in HHS OIG enforcement, fraud and exclusion cases.	FY 2008: 100% (Target Met)	100%	100%	Maintain
1.3.2: Percentage of decisions issued within 60 days of the close of the record in SSA OIG CMP cases and other SSA OIG enforcement cases.	N/A	N/A	100%	Maintain
1.3.3: Percentage of decisions issued with 180 days of filing of provider or supplier enrollment appeal.	N/A	N/A	100%	Maintain
1.4.1: Number of cases open at end of Fiscal Year that was opened in previous Fiscal Years.	FY 2008: 45 (Target Met)	≤2008	≤2009	Maintain
1.5.1: Number of conflict resolution seminars conducted for HHS employees.	FY 2008: 11 Sessions (Target Exceeded)	11 sessions	15 sessions	Maintain
1.5.2: Number of DAB cases (those logged into ADR Division database) requesting facilitative ADR interventions prior to more directive adjudicative processes.	FY 2008: 75 (Target Exceeded)	75	80	Maintain

[1] Long Term Objective 3 has been revised to include the new regulatory timeliness requirement at 42 CFR § 489.220 and to include an existing regulatory timeliness requirement at 20 C.F.R. ' 489.220 which had not been included in the previous measure.

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.6.1: Average time to complete action on Part B Requests for Review measured from receipt of case folder. (FY 2001 and following Fiscal Years) Note: Results for FY 05 determined after excluding outlier cases in which delays related to court proceedings beyond DAB's control.	FY 2008: 185 days (Target Not Met)	160 days	155 days	-5 days
1.7.1: Number of dispositions. Counting method changed in FY 05 (see narrative below); FY 04 comparable results are 2183 cases.	FY 2008: 2,689 (Target Exceeded)	2,200	2,200	Maintain
Appropriated Amount ($ Million)	**$9.641**	**$9.981**	**$11.457**	**+1.476**

Performance Narrative

The Departmental Appeals Board (DAB) does not directly administer any of the HHS programs that support the HHS Strategic Plan goals and objectives. However, the DAB promotes these goals and objectives by providing timely and quality decisions that resolve disputes arising in those programs (or ADR assistance that helps the parties resolve their own disputes). Specifically, DAB decisions help ensure that funds are spent only for authorized purposes, that healthcare quality standards are enforced, and that program and research integrity is maintained. Also, by providing a fair and transparent process to resolve disputes, the DAB enhances relationships with states, providers, universities, and others whose cooperation is needed for HHS to achieve its goals.

APPELLATE DIVISION

Board Members, including the Board Chair, sit in panels of three to decide appeals from: (1) determinations by HHS OPDIVS involving grant funds; (2) decisions by DAB Administrative Law Judges (ALJs); or (3) decisions by FDA or Department of Interior ALJs. The Board Members are supported by attorneys and other administrative personnel in the Appellate Division.

In FY 2008, the Board/Appellate Division closed 182 cases (decisions were issued in 100 of these cases). In FY 2007, the Board closed 135 cases. This represents an increase of 35% in the number of closed cases. The Appellate Division also exceeded its FY 2008 timeliness standard. In FY 2008, 76% of Board decisions had a case age of six months or less. This represents a significant improvement over FY 2007, when 45% of Board decisions issues had a case age of six months or less.

During FY 2008, Federal courts reviewed 13 Board decisions. All of those decisions were affirmed. In one case, the court of appeals reversed a district court decision that had reversed the underlying Board decision. The Board maintained its extraordinary record of having no more that 2% of its total decisions overturned by court.

The increase in decisional output was aided greatly by a team-based approach to decision-making. The Chair and Division Chief identified cases to be decided during each quarter in FY 2008. Case assignments were agreed upon by the Board Members with input from the attorneys. Board Members met weekly to provide progress reports, and attorneys and Board Members met monthly to provide progress reports and, if necessary, make reassignments. During most of FY 2008, the Board functioned with four Members, including the Board Chair. A vacant Board Member position was filled in the fourth quarter of FY 2008, which will allow the Board Chair to devote more time to management matters in FY 2009. Appellate case processing resources and output are projected to remain relatively constant for FY 2009.

CIVIL REMEDIES DIVISION (CRD)

DAB has five ALJs who provide hearings in civil remedies cases involving the Inspector General, Centers for Medicare & Medicaid Services or the Office of Research Integrity. The ALJs are supported by attorneys, paralegals and other administrative personnel in the Civil Remedies Division.

CRD closed 870 cases in FY 2008, compared to 707 cases in FY 2007. This represents an increase of 23% in the number of closed cases. In FY 2008, CRD focused on deciding the most aged appeals. At the close of FY 2007, 13 cases were pending for more than one year from the date of the close of the record. By the end of FY 2008, CRD had eliminated its backlog of cases that had been pending for more than one year from the date of the close of the record. The increase in the number of total cases closed and reduction in the number of aged cases was achieved by raising performance standards in the critical element of productivity for staff attorneys. In addition, unpaid law school interns and externs conducted legal research for judges and participated in prehearing conferences thereby freeing staff attorneys to focus on decision writing.

CRD also exceeded its timeliness goal. In FY 2008, 100% of Office of the Inspector General cases was issued within the 60-day regulatory deadline. Another CRD goal was to have no more than 85 cases received in FY 2007 or earlier still pending at the end of FY 2008. CRD exceeded this goal, as only 45 cases received in FY 2007 or earlier were still pending at the end of FY 2008. Long Term Objective 3 has been revised to include the new regulatory timeliness requirement at 42 CFR § 498.79, as well as an existing regulatory timeliness requirement at 20 C.F.R. § 489.220, which had not been included. CRD recently lost a Senior ALJ and attorney and reassigned two attorneys to the Medicare Operations Division. In FY 2009, meeting timeliness goals will be a challenge without more staff, but the proposed budget for FY 2010 will allow CRD to replace staff losses and meet all timeliness goals.

MEDICARE OPERATIONS DIVISION (MOD)

The Board Chair, four Administrative Appeals Judges and one Appeals Officer comprise the Medicare Appeals Council (Council). The Council decides appeals from decisions involving Medicare claims and entitlement by Administrative Law Judges (ALJ) in HHS' Office of Medicare Hearings and Appeals (OMHA) or Social Security Administration ALJs. The Council is supported by the attorneys, paralegals and other administrative personnel of the Medicare Operations Division.

In FY 2008, the number of MOD closed cases increased to 2,689 cases (involving 18,219 claims), from 1,511 cases (involving 10,583 claims) in FY 2007. This represents a 78% increase in the number of closed cases. At the end of FY 2007, 1,471 cases were pending in the MOD. New cases

received in FY 2008 totaled 2010. At the end of FY 2008, the number of pending cases had been reduced to 761 cases.

At the beginning of FY 2008, MOD had 356 cases pending from Calendar Year 2005 and Calendar Year 2006. At the end of FY 2008, only 20 of these cases were still pending. Reducing this backlog was MOD's primary focus for FY 2008, resulting in MOD missing its timeliness target for Goal 6, despite making substantial progress on meeting the 90-day statutory deadline. At the beginning of FY 2008, MOD was deciding cases on average more than 3 months past the deadline, whereas by the end of FY 2008, nearly all cases were decided within two weeks of the deadline. Currently in FY 2009, MOD is issuing the majority of cases prior to the deadline.

The increase in the number of total cases closed and reduction in the number of aged cases in FY 2008 was achieved through several means. First, performance standards in the critical element of productivity were raised for AAJs and attorneys. Attorneys from other divisions within DAB were detailed to MOD to handle the most complex and aged cases. Unpaid law school interns and externs screened incoming cases, thereby freeing staff attorneys to focus on decision writing. A contract attorney and a contract paralegal were hired for six months to assist with the most complex and aged cases. Although MOD will not have resources for contract attorneys or paralegals in FY 2009, two CRD attorneys were recently reassigned to MOD. Nevertheless, MOD's resources will also be stretched in FY 2009 by the large caseload and the demand for more certified administrative records for Federal court appeals, which has increased dramatically due to the much higher case closings than in previous years. At current staffing levels, MOD will not have sufficient resources in FY 2009 and FY 2010 to meet both the Objective 6 target and the 90-day deadline in all cases and Federal court imposed timelines for producing certified court records.

ALTERNATIVE DISPUTE RESOLUTION DIVISION (ADR)

The Board Chair serves as the Dispute Resolution Specialist for HHS. The Alternative Dispute Resolution Division provides policy guidance, training, mediation and other ADR services. DAB has a very small ADR staff but leverages its resources through the use of staff from other DAB divisions who are trained mediators and use its Sharing Neutrals Program. The Sharing Neutrals Program design allows Federal employees who are trained and experienced mediators to mediate disputes for Federal agencies other than their home agency, in exchange for similar services from Sharing Neutrals mediators employed by different agencies.

In FY 2008, the ADR Division conducted 11 conflict resolution seminars and provided ADR services in 75 HHS cases **(**32 program and 43 workplace). In comparison, in FY 2007, the ADR Division conducted eight conflict resolution seminars and provided ADR services in 50 HHS cases **(**22 program and 28 workplace). This represents a 50% increase in the workload over FY 2007.

In addition, the ADR Division undertook numerous initiatives, such as:

- working with HHS University and Office of Diversity Management and EEO to develop on-line ADR training course;
- delivering ADR presentations at the OS New Employee Orientation sessions regularly; and
- developing classes for Departmental components such as NIH, OIG and HR that are specifically adapted to meet their ADR needs.

OFFICE ON DISABILITY

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2009 +/- FY 2008 Omnibus
Budget Authority	$779,000	$805,000	$814,000	+$9,000
FTE	4	5	6	1

FY 2010 Authorization .....Indefinite
Allocation Method .....Direct federal

Program Description and Accomplishments

The mission of the Office on Disability (OD) is to oversee the implementation and coordination of disability programs, policies and special initiatives in HHS pertaining to the health and health-related programs for over 54 million persons with disabilities in the United States. OD's mission is guided by three core strategic goals:

- Healthcare
- Public Health Promotion, Disease Prevention, and Health Promotion
- Human Services

OD's long-term goal is to promote the abilities of all persons with disabilities, leading to the vision of an inclusive America.

The following OD objectives and supporting programs are funded by this budget:

Promote Integrated Health and Wellness Services

- Promote the Surgeon General's Call to Action (CTA) to Improve the Health and Wellness of Persons with Disabilities including monitoring of the National Action Plan to operationalize CTA recommendations and strategies.
- Ensure the understanding of Medicaid programs and services for persons with disabilities through collaboration with CMS.
- Promote physical fitness for youth with disabilities in conjunction with the Healthier US Initiative and the President's Council on Physical Fitness and Sports, through the OD's "I Can Do It, You Can Do It" program promoting physical fitness among children and youth with disabilities.
- Advance the action plan in collaboration with the Office of on Women's Health to address health screening and access barriers for women with disabilities.
- Ensure disability attention to all Departmental initiatives including emergency response, eliminating health disparities, health promotion/disease prevention, Healthy People 2010 objectives, and Healthy People 2020 planning.
- Address with the Administration on Aging and other HHS partners the caregiver/workforce challenges for persons with disabilities, including promotion of interagency funding collaborations.

Promote Effective Access Employment Opportunities

- Work with Federal and private sector employers to address employment of persons with disabilities as an important factor in health care access and health status. Help employers to overcome barriers to hiring persons with disabilities as well as ensure accessibility and disability relevance of employer-sponsored health services.
- Address the resettlement of refugees who have a disability and the development of employment opportunities for this population.
- Promote information on tax incentives and individual investment plans for employers and tax credits for persons with disabilities.

Efficient Community Integration of Services

- In partnership with the HHS Assistant Secretary for Preparedness and Response, the Federal Emergency Management Agency, and the Department of Homeland Security develop and help promote disability-based emergency preparedness templates, evidence-based and best practices, and toolkits to support the special needs of persons with disabilities, first responders and other emergency response providers at the Federal, State and local levels during all emergency situations.
- With the HHS Assistant Secretary for Preparedness and Response, monitor the inclusion of at-risk populations, including persons with disabilities, in infectious disease prevention planning as per the Pandemic and All Hazards Preparedness Act requirements.
- Increase the number of HHS Public Health Service Corps personnel, Federal, State, Local and Tribal Emergency Managers trained in addressing the needs of persons with disabilities during emergency planning and response.
- Help enhance medical and general shelters accessibility for persons with disabilities by including access to accommodating mobility devices, personal care support, and other accommodations.
- Implement and manage the OD interdepartmental program, Needs of Youth with Co-Occurring Developmental Disabilities and Emotional/Substance Abuse Disorders.
- Convene regularly scheduled interagency meetings to share, inform and educate agencies on all aspects of disability and related matters especially regarding integration of all age groups on the Medical Home Systems initiative with the Health Resources Services Administration, American Academy of Pediatrics, and other HHS agency programs.
- Foster collaboration with constituent advocacy organizations on the Surgeon General's Call to Action while increasing opportunities to reach people with disabilities, disability advocates, healthcare providers, and diverse other audiences, including the general public.
- In conjunction with Federal agencies and Departments identify current gaps and corrective actions to help address current limited state and local Traumatic Brain Injury (TBI) rehabilitation services coordination.
- Create national attention on the successes of Americans with disabilities in professional and personal endeavors.

Individual Self-Determination /Assistive Technology

- Manage and ensure Department-wide adherence including accessible electronic documents required by Section 508 of the Rehabilitation Act through on-going technical assistance and training of 508 officials and managers responsible for procurement across all HHS Operating Divisions.
- Manage and enhance the OD website, a focal point and clearinghouse on HHS-related and other government disability information.
- Expand on Federal-State interactive website communication processes for persons with disabilities to ensure a one-stop information based on entitlements and other health and human service supports to heighten the interaction of HHS programs and disability-based State partners.

Funding History

FY 2005	$655,000
FY 2006	$643,000
FY 2007	$739,000
FY 2008	$779,000
FY 2009	$805,000

Budget Request

The Office of Disability's (OD) FY 2010 request of $814,000 is an increase of $9,000 over the FY 2009 enacted level. This amount will cover the annualization of the January 2009 pay raise, the anticipated January 2010 pay raise for OD's staff, and through restructuring of program expenditures fund the addition of one additional mission critical position. In FY 2010, OD will continue to oversee the Department's implementation and coordination of disability programs, policies, and special initiatives pertaining to health and health care-related programs to support the President's health care initiatives for all Americans. The budget request for OD will be used to continue to effectively provide cost effective advice and support to the Secretary and Department's disability initiatives and programs.

Outputs / Outcomes Table

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
2.2.1**:** Increase the number of youth participating in the "I Can Do It, You Can Do It" Program. *(Outcome)*	FY 2008: 1,000 (Target Met)	1,800	2,500	+4,300
2..3.1**:** In partnership with HHS Office of the Assistant Secretary for Preparedness and Response (ASPR), implement and monitor the use of the disability-based tool kit and future use of public health staff education modules modules. *(Output)*	FY 2008: 30 (Target Met)	40	50	+10
Program Level Funding ($ in millions)	**N/A**			

SECRETARIAL INITIATIVES AND FLEXIBILITY

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
BA	----	----	$6,500,000	+$6,500,000
FTE	----	----	27	+27

FY 2010 Authorization: …….. Indefinite
Allocation method: ……. Direct Federal; Contracts

Program Description and Accomplishments

The Secretarial Initiatives and Flexibility request will provide the incumbent Secretary with the flexibility necessary to identify, refine, and implement programmatic and organizational goals. The request will help meet the needs of the incumbent Secretary, while remaining within a reasonable and modest funding level compared to the overall HHS budget and GDM appropriation. The request covers any staff and salary costs as well as costs associated with implementing programs to support the Secretary's priorities. The budget request will enable the Secretary to respond to emerging health issues as well as provide additional support to ongoing activities supported by the component office within the Office of the Secretary (OS). The request will allow the Secretary to proactively respond to the needs of OS component offices as they continue to implement programs intended to improve and ensure the health and welfare of Americans. These funds will be directed to the Secretary's highest priorities and will be directed, implemented and monitored judiciously. As with any appropriation, execution of these funds will be tracked in the financial management system, including monthly status of funds reports, at a minimum, and more frequently if the nature of response or project necessitates. Additionally, the impact of these resources will be monitored based on the Secretary's stated goals and objectives for their use.

Budget Request

The FY 2010 request for Secretarial Initiatives and Flexibility is $6,500,000. As the Administration's priorities continue to emerge, the budget request will allow the Secretary to be prepared to support OS component offices as they respond to new legislative requirements and implement programs to address new and existing critical health issues. The budget request will allow the Secretary to provide necessary support as HHS Operating Divisions (OPDIV) and Staff Divisions (STAFFDIV) establish programs and initiatives in support of the Administration's mission and goals.

HHS OPDIVs and STAFFDIVs have been proactively seeking ways to respond to health issues that have emerged as a result of our current economic climate. As a result, HHS OPDIVs and STAFFDIVs have implemented programs and initiatives intended to respond to the critical health needs of the public. The budget request will allow the Secretary to establish and support priorities aligned with OPDIV and STAFFDIV activities, enabling the Secretary to provide necessary and expected leadership. These supportive activities will also enable the Secretary to ensure appropriate accountability and transparency, emphasizing Administrative priorities. The budget request includes and estimated 27 full time equivalent employees to carry out this work. However, as the specific nature of the work is unknown the mix of FTE supported and other costs will be adjusted accordingly.

Accountability in HHS

Throughout this document are targeted funding increases totaling $7,600,000 requested for individual Staff Divisions to improve Departmental Accountability functions and activities. These funds will ensure that key offices have the necessary resources to support risk mitigation efforts for ongoing HHS activities. This request reflects an increased need for additional resources to support those offices which are responsible for creating and implementing guidance, policies, and controls crucial to the effective management of HHS programs. Growth of HHS programs has resulted in increased demands on these offices. As a result, OS intends to be responsive by providing oversight to programs critical to the safety and well being of the American public. As OS responds to the Administration's priorities to employ rigorous standards of accountability and transparency throughout the Federal government, this funding will allow responsible offices to: enhance oversight of and policy guidance for acquisitions; strengthen legal review and oversight; improve financial reporting and financial controls; and implement robust budgetary oversight execution controls and performance tracking. In support of these efforts, this request includes salaries and expenses to employ the necessary staff with the distinctive skill-sets required to execute these functions. Details supporting the budget request can be found in the individual FY 2010 budget requests of each affected office as follows:

Staff Division	Purpose	Amount Requested*
Assistant Secretary for Public Affairs	Improve transparency via improved communications	$1,000,000
Assistant Secretary Legislation	Better support President's legislative agenda especially health reform and food safety	$500,000
Assistant Secretary for Resources & Technology	Improve financial reporting and financial controls, implement more robust budgetary execution controls and performance tracking;	$1,750,000

	improve grants management and operations oversight, and eliminate improper payments	
Assistant Secretary for Administration & Management	risk mitigation in contracts administration by expanding oversight and accountability	$750,000
Office of the General Counsel	For legal analysis and counseling throughout the acquisition process to reduce legal risk on procurement actions	$2,000,000
Departmental Appeals Board	To hire an Administrative Law Judge and senior to handle existing and anticipated increasing caseload resulting from heightened enforcement efforts	$1,300,000
Office of Public Health & Science	Improve internal controls through A-123 audit support	$300,000

*Staff Division increases reflect higher total increases due to amounts for pay and inflation for current staff levels.

OFFICE OF GLOBAL HEALTH AFFAIRS

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$9,610,000	$16,740,000	$11,741,000	-$4,999,000
FTE	30	31	31	---

Program Description and Accomplishments

The Office of Global Health Affairs (OGHA) represents HHS to other governments, Federal departments and agencies, international organizations, and the private sector on global health, welfare and family issues. For FY 2010, OGHA is requesting a total of $11,741,000 to support the following: the U.S.-Mexico Border Health Commission (USMBHC); the Afghanistan Health Initiative; the Health Diplomacy Initiative; and continuation of critical international policy development and coordination.

- $5,789,000 for the Afghanistan Health Initiative, to improve maternal and neonatal health at Rabia Balkhi Hospital (RBH) in Kabul, Afghanistan. HHS's efforts focus on training health personnel and developing logistics and management capacity at RBH.
- $3,523,000 for the USMBHC, including the Commission's work in developing a border health research forum, hosting U.S.-Mexico community venues for Border Bi-national Health Week, and engaging the U.S. and Mexican border States and local health departments to better align programmatic strategies at the federal levels and in such areas as influenza preparedness, early warning surveillance and response, and import safety issues to improve the health of the border populations.
- $429,000 to continue funding crucial OGHA activities that have expanded significantly while reimbursement agreements with the U.S. Department of State, U.S. Agency for International Development (USAID) and others have simultaneously decreased. Despite reduced or loss of revenue streams, programmatic needs remain or even increase.
- $2,000,000 for the Health Diplomacy Initiative to channel U.S government and private sector resources to touch people's lives by delivering direct patient care and training local health workers, starting in Central America, thereby improving the image of the United States in the Hemisphere. The FY 2010 request level will be used to carry out the existing Latin American Health Initiative.

Each of these programs and requests is described in more detail on the following pages.

OFFICE OF GLOBAL HEALTH AFFAIRS

FUNDING SUMMARY

Activity	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request
GDM Appropriation:			
Afghanistan Health Initiative	$5,789,000	$5,789,000	$5,789,000
U.S.-Mexico Border Health Commission	$3,523,000	$3,523,000	$3,523,000
Other GDM	$298,000	$428,000	$429,000
Health Diplomacy Initiative	0	$7,000,000	$2,000,000
Subtotal, OGHA Budget Authority	***$9,610,000***	***$16,740,000***	***$11,741,000***
Biotechnology Engagement Program (estimated funds transferred from State Dept)	$1,500,000	$450,000	$450,000
Reimbursables (estimated)	$7,112,000	$6,311,000	$5,811,000
Subtotal, OGHA Other	***$8,612,000***	***$6,761,000***	***$6,261,000***
TOTAL, OGHA Program Level	**$18,222,000**	**$23,501,000**	**$18,002,000**

Afghanistan Health Initiative

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$5,789,000	$5,789,000	$5,789,000	--
FTE	3	4	4	--

Authorizing Legislation .....Afghanistan Freedom Support Act of 2002
FY 2010 Authorization .....Expired
Allocation Method .....Contract, competitive grant

Program Description and Accomplishments

Funding for the Afghanistan Health Initiative was established through the Afghanistan Freedom Support Act of 2002. Starting in Fiscal Year (FY) 2003, the Department of Health and Human Services (HHS) received funding for the initiative, aimed at supporting the reconstruction of that country by improving maternal and child health, and reducing maternal and child mortality. Specifically, the activities of the HHS Afghanistan Health Initiative have focused on Rabia Balkhi Hospital (RBH), in Kabul, Afghanistan, as RBH is a Ministry of Public Health supported hospital which delivers care to high-risk women at a rate of 13,000-14,000 infant deliveries a year. Accomplishments have focused on the following:

- Increase the core knowledge and clinical skills of the physicians and other health-care professionals at RBH;
- Improve the leadership and management skills of the hospital administrators;
- Implement a quality-assurance collaborative for Caesarian-Section (C-Section) to reduce such rates as the overall intrapartum and postpartum maternal mortality rate; and
- Improve the case-specific maternal mortality rate associated with C-sections, the perinatal intrapartum mortality rate, and newborn pre-discharge mortality rate, as well as improvement in anesthesia outcomes that affect infants and mothers.

By strengthening hospital management and leadership, and clinical capacity for physicians, midwives and other health providers at RBH, we are working to improve the quality of maternal and infant health-care delivery and birth outcomes. As part of the Afghanistan Health Initiative, HHS has also worked with the Afghanistan Ministry of Public Health (MoPH) to help the MoPH implement its national health strategy which focuses on implementing a basic package of care for all Afghans and a comprehensive health-care delivery system from the community-health worker, to comprehensive health centers, to district- and tertiary-level hospitals, and to support the MoPH as it builds capacity to sustain these public-health and medical investments in RBH.

Funding History

FY 2005	$5,850,000
FY 2006	$5,890,000
FY 2007	$5,892,000
FY 2008	$5,789,000

FY 2009 $5,789,000

Budget Request

The FY 2010 funding request remains level at $5,789,000 for the Afghanistan Health Initiative and supports improving maternal and newborn health outcomes at Rabia Balkhi Hospital (RBH) in Kabul, Afghanistan. The initiative focuses on improving the clinical capacity and developing logistics and management capacity of staff at RBH. Approximately 99 percent of hospital staff including physicians, nurses and midwives participated in these training activities to improve the quality of care provided in 2007. This continues to align well with the work of the Afghan Government's Urban Health Task Force (UHTF) in its development of a comprehensive maternal and newborn referral system within Kabul as a potential model for maternal care throughout Afghanistan. Recent Kabul surveillance data from hospitals reported a deterioration of important maternal and newborn health indicators that required urgent attention. The indicators also reflected an inability to properly implement on a population basis (Kabul) the high-risk intervention associated with emergency obstetrical care (Cesarean Section) so urgently needed in a low-resource setting like Kabul.

Beginning in Fiscal Year 2008, and working closely with U.S. Embassy colleagues, HHS has increased its expertise in-country to engage directly with RBH and the Ministry of Public Health in the implementation of a quality assurance collaborative program. HHS engages through teams of two to four experts for an in-country period ranging from two to six weeks. Time in the country is focused on training and capacity building in such areas as obstetrics, pediatrics, pharmacology, health informatics, anesthesia, and systems surveillance. HHS continues to dedicate some of its appropriated dollars to support the activities of the Afghanistan Ministry of Public Health (MoPH), and non-governmental organizations.

In FY 2010 the Office of Global Health Affairs requests $5.789 million for the Afghanistan Health Initiative to cover the following activities:

- Focus on RBH and a quality-assurance collaborative on C-sections program by:
    - rapidly improving the quality and efficiency of implementing C-section as a means to reduce maternal and newborn mortality and morbidity. This collaborative will focus on the technical area and logistical aspects of performing a C-section and seeks to rapidly spread existing knowledge or best practices related to performing a C-section at RBH and the other maternity services in Kabul through systematic improvement efforts, usually lasting from 12 to 24 months.
    - Increasing engagement by HHS experts in areas such as obstetrics, pediatrics, clinical pharmacology, anesthesia, health informatics, hospital personnel staffing, and health systems (community-based to tertiary-level care settings.
- Assist the MoPH in its capacity to further reduce maternal and newborn mortality in Afghanistan by:
    - bolstering provision of health care among underserved high-risk populations,
    - improving its responsible governance and stewardship role in public health and the delivery of health care to its citizens,

- improving the implementation of MoPH programs in maternal and newborn health, and
- enhancing public knowledge and the knowledge of MoPH/MNH providers through strengthening of clinical decision making, public health surveillance, use of medical records within RBH and working toward consistent use of a medical record at any point of entry into the Afghan health system.

- As the Department focal point of coordination, OGHA will continue coordination coordinates with senior Afghan public health leadership and the donor community in Kabul, as well as across HHS and with U.S. DOD and USAID colleagues to align respective contributions and maximize efforts in country, e.g., improve the various elements within the Afghan health-care delivery system in Kabul.
- Continue efforts to enable more strategic collaboration with other U.S. Government partners (U.S. Department of Defense and the U.S. Agency for International Development), other international donors, and the MoPH to scale-up needed interventions in a sustainable way, to minimize risks to mothers, infants and the larger community.
- Concentrate on creating a quality-assurance collaborative to make C-section births safer at RBH, and on developing a vertical referral network of community clinics and hospitals within RBH's catchment area. The public-health component targets the development of surveillance systems linked to the quality-assurance process that initially focused on C-sections at RBH, and on the development of capacity at the MoPH to use data to make informed decisions about patient care and hospital management, including using data to shape the foundation for a quality-assurance collaborative on C-sections that began in 2009.

Outputs and Outcomes

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.1: The mortality rate at Rabia Balkhi Hospital (RBH) in Kabul, Afghanistan *(In 2008 this was changed to mortality rate per 100,000 C-sections).	FY 2007: 129.5 (Target Met)	110	105	+5
1.2: The percent of trainees enrolled in courses.	FY 2008: 95% (Target Exceeded)	90%	95%	+5%
1.3.: The time to hire and deploy essential staff trainers.	FY 2008: 2.0 mos (Target Exceeded)	2 mos	1.5 mos	-5 mos
1.4: The percent of staff trainers who fulfill the agreed upon in-country contract.	FY 2008: 90% (Target Unmet, but Improved)	95%	95%	Maintain
1.5: The intrapartum mortality rate among neonates with a birth specific rate of 2500 grams at RBH in Kabul, Afghanistan.	FY 2008: 14.3 (Target Not met; preliminary, data still being evaluated)	5.8	5.2	-.6

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.6: The predischarge neonatal mortality rate among neonates with a birth specific weight of 2500 grams at RBH in Kabul, Afghanistan.	FY 2008: 1.9 (Target not met)	1.9	1.8	-.1
1.7: The percent of nurse midwives who meet competency measures on the 37 Afghanistan Standards of Practice.	FY 2008: 80% (Target not met)	92%	95%	+3%
1.8: The post-operative infection rate among maternity patients at RBH in Kabul, Afghanistan.	FY 2008: 4.0 (Target appears to be not met, but reporting rate set too low)	2.5	2.3	-.2
Program Level Funding ($ in millions)	**$5.789**	**$5.789**	**$5.789**	**+/- $0**

United States-México Border Health Commission

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$3,523,000	$3,523,000	$3,523,000	--
FTE	3	3	3	--

Authorizing Legislation .....United States-Mexico Border Health Commission Act
FY 2010 Authorization .....Indefinite
Allocation Method: .....Non-competitive co-operative agreement

Program Description and Accomplishments

The United States-México Border Health Commission (USMBHC), established as a binational entity in 2000, provides international leadership to optimize health and quality of life along the United States–México border. Its primary goals are to institutionalize a U.S. domestic focus on border health, and create an effective binational venue to address the public health challenges that impact border populations in sustainable and measurable ways. The USMBHC facilitates identification of public health issues of mutual significance; supports studies and research on border health; and brings together effective federal, state and local public/private resources by forming dynamic partnerships and alliances to improve the health of the border populations through creative, multi-sectoral approaches. The Office of Global Health Affairs is the HHS Secretary's focal point of coordination for the USMBHC; and the Secretary is the Commissioner for the U.S. Section.

The USMBHC promotes (1) sustainable partnerships which engage international, federal, state and local public health entities in support of annual initiatives around critical border health priorities that for 2010 that will focus on tuberculosis, obesity and diabetes and infectious disease as impacted by public health emergencies; (2) leads the development of a comprehensive border health research agenda that will inform policy makers, researchers and entities which fund research where research gaps, needs and opportunities lay; (3) hosts the annual National Infant Immunization Week/Vaccination Week of the Americas (NIIW/VWA) that promotes the benefits of infant immunization in a regional and binational approach and hosts the annual Border Binational Health Week events along the entire U.S.-México border, which bring together local communities for health screenings, health education interventions and other unique training and education forums. In FY 2009 for Border Binational Health Week, the USMBHC helped to host 120 events along both sides of the border, engaging over 300 partners, and providing over 43,000 free health screenings and educational opportunities to U.S. and México border residents (U.S. side nearly 21,000 and México side nearly 22,000), reflecting a composite of various resources (including financial and in-kind support) from federal, State, local and community stakeholders.

Funding History

FY 2005	$3,503,444
FY 2006	$3,493,451
FY 2007	$3,464,580
FY 2008	$3,523,000
FY 2009	$3,523,000

Budget Request

The FY2010 funding request has remained level at $3,523,000 for the U.S. Mexico Border Health Commission. The Commission will continue to serve as a catalyst for border health issues, identify measurable and sustainable binational solutions through the engagement of public and private stakeholders at the international, federal, state, and local levels; and provide international leadership to optimize health and quality of life along the United States–México border. For example, in Fiscal Year 2010, the Commission, in its leadership role will host binational forums on infectious disease coordination and cooperation, on tuberculosis with added focus on multi-drug resistant tuberculosis and further coordinate an additional forum on the legal issues surrounding interstate and binational co-management of tuberculosis cases. In its catalytic role, the Commission in FY 2009 is hosting a number of key events including the second bi-annual border health research forum and the first-ever border health children's forum**.** The Commission will also publish the midterm review of the *Healthy Border 2010* objectives and will continue to promote critical research and other publications using the E-Border Health Bulletin. Funding in Fiscal Year 2010 will support important activities including:

- The priorities of tuberculosis, obesity/diabetes and infectious disease
- The seventh Border Binational Health Week
- National Infant Immunization Week/Vaccination Week of the Americas (NIIW/VWA) (6^{th} year)
- The first annual U.S.-Mexico Border Health Infectious Disease Conference
- The annual U.S.-Mexico Border Tuberculosis Conference in partnership with the newly established U.S.-Mexico Border TB Consortium that will include the ten border states and other federal and private partners
- The first-ever U.S.-Mexico TB Legal Issues forum to address the key legal issues impacting on interstate and cross-border case-management coordination
- Publication of Models of Excellence compendiums that will highlight unique programs that are utilizing successful interventions around tuberculosis and obesity/diabetes
- The promotion of binational community efforts through Commission supported binational health councils
- Studies that provide the necessary evidence-base to inform federal, state and local policymakers
- Continued binational engagement to institutionalize a U.S. domestic focus on border health, and create an effective binational venue to address the public health challenges that impact border populations in sustainable and measurable ways. Areas of focus include influenza preparedness, early warning surveillance and response, and import safety issues to improve the health of the border populations.

Outputs and Outcomes Table

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.1**:** Reduce the percent of indirect spending on border health activities	FY 2008: 7% (Target not met, but improved)	7%	6%	Maintain
1.2**:** The percentage of Health Border 2010 population level health outcome objectives with baseline data that have been achieved.	FY 2008: N/A (2010 Outcome)	N/A	50%	N/A
1.3**:** The incidence of tuberculosis cases per 100,000 inhabitants on the U.S. side of border.	FY 2008: N/A (2010 Outcome)	N/A	5	N/A
1.4**:** The incidence of HIV cases per 100,000 inhabitants on the U.S. side of border.	FY 2008: N/A (2010 Outcome)	N/A	4.2	N/A
1.5: The diabetes death rate on the United States side of the border (number of deaths per 100,000 inhabitants).	FY 2008: N/A (2010 Outcome)	N/A	5	N/A
1.6: United States-Mexico Border Health Commission (BHC): Border Binational Health Week (BBHW) celebrated on both sides of the U.S. Mexico Border	FY 2008: 20,576 (Target not met, but improved)	25,000	25,000	Maintain
1.7: Cumulative number of health related organizations that have adopted population-level health outcome objective of the BHC – Healthy Border 2010 Strategy into their planning, programming or funding process. (New Measure – 2008)	FY 2008: 57% (Target not met, new objective)	80%	90%	+10%
Program Level Funding ($ in millions)	**N/A**	**$3.522**	**$3.522**	**+/- $0**

Other GDM

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$298,000	$428,000	$429,000	+1,000
FTE	24	23	23	--

Authorizing Legislation .....……General Departmental Management
FY 2010 Authorization .....……..Indefinite
Allocation Method: .....…….Direct Federal

Program Description and Accomplishments

In FY 2010 $429,000 will continue to fund crucial OGHA activities that have expanded significantly while reimbursement agreements with the U.S. Department of State, U.S. Agency for International Development (USAID) and others have simultaneously decreased. Despite reduced or loss of revenue streams, programmatic needs remain or even increase. Such activities include: continued support for African public health activities (i.e. infectious disease control, maternal and child health) and workforce strengthening that were funded under a USAID Participating Agency Service Agreement (PASA); support of biotechnology engagement with Russian and surrounding States due to former bioweapon scientists remaining a public health security for HHS and the U.S. Government; and increasing global health engagement on policy and programmatic levels for the African and the Americas Region.

OGHA's activities have expanded significantly over recent times. Public health and science have been at the center of a number of global policy dialogues, especially within multilateral venues – at the United Nations and its councils and specialized agencies, the Organization of Economic Cooperation and Development (OECD), and at the G-8 Summit conferences – and OGHA remains the Department's focal point for the development and coordination of international policy. From January 2002 until the end of Fiscal Year 2004, OGHA was administratively attached to the Office of Public Health and Science, which paid OGHA's administrative expenses out of GDM. When OGHA became a Staff Division FY2005, the funds that had been supporting OGHA's administrative costs were not transferred into OGHA's budget. Since then, a number of OGHA's reimbursables have been decreasing at the same time.

Similarly, the Department's bilateral engagement has increased including such governments as Iraq, México, Russia and other Eurasian countries, Viet Nam and China, as well as European countries, where governments are increasingly interested in comparable data-collection methods and ways in which to share data for decision-making, public/private approaches to insurance coverage and increased patient choice, the intersections between trade and health and the impact of infectious-and chronic- disease burdens on governance and economies. OGHA's coordination of bilateral engagement for the Secretary and other HHS leaders enables the Department's effective role as the U.S. Ministry of Health, by engaging the best policy and technical experts within HHS to engage in comprehensive dialogue, set strategic directions and policies and explore potential collaboration, as appropriate.

There are also the long standing and recent special initiatives that OGHA leads for the Department or in which the office participates actively, including the Biotechnology Engagement Program, with Russia and other Eurasian countries; the Security and Prosperity Partnership (SPP) of North America, with Canada and Mexico; the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria; and the Global Health Security Initiative (G-7 countries plus Mexico).

HHS leaders have significantly expanded their international engagement as well, such as through the United States-China Strategic Economic Dialogue and current Departmental focus on import safety. Such increased activities need expanded staff and increased support for existing staff, including our Health Attachés in Switzerland, India, China, Brazil, South Africa, Viet Nam, and Iraq.

Funding History

FY 2005	$207,000
FY 2006	$60,000
FY 2007	$375,000
FY 2008	$298,000
FY 2009	$428,000

Budget Request

The FY 2010 request of $429,000 is an increase of $1,000 and is needed to continue funding crucial OGHA activities that have expanded significantly while reimbursement agreements with the U.S. Department of State, U.S. Agency for International Development (USAID) and others have simultaneously decreased. Historically, OGHA has benefited from substantial external resources from a number of agreements with U.S. Agencies like the U.S. Department of State and the U.S. Agency for International Development. However these revenue sources had decreased significantly, necessitating a needed shift in OGHA's budgetary sources of funding. For example, the Agreement with the U.S. Agency for International Development (known as the African PASA) ends in 2009; funds from the U.S. Department of State's Biotechnology Engagement Program to OGHA have decreased from $1.2 million in FY 2008 to $450,000 in FY 2009, a portion of these support OGHA's staff and management costs.

Health Diplomacy Initiative

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	0	$7,000,000	$2,000,000	-$5,000,000
FTE	N/A	1	1	--

Authorizing Legislation……General Departmental Management
FY 2010 Authorization……...Indefinite

Program Description and Accomplishments

The Health Diplomacy program channels U.S. Government and private-sector resources to touch people's lives by delivering direct patient care and training local health workers in Latin America and the Caribbean and other regions of the world, thereby improving the image of the United States. The initiative has four main objectives:

- Train Central American health-care workers through a Regional Health-Care Training Center (RHCTC) located in Panamá City. Students return to their homes and apply the skills learned, thereby contributing to the improvement of health care provided at the community-level;
- Train U.S. Government medical personnel through forward-deployment missions, focusing first on Central American and Caribbean countries, as part of U.S. military medical and humanitarian missions to provide health care, including oral health care, for poor populations in the region; and
- Establish a strategic approach to engage with U.S. Government-funded, non-governmental organizations (NGOs) that provide health care in Latin America and other underserved communities.
- Establish pilot programs in other regions of the world, including Africa.

Funding History

FY 2009 $7,000,000

Budget Request

The FY2010 budget request is a decrease of $5,000,000 from FY 2009. In FY 2009, the $7 million will support the continued strengthening of health-care systems in developing countries to strengthen their health infrastructure and systems and achieve better health for both the people in the developing country and the United States. During FY 2009, the Health Diplomacy program will focus on training healthcare workers and providing other services in, but not limited to, Central and South America. This initiative will also help control diseases such as HIV/AIDS, tuberculosis, and malaria by giving local residents the training they need to provide basic health care in Latin America and other underserved communities.

In FY 2009, the following will be targeted:

- Provide additional health care services in Latin American through deployment of USPHS Officers on humanitarian and medical training missions.
- The continued strengthening of the RHCTC as a viable training center for Central America, aimed at increasing skill sets and expertise for students from communities at highest-risk and needs in a range of public health areas, including influenza preparedness, oral health, and maternal/child health.
- Support strategic policy frameworks for countries in Latin America and the Caribbean to help them develop effective oversight, coalition building, system-design, regulations and incentives.
- Support the strengthening of the health systems in Latin America and the Caribbean to improve access to medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and advance their scientifically sound and cost-effective use.
- Support building health information systems in Latin America and the Caribbean that ensure the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.
- Selected pilot programs – other regions of the world, including Africa.

In FY 2010, the $2 million funding will support the continued HHS engagement to collaborate with the RHCTC strategically. The funding support will provide for continued humanitarian missions, training, and development of course materials, and additional engagement of trainers with the most needed skills. The 2010 Budget includes funding to sustain the most productive activities funded with the FY 2009 appropriation, but would not fund expansions.

Outputs and Outcomes Table

Program funding was not allocated for FY 2008. Performance measures are currently being developed for FY 2009.

OFFICE OF PUBLIC HEALTH AND SCIENCE

Executive Summary

Agency Overview

The Office of Public Health and Science (OPHS) provides leadership to the Nation on public health and science, and communicates on these subjects to the American people. OPHS is a unique Staff Division in the Department of Health and Human Services (HHS) in that it performs both policy and program roles.

Authorized in 1995[1], OPHS, headed by the Assistant Secretary for Health (ASH), is a division in the Office of the Secretary (OS). This role encompasses responsibilities as senior advisor for public health and science to the Secretary thereby providing senior professional leadership on population-based public health and clinical preventive services, directing a variety of program offices housing essential public health activities, providing senior professional leadership across HHS on White House and special Secretarial initiatives involving public health and science, and guiding and providing technical assistance to the ten Regional Health Administrators. By providing valuable coordination within and across the divisions of HHS, OPHS helps HHS achieve greater success in enhancing the health and well-being of Americans.

In its authorizing regulation[2], the ASH, through OPHS, is given as a primary function the coordination of public health and science activities across HHS components. Specifically, OPHS is charged with leadership in development of policy recommendations "on population-based public health and science" and, at the direction of the Secretary, with coordination of "initiatives that cut across agencies and operating divisions" of HHS[3]. In fulfillment of this function, OPHS works closely with the various operating divisions of HHS on implementation of programs and policies at the convergence of public health and science.

Mission

The mission of OPHS is to protect and promote the public health of the Nation through policies and programs that apply science-based approaches that enable people to live healthier lives.

Vision

The OPHS sees a Nation in which healthy people live in healthy communities, sustained by effective, efficient, and coordinated public health systems.

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[1] "Office of the Secretary and Public Health Services: Statement of Organization, Functions, and Delegations of Authority", Federal Register, Vol. 60, No. 217. Thursday, November 9, 1995, p. 56605-56606.

[2] Office of the Secretary, p. 56606.

[3] Office of the Secretary, Federal Register, p. 56606.

Values

The OPHS has identified and defined five core values, which are listed below.

Put People First

- Honor the public's trust and confidence;
- Respect for colleagues and the public health professions; and,
- Recognize the invaluable contributions of OPHS staff.

Integrity

- Adhere to the highest ethical standards;
- Ensure products and services are truthful, accurate, and comprehensive;
- Assure health research conforms to scientific norms; and,
- Recognize that privacy and safety of human participants is paramount.

Excellence

- Conduct programs and activities guided by science and driven by results;
- Delineate clear and enforce consistent accountability for program outcomes;
- Design programs and activities so that rigorous program evaluations can and will be performed; and,
- Promote public health that is effective, efficient, and community-delivered.

Diversity

- Embrace the richness of OPHS' diversity and seek to strengthen it;
- Value the diversity of our Nation and the perspectives brought by differences in race, ethnicity, gender, age, and socio-economic status; and,
- Believe that all Americans should benefit from advances in health promotion.

Leadership Through Collaboration

- Commit to disease prevention and health promotion;
- Believe that collaboration and coordination builds effective, efficient, responsive, and sustainable public health systems; and,
- Foster input from all relevant partners and stakeholders in program operations.

The values and mission statement establish the direction of OPHS activities toward achievement of the vision. The vision is the target outcome for current and future OPHS activities.

Discussion of Strategic Plan

The following three goals and associated objectives and strategies are the methods to reach the

vision. Over the next four years, OPHS leadership will concentrate resources and management efforts on achieving these goals:

Goal 1: Prevention - Prevent disease and improve the health of individuals and communities

Goal 2: Disparities - Reduce and, ultimately, eliminate health disparities

Goal 3: Public Health Infrastructure - Promote effective, sustainable, and consistent public health systems

As a framework, this Plan is specific enough to fit within the more expansive goals of the HHS Strategic Plan. This framework also remains sufficiently broad that programs and activities of individual OPHS offices will fit within the structure.

Discussion of OPHS Performance Plan

Associated with each of the three goals are five objectives:

- Shape public health policy at the local, state, national, and international, levels;
- Communicate strategically;
- Promote effective partnerships;
- Build a stronger science base; and,
- Lead and coordinate key initiatives of HHS and Federal health initiatives.

They are complex national challenges and reach beyond the control and responsibility of the Federal government. Achievement is dependent on various health programs and providers, all levels of government, and the efforts of the private sector as well as individual contributions. In some instances, OPHS's contributions act as a catalyst for action; in other instances OPHS provides the leadership and "glue" that makes the difference in collective efforts.

Specific strategies associated with each goal and each objective further define the actions OPHS will take today and in the future to ultimately reach the vision. The three goals will be achieved through implementation of the explicit strategies which follow.

Goal 1: Prevent Disease and improve the health of individuals and communities

Objective A: Shaping Policy at the Local, State, National, and International Level

Strategy 1.A.1: Lead the development and oversight of Healthy People 2020 for the Nation.

Strategy 1.A.2: Lead the development and monitoring of the *National Vaccine Plan* to ensure coordination of the various components of the Nation's vaccine system in order to achieve optimal prevention of human infectious diseases through immunization.

Strategy 1.A.3: Lead the HHS reproductive health programs that reduce unintended pregnancies, adolescent pregnancies, and the transmission of sexually transmitted diseases by developing and implementing policies and programs related to family planning and other preventive healthcare services, including education and social support services.

Objective B: Communicate Strategically

Strategy 1.B.1: Ensure that *healthfinder.gov* becomes the pre-eminent federal gateway for up-to-date, reliable, evidence-based prevention information so that individuals are empowered to adopt healthy behaviors.

Strategy 1.B.2: Maximize the number of Americans who know their HIV health status through targeted HIV awareness and testing campaigns.

Strategy 1.B.3: Emphasize effectively with federal, state, and local stakeholders the extensive systems changes needed in school nutrition and physical activity programs, community infrastructure, and nutrition programs for the poor to reduce childhood obesity.

Strategy 1.B.4: Advance programs and activities that improve health literacy through provision of evidence-based and culturally competent health care.

Objective C: Promote Effective Partnerships

Strategy 1.C.1: Use the *Healthy People Consortium* to make Americans healthier by encouraging use of *Healthy People 2020* objectives at national, state, and local levels.

Strategy 1.C.2: Partner with national public health organizations and medical associations to identify emerging public health and science issues, disseminate information on key initiatives and priorities, and leverage existing programs in order to maximize the positive impact on the nation's health.

Strategy 1.C.3: Through a variety of collaborations, drive community-led discussions about HIV-related stigma and risk behaviors to strengthen HIV/AIDS prevention efforts.

Objective D: Build a Stronger Science Base

Strategy 1.D.1: Lead the development, promotion, and evaluation of evidence-based *Physical Activity Guidelines* for the Nation to help Americans achieve appropriate levels of physical activity that lead to good health.

Strategy 1.D.2: Lead, with the United States Department of Agriculture, the development, promotion, and evaluation of evidence-based *Dietary Activity Guidelines* for the Nation to help Americans eat a nutritionally balanced diet.

Strategy 1.D.3: Develop and promote future *Surgeon General's Calls to Action* such as those on the prevention of deep venous thrombosis (DVT), on the prevention and reduction of underage drinking, on improvement of the health and wellness of persons with disabilities, on the promotion of oral health, and on the prevention and reduction of overweight and obesity.

Objective E: Lead and Coordinate key Initiatives of HHS and Federal health initiatives

Strategy 1.E.1: Lead the department in its effort to improve vaccine safety and public confidence in vaccines in order to maintain high national immunization rates.

Strategy 1.E.2: Develop and implement a HHS plan to reduce healthcare associated infections (HAI) that includes prioritizing recommended clinical practices, strengthening data systems, and developing and launching a national HAI prevention campaign.

Strategy 1.E.3: Lead the Federal initiative, *Healthy Youth for a Healthy Future*, to prevent childhood overweight and obesity, by partnering with communities throughout the Nation that are helping kids stay active, encouraging healthy eating habits, and promoting healthy choices.

Strategy 1.E.4: Lead the *President's Council on Physical Fitness & Sports (PCPFS)* in efforts to significantly increase physical activity in this country.

Strategy 1.E.5: Continue OPHS' historic leadership to prevent and treat tobacco abuse and dependence.

Goal 2: Reduce, and ultimately, eliminate health disparities

Objective A: Shape public health policy at the local, state, national, and international levels

Strategy 2.A.1: Provide leadership across the Nation to guide, organize, and coordinate the systemic planning, implementation, and evaluation of policies and programs designed to achieve targeted results relative to minority health and health disparities reduction.

Strategy 2.A.2: Provide leadership to promote health equity for women and girls through the development of innovative programs, through the education of health professionals, and through the motivation of consumer behavior change by disseminating relevant health information.

Strategy 2.A.3.: Expand Commissioned Corps initiatives to recruit and retain officers in assignments that meet the public health needs of underserved populations.

Objective B: Communicate strategically

Strategy 2.B.1: Ensure that the *Office on Women's Health Resource Center* and the *Office of Minority Health Resource Center* become the nation's pre-eminent gateways for women's health and minority health information.

Strategy 2.B.2: Significantly increase the number of health care professionals using the nationally accredited on-line *Cultural Competency Training* modules to increase their knowledge and skills to better treat the increasingly diverse U.S. population.

Strategy 2.B.3: Advocate for widespread access for health care providers to foreign language resources to improve communications with patients and families with limited English proficiency (LEP).

Objective C: Promote effective partnerships

Strategy 2.C.1: Ensure that the *National Partnership for Action to End Health Disparities* connects and mobilizes organizations throughout the Nation to build a renewed sense of teamwork across communities, share success stories for replication, and create methods and tactics to support more effective and efficient actions.

Strategy 2.C.2: Through the *Leadership Campaign on AIDS*, provide technical assistance to minority communities so that they are at the forefront in the fight against HIV/AIDS.

Objective D: Build a stronger science base

Strategy: 2.D.1: Develop and test interventions designed to address racial and ethnic disparities through community-level activities that promote health, reduce risks, and increase access to and utilization of appropriate preventive healthcare and treatment services.

Strategy 2.D.2: Foster the development of evidence-based health and disease prevention practices for women through innovative national and community-based programs focused on conditions affecting women's health.

Objective E: Lead and coordinate key initiatives of HHS and Federal Health Initiatives

Strategy 2.E.1: Ensure that the distinctive cultural, language, and health literacy characteristics of minority and special needs populations are integrated into all-hazards emergency preparedness plans.

Strategy 2.E.2: Provide leadership and oversight for the *Minority AIDS Initiative* to ensure that departmental efforts strengthen the organizational capacity of community-based providers and expand HIV-related services for racial and ethnic minority communities disproportionately affected by HIV/AIDS.

Strategy 2.E.3: Lead and manage the *HHS American Indian Alaska Native Health (AI/AN) Research Advisory Council* to ensure input from tribal leaders on health research priorities, to provide a forum through which HHS can better coordinate its AI/AN research, and to establish a conduit for improved dissemination of research to tribes.

Strategy 2.E.4: Lead and manage the *HHS Work Group on Asian, Native Hawaiian and Other Pacific Islander issues* to provide a forum for HHS to develop strategies for improving the health of these communities.

Goal 3: Promote effective, sustainable, and consistent public health systems

Objective A: Shape public health policy at the local, state, national, and international levels

Strategy 3.A.1: Promote emergency preparedness by strengthening the capacity and capability of Medical Reserve Corps (MRC) units in local communities across the country.

Strategy 3.A.2: Provide advice and consultation to the Executive Branch on ethical issues in health, science, and medicine.

Strategy 3.A.3: Lead the development of national blood, tissue, and organ donation policy to maintain and enhance safety through prevention of disease transmission and other adverse events during transfusion and transplantation.

Strategy 3.A.4: Strengthen the public health mission of the Public Health Service Commissioned Corps through research, applied public health, and provision of health care services including behavioral and mental health.

Objective B: Communicate strategically

Strategy 3.B.1: Foster effective communication to the public that promotes and increases blood and organ donation.

Strategy 3.B.2: For people with multiple chronic conditions, advocate for changes in the research, clinical, health professional education, financing, and health delivery enterprises so that their health can be better managed and acute exacerbations of conditions can be prevented.

Objective C: Promote effective partnerships

Strategy 3.C.1: Expand memorandums of understanding (MOUs) and memorandums of agreement (MOAs) between the Commissioned Corps and local, state, and federal health agencies to allow placement of officers in other government organizations (outside HHS).

Strategy 3.C.2: Support Commissioned Corps initiatives to recruit, develop, and retain a competent health care workforce.

Objective D: Build a stronger science base

Strategy 3.D.1: Educate the broad research community on federal regulations that protect human subjects in research.

Strategy 3.D.2: Educate the broad research community on research integrity to minimize cases of research misconduct and to decrease the number of misconduct cases that go unreported.
Strategy 3.D.3: Ensure that Public Health Reports remains a pre-eminent peer-reviewed journal on public health practice and public health research for healthcare professionals.

Objective E: Lead and coordinate key initiatives of HHS and Federal health initiatives

Strategy 3.E.1: Lead the transformation of the Commissioned Corps into a mobile, organized, ready, and responsive force that ensures the preparedness of the Nation for emergency response.

Strategy 3.E.2: Engage the Commissioned Corps in health diplomacy missions to provide critically needed medical and public health services beyond our borders.

Strategy 3.E.3: Support the Regional Health Administrators as key coordinators of prevention and preparedness activities at the local, state, and regional level.

Strategy 3.E.4: Lead HHS initiatives to enhance transfusion and transplantation safety and to improve blood availability through collaboration and coordination with relevant stakeholders internal and external to HHS.

OPHS Overview of Performance

While the OPHS components are diverse in nature and focus, they work in partnership with each other and with other HHS divisions to form a proficient and capable Federal public health system. Recent OPHS contributions are listed by objective below:

Shape public health policy at the local, state, national, and international levels

Highlights:

- OPHS received funding from the U.S. Navy to provide United States Public Health Service (USPHS) Commissioned Officers help improve health and healthcare around the world. In FY 2008, several significant health diplomacy missions were conducted aboard the USS Boxer, the USS Kearsarge, and the USNS Mercy. The OPHS has worked closely with U.S. Navy Public Affairs to ensure that the USPHS and HHS were actively involved in the U.S. Navy media affairs activities as well as in the in-country media events. This included presentations on blood safety to the European Haemovigilance Network, the WHO's Global Collaboration on Blood Safety, and the International Society for Blood Transfusion.

- OPHS is leading efforts with the Office of Global Health Affairs to expose Iraqi physicians to advances in evidence-based medicine and quality systems of care so they can apply and share this knowledge in their clinical practice settings, while enhancing the cultural competency of the American healthcare providers who serve as their hosts. In October 2008, HHS hosted a group of approximately 30 Iraqi physicians to engage in a month-long clinical observership at U.S. based institutions. These physicians were identified by the Iraqi Ministry of Health. These clinical observerships provided an understanding of the mutual benefits of exploring methods and theories to improve the delivery of health care in challenging and difficult settings and making the results of the cooperation available to others interested in the same outcomes. An orientation conference was provided for the Iraqi physicians with a representative from each host site to serve as a preceptor for the Iraqi physician. After this orientation, the physicians traveled to the host sites to serve as physician observers in clinical health-care facilities. At the conclusion of the observership period, the physicians and host-site representatives collaborated to analyze the knowledge, skills, and abilities gained from this project, and evaluate and disseminate the findings and lessons learned for the use of all interested in the objectives of the project.

Communicate strategically

Highlights:

- The National President's Challenge was held March 20 - May 15, 2008. Close to 90,000 people from all 50 states, D.C. and several U.S. territories participated. The President's Council on Physical Fitness and Sports Adult Fitness Test was launched in May 2008. This is a free on-line tool to assess the fitness levels of adults. 75,000 people took the test in the first week following the launch with almost 90,000 Americans rising to the challenge and pledging to become more active.

- OPHS published a new bilingual booklet, “La Buena Vida (The Good Life),” based on the Dietary Guidelines for Americans. It is intended to guide Latinos and their families toward the goal of enjoying *La Buena Vida* and describes how food and physical activity choices affect personal and family health –today, tomorrow, and in the future.

Promote effective partnerships

Highlights:

- The OPHS has continued its partnership with the Assistant Secretary for Preparedness and Response on public health and science matters related to pandemic preparedness. In July 2008, HHS released guidance on allocating and targeting pandemic influenza vaccine. The guidance provides a planning framework to help state, tribal, local and community leaders ensure that vaccine allocation and use will reduce the impact of a pandemic on public health and minimize disruption to society and the economy.

- The OPHS has launched the National HIV Testing Mobilization Campaign, a nationwide effort to encourage all sexually active Americans to get tested for HIV. Outreach occurs through existing events at which regional coordinators exhibit and present in workshops; partnerships with national and regional organizations; and general outreach through channels that reach audiences disproportionately impacted by HIV. The total number of persons reached through partnership activities, events, and general outreach is 3.5 million.

Build a stronger science base

Highlights:

- The President's Council on Bioethics published a large volume on human dignity. In addition to the publication, the Council convened five colloquia around the country to stimulate discussion and debate on human dignity and bioethics. Four major inquiries were also completed on the topics of organ transplantation, definition of death, newborn screening, and health care reform.

- Due to enhanced awareness, knowledge, and enforcement of research conduct, allegations of misconduct to the Office of Research Integrity were reduced. This demonstrates the success of OPHS on clarifying policy, increasing accessibility of tools, and increasing opportunities for reporting and enforcement of misconduct.

Lead and coordinate key initiatives of HHS

Highlights:

- OPHS convened a department-wide Committee focused on increasing tertiary prevention among the estimated 75 million Americans with multiple chronic conditions. Focal areas for this work include: improving the external validity of clinical trials; incorporating multi-morbidity in clinical guidelines; integrating care of patients with multiple chronic conditions in health professions education; designing payment policy incentives to support care coordination; and, supporting self-care management and integrating this with structured case management.

- The Deputy Assistant Secretary for Minority Health co-chairs (with HRSA) a new initiative to advance HHS efforts related to HIT, underserved populations, and reducing health disparities. These efforts are coordinated through the Office of the National Coordinator, along with other HHS agencies as part of the broader HHS initiative around the expansion of HIT. The initiative is looking at evidence based strategies to utilize HIT to reduce health disparities in underserved populations. This partnership is increasing knowledge of the benefits of HIT for minority and/or underserved populations, leveraging support to market, educating and increasing usage of HIT, and increasing accessibility to HHS-sponsored programs.

Coordinate Federal health efforts that bridge departments

Highlights:

- Beginning in May 2008, the Assistant Secretary for Health chaired a cross-government Federal Immunization Safety Task Force that developed a report with recommendations to improve and maintain public confidence in the nations' vaccine program. High priorities were identified from the report for immediate implementation. Recognizing the urgency of moving forward on this important public health issue, efforts are underway to implement programs in vaccine safety science, vaccine policy and practice, public engagement, and improving communications using message mapping technique.

- Building a Healthier Chicago (BHC) was launched in February 2008 and provides baseline health assessment data for future BHC evaluations. BHC is a collaborative initiative among the American Medical Association, the Chicago Department of Public Health, and the Region V Office of the Regional Health Administrator, along with over 75 local, regional, and national partners in the government, non-profit, academic, and business sectors. The goal of BHC is to enhance and support partner's programs and policies that work to increase activity levels, improve healthy eating and prevent, detect and control high blood pressure.

OPHS CJ Performance Measures Table

Long Term Objective: Prevent disease and improve the health of individuals and communities

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.a: Shape public health policy at the local, State, national, and international levels *(Outcome)* Measure 1: The number of communities, state and local agencies, Federal entities, NGOs or international organizations that adopt (or incorporate into programs) policies and recommendations generated or promoted by OPHS through reports, committees, etc.	FY 2008: 32,611 (Target Not Met but Improved)	50,000	50,000	Maintain
1.b: Communicate strategically *(Outcome)* Measure 1: The number of visitors to Websites and inquiries to clearinghouses; Measure 2: Number of regional/national workshops/conferences, community based events, consultations with professional and institutional associations; Measure 3: new, targeted educational materials/campaigns; Measure 4: media coverage of OPHS-supported prevention efforts (including public affairs events).	FY 2008: 54,942,164 (Target Exceeded)	52,000,000	53,000,000	+1,000,000
1.c: Promote effective partnerships *(Outcome)* Measure 1: Number of formal IAAs, MOUs, contracts, cooperative agreements, and community implementation grants with governmental and non-governmental organizations that lead to prevention-oriented changes in their agendas/efforts.	FY 2008: 480 (Target Exceeded)	175	200	+25
1.d: Build a stronger science base *(Outcome)* Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated; Measure 3: the number of promising practices identified by research, demonstrations, evaluation, or other studies.	FY 2008: 159 (Target Not Met)	225	250	+25

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.e: Lead and coordinate key initiatives of HHS and Federal health initiatives *(Outcome)* Measure 1: Number of prevention-oriented initiatives/entities within HHS, across Federal agencies, and with private agencies, and with private organizations that are convened, chaired, or staffed by OPHS; Measure 2: Number of outcomes from efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc.	FY 2008: 1,589 (Target Exceeded)	1,600	1,700	+100

Long Term Objective: Reduce and, ultimately, eliminate health disparities

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
2.a: Shape public health policy at the local, State, national, and international levels *(Outcome)* Measure 1: The number of communities, NGOs, state and local agencies, or Federal entities, that adopt (or incorporate into initiatives) policies and recommendations targeting health disparities that are generated or promoted by OPHS through reports, committees, etc.	FY 2008: 404 (Target Exceeded)	97	100	+3
2.b: Communicate strategically *(Outcome)* Measure 1: The number of visitors to Websites and inquiries to clearinghouses; Measure 2: number of regional/national workshops/conferences or community based events; Measure 3: new, targeted educational materials/campaigns; Measure 4: media coverage of OPHS-supported disparities efforts (including public affairs events); and estimated number of broadcast media outlets airing Closing the Health Gap messages.	FY 2008: 1,949,387 (Target Exceeded)	2,305,000	2,400,000	+95,000

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
2.c: Promote Effective Partnerships *(Outcome)* Measure 1: Number of formal IAAs, MOUs, contracts, cooperative agreements and community implementation grants with governmental and non-governmental organizations that lead to changes in their agendas/efforts to address health disparities.	FY 2008: 331 (Target Exceeded)	126	140	+14
2.d: Build a stronger science base *(Outcome)* Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated; Measure 3: number of promising practices identified in research, demonstration, evaluation, or other studies.	FY 2008: 89 (Target Exceeded)	45	50	+5
2.e: Lead and coordinate key initiatives of HHS and Federal health initiatives (*Outcome)* Measure 1: Number of disparities-oriented initiatives/entities within HHS, across Federal agencies, and with private organizations that are convened, chaired, or staffed by OPHS; Measure 2: number of specific outcomes of the efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc.	FY 2008: 120 (Target Exceeded)	23	25	+2

Long Term Objective: Promote effective, sustainable, and consistent public health systems

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
3.a: Shape public health policy at the local, State, national, and international levels *(Outcome)* Measure 1: The number of communities, NGOs, state and local agencies, Federal entities, or research organization that adopt (or incorporate into programs) policies, laws, regulations and recommendations promoted or overseen by OPHS.	FY 2008: 3,529 (Target Exceeded)	1,800	1,900	+100

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
3.b: Communicate strategically *(Outcome)* Measure 1: The number of visitors to Websites and inquiries to clearinghouses; Measure 2: number of regional/national workshops/conferences, community based events, and consultations with professional and institutional associations; Measure 3: new, targeted educational materials/campaigns.	FY 2008: 2,046,913 (Target Exceeded)	1,178,844	1,200,000	+21,156
3.c: Promote Effective Partnerships *(Outcome)* Measure 1: Number of formal IAAs, MOUs, contracts, cooperative agreements and community implementation grants with governmental and non-governmental organizations that lead to changes in their agendas/efforts related to the public health or research infrastructure.	FY 2008: 131 (Target Exceeded)	30	50	+20
3.d: Strengthen the science base *(Outcome)* Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated; Measure 3: number of public health data enhancements (e.g. filling developmental objectives or select population cells; development of state and community data) attributable to OPHS leadership.	FY 2008: 1,927 (Target Exceeded)	189	200	+11
3.e: Lead and coordinate key initiatives of HHS and Federal health initiatives *(Outcome)* Measure 1: Number of relevant initiatives/entities within HHS, across Federal agencies, and with private organizations that are convened, chaired, or staffed by OPHS; Measure 2: specific outcomes of the efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc. [OSG]: M2: # Reserve Officers Commissioned [OSG] M3: # Activation days[OSG] M4: # Officers trained	FY 2008: 3,114 (Target Not Met)	7,300	7,500	+200

OFFICE OF PUBLIC HEALTH AND SCIENCE
Summary Table

	FY 2008 Appropriations		FY 2009 Omnibus		FY 2010 President's Budget Request	
GDM Direct:	FTE	AMOUNT	FTE	AMOUNT	FTE	AMOUNT
Immediate Office	37	7,940,000	45	8,820,000	47	9,219,000
Office of HIV/AIDS Policy	4	905,000	6	930,000	6	942,000
Adolescent Family Life	12	29,778,000	12	29,778,000	12	29,778,000
Office of Disease Prevention & Health Promotion	20	7,106,000	23	7,232,000	23	7,273,000
President's Council on Physical Fitness & Sports	6	1,196,000	6	1,228,000	6	1,241,000
Office of Minority Health	55	49,118,000	62	52,956,000	63	55,956,000
Office on Women's Health	39	31,033,000	43	33,746,000	43	33,746,000
Office for Human Research Protections	31	6,710,000	33	6,959,000	33	7,048,000
National Vaccine Program Office	10	6,790,000	17	6,879,000	17	6,896,000
Public Health Reports	2	443,000	2	450,000	2	453,000
Commissioned Corps Initiatives	26	4,119,000	31	14,813,000	31	14,813,000
Subtotal, GDM	242	145,138,000	280	163,791,000	283	167,365,000
GDM Reimbursable:						
Office of Research Integrity[1]	21	[8,571,000]	24	[8,909,000]	24	[9,118,000]
Other	38	---	107	---	111	---
Subtotal, Reimbursable	59	---	131		135	
	---		---		---	
TOTAL OPHS	**301**	**145,138,000**	**411**	**163,791,000**	**418**	**167,365,000**
PHS Evaluation Set-Aside; non-add		*[4,510,000]*		*[4,010,000]*		*[4,510,000]*

[1] ORI is funded by NIH dollars, which are reflected as a non-add.

OPHS IMMEDIATE OFFICE

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$7,940,000	$8,820,000	$9,219,000	$399,000
FTE	75	80	82	+2

Authorizing Legislation……...…Title III, Section 301 of the Public Health Service Act
FY 2010 Authorization……...Indefinite
Allocation Method……..Direct federal

Program Description and Accomplishments

This request provides funding to support the Immediate Office of the Office of Public Health and Science (OPHS) and the Office of the Surgeon General (OSG). OPHS is under the direction of the Assistant Secretary for Health (ASH), who serves as the senior advisor to the Secretary on issues of public health and science. The Immediate Office of the ASH serves as the focal point for leadership and coordination across the Department in public health and science, provides advice and counsel to the Secretary on these issues, and provides direction to policy offices within OPHS.

The role of the Surgeon General (SG) is to protect and advance the health of the Nation. The SG, who reports to the ASH, provides a highly recognized symbol of national commitment to protecting and improving the public's health, communicates with the American people on issues related to health and advises on health related behaviors and interventions.

The Immediate Office and OSG directly support several of the HHS priorities, such as Obesity Prevention, Pandemic Preparedness, and Emergency Response and Commissioned Corps Renewal. In its leadership role, the Immediate Office ensures a public health perspective on all Secretarial and Presidential priorities. The Immediate Office provides leadership to and oversight of the OPHS policy/program offices as they implement their programs and other HHS and Presidential priorities.

OPHS strives to establish and strengthen effective networks, coalitions, and partnerships to identify public health concerns and to stimulate and undertake innovative projects that solve them. OPHS reaches out to professional groups, advocacy groups, international partners, non-governmental organizations, and colleagues in Federal, State, tribal and local governments, engaging in collaborative work to assist in the identification of health concerns and problems and development of creative solutions. The OPHS goal is to increase by at least ten percent annually, commitments to prevention on the part of public and private entities, as measured by the number of these entities that change or strengthen their prevention efforts as a result of partnerships with OPHS.

Support for Presidential and Secretarial initiatives was a priority across all of the OPHS program offices. The Secretarial Prevention Initiative, led by OPHS, has received over $327 million in donated media support, a quantifiable index for measuring a campaign's success. Ad Council tracking research has also revealed a significant increase in the number of adults reporting healthier habits (16 percent to 23 percent) and that levels of reported physical activity have risen dramatically (45 percent to 56 percent). OPHS also supported the Medicare Prevention tour by sending many senior staff to participate in events and engaging local OPHS partners.

OPHS has a critical role in helping to improve health and healthcare in the United States and around the world through the operational and subject matter expertise of the U.S. Public Health Service Commissioned Corps. This past year, over 1,500 Commissioned Corps officers were deployed on 28 different missions, including Hurricanes Gustav and Ike. Deployed officers provided: over 400 water quality inspections; 500 air quality inspections; 175,000 patient care encounters; 300,000 pharmacy encounters; 300 mental health encounters; 400 veterinarian services; and over 13,200 hours completing public health infrastructure surveys. In direct response to both Presidential and Secretarial initiatives, the Commissioned Corps deployed officers on three separate international health diplomacy missions:

- In the spring, the USS BOXER undertook a two-month mission to three countries in Latin and South America including Nicaragua, El Salvador and Peru. During two successive public health detachments over 21 officers participated.
- The USNS MERCY undertook a four-month mission to six Pacific Island and Pacific Rim countries which included three successive public health detachments and 45 officers participating. In addition to the valuable training environment afforded to the embarked personnel, the skills and expertise of the officers enabled the delivery of medical, surgical, dental, veterinarian, engineering and public health services to thousands of indigenous patients.
- The USS KEARSARGE conducted a four-month mission to seven countries in Latin America and the Caribbean including Nicaragua, Colombia, Haiti, Curacao, Dominican Republic, Trinidad & Tobago, and Guyana. More than 36 public health officers participated in three successive detachments.

OPHS, as part of its responsibility to help employ the HHS Pandemic Influenza Implementation Plan, leads interagency groups focused on antiviral drug use strategies, vaccine prioritization strategies, and surveillance of Influenza A/H5N1. Additionally, the Commissioned Corps has increased its partnership with the United States Southern Command (SOUTHCOM), in particular the Office of the Command Surgeon. The Commissioned Corps continued work on establishing the framework for public health Medical Readiness Training Exercises with SOUTHCOM and established a detail with the Interagency Partnering Directorate to enhance cooperation on health diplomacy initiatives.

Collaboration is a cornerstone of the work of OPHS. Highlights of recent accomplishments and collaborations include:

- ODPHP is drawing on the expertise of a Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 in developing the next iteration of *Healthy People*. Public participation will shape *Healthy People 2020*, its purpose, goals, organization, and action plans. HHS is seeking input from communities and stakeholders through public meetings across the country and public comment periods.
- OHRP is building international collaborations to enhance and expand global protections for human subjects in research. The OHRP in FY 2008 presented on human subject protections and ethical challenges at invitational meetings in Nigeria, Poland, and Austria. In addition, OHRP released a new pamphlet, "Becoming a Research Volunteer: It's Your Decision" to raise awareness to participating in research programs and promote informed decision-making. This pamphlet was also translated into Spanish to help promote diversity in research as well.
- Office of the Surgeon General (OSG) is leading the HHS Childhood Overweight and Obesity Prevention Initiative. A senior level interagency council charged with developing synergistic activities to leverage the reach and impact of departmental programs. Over 30 departmental partnerships and joint activities have been launched to date. This unprecedented level of coordination has not only maximized HHS attention to the issue, but served as a catalyst and an important model to states and communities to work together across organizational boundaries to accomplish important goals. Additionally, a national Surgeon General's outreach tour, "Healthy Youth for a Healthy Future" (HYHF) has visited 37 states, participated in over 70 events, given 75 Surgeon General Champion Awards, convened nearly 30 Roundtable discussions, and modeled healthy behaviors directly with children across America.
- The Office of the Surgeon General, in partnership with National Institute on Alcohol Abuse and Alcoholism and Substance Abuse and Mental Health Services Administration, continues to promote the messaging in The Surgeon General's Call To Action to Prevent and Reduce Underage Drinking. This past year the Acting Surgeon General visited seven States to raise awareness and dialogue with community and state leaders to further prevent and reduce underage drinking.
- The U.S. Surgeon General's Family History Initiative's new interoperable and standardized *My Family Health Portrait* tool was release in January 2009. This initiative encourages all Americans to know their family health history, and share it with their clinicians as a prevention screening tool.
- The Office of the Surgeon General held a Surgeon General's Conference on the Prevention of Preterm Birth with the National Institutes of Health, National Institute of Child Health and Development to increase awareness of preterm birth in the United States, review key findings and reports issued by experts in the field and establish an agenda for activities in both the public and private sectors to mitigate this public health problem.

- The Office of the Surgeon General, in partnership with National Institutes of Health, National Heart, Lung and Blood Institute, released a Surgeon General's Call to Action to Prevent Deep Vein Thrombosis and Pulmonary Embolism. The Acting Surgeon General continues to speak at national forums on this public health issue.

Funding History

FY 2005	$8,042,000
FY 2006	$8,131,000
FY 2007	$8,165,000
FY 2008	$7,940,000
FY 2009 Omnibus	$8,820,000

Budget Request

The FY 2010 request is $9,219,000, an increase of $399,000 above the FY 2009 Omnibus Appropriations level. This level will allow the Immediate Office of the ASH and the OSG to maintain its cadre of senior public health staff. Funds support salaries and benefits, rent, and other overhead costs. In FY 2010, OPHS will continue to build upon its solid foundation of providing leadership and focus for HHS and the nation on health and science initiatives. OPHS will lead and coordinate Presidential and Secretarial priorities and initiatives on public health and science issues.

The FY 2010 budget request includes an increase of $300,000 to enable the Immediate Office of the ASH to implement audit standards as described in OMB Circular A-123. These funds will be used to improve the accountability and effectiveness of OPHS programs through stronger internal controls. OPHS will implement a series of systematic and proactive audit standards to produce result-oriented management initiatives that will translate into OPHS' ability to better meet the established goals and objectives needed to fulfill the OPHS Mission.

Through the Surgeon General, the OSG will issue Reports or Calls to Action as necessary, and will continue to lead national public health initiatives. The Childhood Overweight and Obesity Prevention Initiative, "Healthy Youth for a Healthy Future" plans to visit the remaining 15 States in its national tour over the next several months. Additional keynote addresses have and continue to focus on other public health messages consistent with the OSG priorities and specific Surgeon General documents including prevention of preterm birth, osteoporosis, and deep vein thrombosis and pulmonary embolism. Promotion of the "My Family Health Portrait" will continue with prevention efforts to build an interoperable risk assessment tool. Surgeon General's documents scheduled to be completed and released in the upcoming year include a "Surgeon General's Report on How Tobacco Causes Disease: The Biology and Behavioral Basis for Tobacco-Attributed Diseases" and a "Call To Action: On Healthy Homes."

The OSG, through the Commissioned Corps will also continue to support Health Diplomacy initiatives by participating in missions designed to increase the operational capacity of U.S. Government personnel to deliver humanitarian assistance, perform public health assessments, conduct public health infrastructure repair and provide health care training of indigenous health care workers. The Commissioned Corps has been specifically requested to participate in the Pacific Partnership 2009 mission, which is a U.S. Navy ship-based training mission scheduled to begin in early June and run through mid-September of 2009. Three successive, pre-configured teams of 10-12 USPHS officers will provide public health, medical and dental services for the duration of the 125-day mission to Pacific Islands.

OFFICE OF HIV/AIDS POLICY

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$905,000	$930,000	$942,000	$12,000
FTE	4	6	6	---

Authorizing Legislation……...…Title III, Section 301 of the Public Health Service Act
FY 2010 Authorization……...Indefinite
Allocation Method……..Direct federal

Program Description and Accomplishments

The Department of Health and Human Services (HHS) Secretary has delegated the Assistant Secretary for Health (ASH) responsibility for coordinating, integrating, and directing the Department's policies, programs, and activities related to HIV/AIDS. The Office of HIV/AIDS Policy (OHAP) works with the ASH to meet HHS' needs by supporting its mission and goals in the following areas:

- Providing strong, responsive, and accountable administrative structure to HIV/AIDS related issues for OPHS and OS to ensure the success of the Department's HIV/AIDS programs, policies, and activities, while maintaining fiscal accountability and engaging in outcome evaluation.
- Serving as the senior advisory agency on HIV/AIDS issues to the Secretary, the Deputy Secretary and the ASH, OHAP provides policy information and analysis to the Department's Operating Divisions (OPDIV) and Staff Divisions (STAFFDIV). OHAP ensures that senior Department officials are fully briefed on HIV/AIDS-related matters and that they are able to provide information on HIV/AIDS policies, programs, and activities to the White House or to members of Congress in an expeditious manner. With both internal and external partners, OHAP promotes awareness, understanding, and implementation of HHS policies on HIV/AIDS.
- OHAP coordinates department-wide internal assessments and evaluation activities covering such areas as HIV testing, technical assistance and prevention strategies. In working with all OPDIVs and STAFFDIVs with an HIV/AIDS portfolio, OHAP seeks areas for future collaboration, elimination of redundancy, filling of vital gaps, and recommendations on best practices.
- OHAP will host a series of lectures and in-service forums to keep executive senior staff apprised of cutting edge issues and topics on the HIV/AIDS horizon. These fora will provide information on major advances in science, technology and behavioral studies which will have a significant impact of the delivery of care and treatment, the positioning of prevention interventions and programs. As

appropriate these fora will be used to forge collaborations and partnerships across HHS, federal, state and local governments.

OHAP continues to provide leadership for the Minority AIDS Initiative (MAI) programs and activities. OHAP directs and provides administrative support to the MAI Steering Committee for Evaluation and Implementation. OHAP provides leadership to the Department's HIV Executive Coordination and Planning Group (HECPG), which is comprised of principals from all of the HHS agencies with key HIV/AIDS portfolios. Following a program assessment, OHAP began a comprehensive evaluation and assessment of the MAI Fund which is a subset of programs and activities under the MAI. Included in this effort will be an inventory of all MAI supported programs and activities.

In the 2009 Appropriations Committee report, Congress encouraged HHS to develop and implement a single national AIDS strategy to promote coordination among Federal agencies and state and local governments, set clear goals and benchmarks, and provide a basis for insuring accountability. With the Planning Group, OHAP and the HHS Secretary will lead HHS efforts, along with the White House Office on National AIDS Policy, to develop the *National AIDS Strategic Plan*.

OHAP coordinates the Department's participation in a wide variety of HIV/AIDS-related conferences to ensure cost-effective and outcome-driven participation and successes. OHAP organizes information and activities around numerous National HIV Awareness Day, and coordinates both inter-agency and intra-agency HIV/AIDS activities. OHAP works to keep front-line and senior-level staff informed about the Department's HIV goals and objectives and how they affect communities, as well as to demonstrate effective ways to disseminate information about those policies inside and outside the Department.

In addition, AIDS.gov which is managed by OHAP is now the premier information gateway for Federal domestic HIV/AIDS information and resources. AIDS.gov:

- Provides basic HIV/AIDS information and drives traffic to individual agency websites and resources—supporting the Department's HIV prevention, testing, and treatment objectives and improving access to Federal information about HIV/AIDS
- Provides training and information to Federal colleagues, state and local health departments, and AIDS service organizations on using new media in response to HIV/AIDS
- Provides links to HIV/AIDS resources (including both Federal and non-Federal partners)

OHAP's performance goals have been to advise Department officials on all HIV/AIDS-related issues and to coordinate the Department's internal and external HIV/AIDS programs, policies, and activities. Those goals have been met, as evidenced by the increasing reliance of the Secretary's office, the White House, the Department's OPDIVs and STAFFDIVs, and other Federal agencies on the information and services that OHAP provides. In the last year, OHAP has increased the number of projects and events it manages by 25 percent.

Funding History

FY 2004	$953,000
FY 2005	$992,000
FY 2006	$932,000
FY 2007	$930,000
FY 2008	$905,000
FY 2009 Omnibus	$930,000

Budget Request

The FY 2010 request is $942,000, an increase of $12,000 above the FY 2009 Omnibus Appropriations level. The increase provides funds for staff pay increases and enables the program to continue to support existing projects.

In FY 2010, OHAP will continue to serve as the senior advisory agency on HIV/AIDS issues to the Secretary, the Deputy Secretary and the ASH, including serving as the Department's central coordinating office for the Minority HIV/AIDS Initiative and as the Co-Chair of the Department's HIV/AIDS Management Coordination Team. OHAP will continue to coordinate the Department's participation in a wide variety of HIV/AIDS-related conferences and meetings, such as activities around National HIV Awareness Day and World AIDS Day.

ADOLESCENT FAMILY LIFE

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$29,778,000	$29,778,000	$29,778,000	---
FTE	12	13	13	---

Authorizing Legislation…….Title XX of the PHS Act
FY 2010 Authorization…….Expired
Allocation Method……..Competitive Grant; Contract; Direct Federal

Program Description and Accomplishments

The purpose of the Adolescent Family Life (AFL) program is to evaluate innovative and integrated approaches to the delivery of comprehensive services to pregnant and parenting adolescents, and provide and evaluate teenage pregnancy services that promote abstinence from sexual activity for adolescents. The AFL program targets pre-adolescents, adolescents, families, infants of parenting teens, as well as teen fathers. All AFL demonstration projects focus on ways to build and strengthen families. AFL demonstration grants are awarded for a five-year project period; all grantees are required to reapply each year of their continuing grant.

The AFL program currently supports two types of demonstration programs:

- *Prevention* demonstration programs develop, test and evaluate pregnancy prevention interventions comprised of different curricula and youth development and other innovative approaches designed to encourage adolescents to postpone sexual activity and reduce their risks for teenage pregnancy and STDs; and

- *Care* demonstration programs to develop, test and evaluate interventions with pregnant and parenting teens, in an effort to ameliorate the negative effects of childbearing on teen parents, their infants and their families.

AFL Care demonstration projects assist in preventing disease, particularly STDs including HIV/AIDS; promoting early childhood and youth development; reducing child abuse and neglect; and reducing health disparities among pregnant and parenting adolescents by ensuring access to adequate prenatal and postnatal care as well as pediatric care. In addition, AFL Prevention demonstration projects educate adolescents about good health habits, preventing diseases, promoting healthy life styles and youth development, and reducing disparities in health services. In FY 2010, the Department proposes that $13.1 million be used for prevention demonstration grants. Of this, $9.8 million will support programs that replicate the elements of one or more teenage pregnancy prevention programs that have been proven through rigorous evaluation to delay sexual activity, increase contraceptive use (without increasing sexual activity), or reduce teenage pregnancy.

The AFL program is also authorized to provide support for basic and applied research focused on the causes and consequences of adolescent premarital sexual relations, adolescent pregnancy and parenting. In 2009, the program supported seven research projects.

The AFL program underwent a program assessment in 2008. The assessment cited the AFL data collection instruments developed for use by Care and Prevention demonstration grantees and the intensive evaluation standards placed on AFL grantees as strong attributes of the program. AFL has six long-term performance measures. Two of the performance measures directly relate to prevention demonstration projects: (2.1.1) "Increase communication among parents and adolescents on topics relating to puberty, pregnancy, abstinence, alcohol, and/or drug" and (2.1.2) "Increase adolescents' understanding of the positive health and emotional benefits of abstaining from premarital sexual activity." AFL has three measures directly related to care projects: (2.2.1) "Maintain the incidence of clients in AFL Care demonstration projects who do not have a repeat pregnancy," (2.2.2) "Increase infant immunization among clients in AFL Care demonstration projects," (2.2.3)"Increase the educational attainment of clients in AFL Care demonstration projects." AFL measures the caliber of evaluations for both care and prevention projects through a measure that seeks to "Improve the quality of the Title XX independent evaluations." The program's efficiency measure seeks to sustain the cost to encounter ratio for both prevention and care programs.

Based on the most recent program data available for fiscal year 2008, the program was able to report on for all of its objectives. While the targets were not met for the two prevention related objectives (2.1.1 parent/adolescent communication and 2.1.2 adolescents understanding of benefits of abstinence), the actual results for both objectives were improvements from FY 2007. The actual for one of the care related objectives (2.2.3 educational attainment) exceeded the proposed target by nine percentage points, while the targets for the other two care objectives (2.2.1 repeat pregnancies and 2.2.2 infant immunizations) were not met. The AFL program did, however, demonstrate progress in the area of quality evaluations for both care and prevention projects – in both cases, the actuals exceeded the targets. This is due in large part to the intense evaluation technical assistance offered on an ongoing basis. The actuals for the efficiency measure for both prevention and care also exceeded the targets by $4-$38 per client hour, indicating the increasing efficiency of programming.

Since the AFL demonstration projects are funded for five years, it is challenging to show consistent improvement in the performance measure data from year to year. At any given time, there are multiple grantee cohorts within the AFL program, all in different years of implementation. There were a handful of new grantees reporting data during FY 2008. Since new grantees do not have the same number of years of AFL expertise and program implementation experience as others, it is possible that outcome performance may have been reduced. Other possible explanations for reduced performance include inconsistent grantee data and inadvertent inclusion of an excluded set of clients in care grantee data.

In FY 2009, AFL initiated a national evaluation of the AFL program. The purpose of this evaluation is to conduct an independent cross-site evaluation of the AFL demonstration program to describe its implementation and to evaluate its impact on desired outcomes. Long term

outcome objectives 1 and 2, with associated measures, will be assessed through this process (see "AFL Outcome Table").

The AFL program supports the HHS Strategic Plan, Goal 3: Promote the economic and social well-being of individuals, families and communities; Objective 3.2 - Protect the safety and foster the well-being of children and youth. In addition, AFL supports the OPHS/HHS strategic goals by contributing to the following measures:

- Increase number of local, state and national health policies that incorporate prevention elements on disease prevention, health promotion, and eliminating health disparities
- Increase the number of substantive commitments to prevention on the part of governmental and non-governmental organizations
- Increase impact of selected Departmental, Federal and public-private collaborative efforts through effective OPHS leadership and coordination

Funding History

FY 2005	$30,742,000
FY 2006	$30,256,000
FY 2007	$30,229,000
FY 2008	$29,778,000
FY 2009 Omnibus	$29,778,000

Budget Request

The FY 2010 request is $29,778,000, the same as the FY 2009 Omnibus Appropriations level. In this request, $13.1 million will be used to support AFL prevention demonstration and research projects. Approximately $9.8 million of this will support programs that replicate the elements of one or more teenage pregnancy prevention programs that have been proven through rigorous evaluation to delay sexual activity, increase contraceptive use (without increasing sexual activity), or reduce teenage pregnancy. The remaining $3.2 million support grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teen pregnancy.

To prepare for the cross-site evaluation, AFL demonstration grantees have been required to strengthen their evaluation designs (as measured by outcome objective 3.1) and complete a detailed evaluation report each year. An independent evaluation contractor reviews each report and scores them using a standardized assessment tool. The AFL program is confident that with stronger program evaluation designs, comprehensive evaluation technical assistance and training for grantees, and a standardized way of assessing evaluation reports, the quality of program evaluations will improve.

The AFL program is striving to ensure efficiency by AFL grantees. An efficiency measure (4.1) tracks the cost per service hour in each program. AFL is committed to ensuring the costs are maintained in each AFL demonstration program over the next five years.

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Long-Term Objective 1: Encourage adolescents to postpone sexual activity by developing and testing abstinence interventions.				
1.1 Increase communication among parents and adolescents on topics relating to puberty, pregnancy, abstinence, alcohol, and/or drugs.	43%	48.8%	51%	+2.2%
1.2 Increase adolescents' understanding of the positive health and emotional benefits of abstaining from premarital sexual activity.	57.5%	74%	80%	+6%
Long-Term Objective 2: : Ameliorate the effects of too-early-childbearing by developing and testing interventions with pregnant and parenting teens				
2.1Maintain the incidence of clients in AFL Care demonstration projects who do not have a repeat pregnancy.	90%	92%	92%	Maintain
2.2 Increase infant immunization among clients in AFL Care demonstration projects.	65%	80%	82%	+2%
2.3 Increase the educational attainment of clients in AFL Care demonstration projects.	79%	72%	74%	+2%
Long-Term Objective 3: Identify interventions that have demonstrated their effectiveness to: 1) promote premarital abstinence for adolescents and 2) ameliorate the consequences of adolescent pregnancy and childbearing.				
3.1 Improve the quality of the Title XX independent evaluations (prevention/care)	48.5%/ 55.5%	35.75% / 54.6%	44%/ 58.8%	+8.25%/ +4.2%
Long-Term Objective 4: Improve the efficiency of the AFL program.				
4.1 Sustain the cost to encounter ratio in Title XX prevention and care demonstration projects (prevention/care)	$25/ $72	$29/ $110	$29/ $110	Maintain
Program Level Funding ($ in millions)		29.778	29.778	---

ADOLESCENT FAMILY LIFE
Program Data

Activity	FY 2008 Actual		FY 2009 Enacted		FY 2010 Pres. Budget	
PROGRAM FUNDING	No.	Amount	No.	Amount	No.	Amount
Care Demonstration Grants						
Continuations	31	$10,999,022	31	$10,999,022	23	$6,306,264
New	0	0	0	0	8	4,692,758
Subtotal, Care	31	$10,999,022	31	$10,999,022	31	$10,999,022
Prevention Demonstration Grants						
Continuations	19	$4,968,966	35	$13,120,000	5	$3,280,000
New	16	8,151,034	0	0	15	9,840,000
Subtotal, Care	35	$13,120,000	35	$13,120,000	20	$13,120,000
Total, Demonstration Grants	66	$24,119,022	58	$24,119,022	51	$24,119,022
Research						
Continuations	6	$997,243	4	$488,787	0	$1,000,000
New	1	100,000	3	511,213	1	100,000
Subtotal, Research	7	$1,097,243	7	$1,000,000	1	$1,100,000
Demonstration related technical assistance and support activities		1,499,446		1,140,000		1,140,000
Research IAAs & Related Activities		640,418		640,418		640,418
Support Costs		2,421,871		2,778,560		2,778,560
TOTAL		**$29,778,000**		**$29,778,000**		**$29,778,000**
CLIENTS SERVED*						
Title XX Care Demonstrations.....	31	5,149	31	5,149	31	3,500
Title XX Prevention Demonstrations..	35	27,665	27	18,700	20	22,700
TOTAL.....	66	32,814	58	23,849	51	26,200

*Number of clients estimated by average 300 clients per year per prevention and 200 per year per care program. In FY 08 efforts were made to help programs increase client hours. Client numbers will decrease in FY 09 based on number of new grants funded and will increase in 2010.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$7,106,000	$7,232,000	$7,273,000	$41,000
FTE	20	23	23	---

Authorizing Legislation .....Title XVII, Section 1701 of the PHS Act
FY 2010 Authorization .....Expired
Allocation Method .....Direct federal, Contract, and Cooperative agreement

Program Description and Accomplishments

The Office of Disease Prevention and Health Promotion (ODPHP) provides leadership for a healthier America by initiating, coordinating, and supporting disease prevention and health promotion activities, programs, policies, and information for the Department of Health and Human Services (HHS) through collaboration with HHS agencies and other partners in prevention. ODPHP's central mandates are to assist the Assistant Secretary for Health and the Office of the Secretary in:

- Leading and coordinating health promotion and disease prevention activities, including *Healthy People 2010, Healthy People 2020, Dietary Guidelines for Americans*, and *Physical Activity Guidelines for Americans*;
- Developing, evaluating, and promoting innovative approaches to communicating health information, increasing health literacy, and operating the National Health Information Center; and
- Addressing cross-cutting and gap-filling issues in public health, prevention and science.

Through *Healthy People*, ODPHP meets its Congressional mandate to establish health goals for the Nation. ODPHP leads the development and implementation of *Healthy People* on behalf of the Department. *Healthy People* underpins many of HHS' programs and strategic planning efforts and provides a framework for prevention and wellness programs of a diverse array of stakeholders. *Healthy People 2010* offers 10-year health objectives for the Nation with two overarching goals: first, to increase the quality and years of healthy life, and second, to eliminate health disparities. The objectives are designed to drive action and represent an opportunity for individuals to make healthy lifestyle choices, for health professionals to put prevention into practice, for policy makers, communities and businesses to support health-promoting policies in schools, worksites and other settings, and for scientists to pursue new research. Examples include Objective 12-9, "Reduce the proportion of adults with high blood pressure," and Objective 14-20, "Reduce hospital-acquired infections in intensive care unit patients." Through measurable, evidence-based objectives, *Healthy People 2010* provides a framework for programs necessary to achieve the vision of a healthier nation. These objectives were reassessed through a mid-decade review that culminated in the publication of the Midcourse Review in FY 2006. In

FY 2009, ODPHP completed the final round of progress reviews to examine the most current data, to look for opportunities and challenges, and to assess the status of objectives in the 28 focus areas of *Healthy People 2010*. The reports of these progress reviews are posted on the healthy people.gov Web site.

Through ongoing program assessment, ODPHP measures the percentage of states that use the national objectives in their health planning processes and the percentage of *Healthy People 2010* focus area progress review summaries that have been written, cleared, and posted on the internet within 16 weeks of the progress review. To date, ODPHP has met its target for both measures. ODPHP uses the program assessment results as a basis for revising targets, measures, and/or processes to align results and demonstrate improved performance as needed. Tracking the disease prevention and health promotion objectives for the Nation and monitoring progress toward meeting the established targets is ODPHP's second core activity. ODPHP has established a long-term outcome measure to increase the percentage of *Healthy People 2010* objectives that have met their targets or are moving in the right direction. Data for this measure will be available in 2010.

Each iteration of *Healthy People* is a product of a multi-year, collaborative process, allowing for input from a diverse array of stakeholders within and outside of the Federal Government. Development of the next decade's national health objectives, *Healthy People 2020,* began in FY 2006 and continued through FY 2009, with a release expected in FY 2010. In FY 2009, ODPHP planned to convene public meetings across the country to garner public comment of a draft set of *Healthy People 2020* objectives. In FY 2008, ODPHP conducted regional public meetings to gain input from key stakeholders on proposed organizing concepts for *Healthy People 2020*. ODPHP, in collaboration with the Regional Health Administrators (RHAs) and HHS operating divisions, successfully conducted six regional meetings which were held in Atlanta, GA; San Francisco, CA; Fort Worth, TX; Chicago, IL; New York, NY, and Bethesda, MD. Over 1200 stakeholders from State and local public health agencies, non-profit organizations, universities and schools of public health, advocacy groups, clinicians and other users of *Healthy People* attended the regional meetings providing oral testimony and contributing to breakout group discussions.

FY 2008 and FY 2009, the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 continued to help guide the *Healthy People 2020* development. The independent, voluntary, 13-member Federal advisory committee is charged with providing to the Secretary advice regarding the process of developing and implementing national health promotion and disease prevention goals and objectives for 2020. In FY 2008, the Committee began its deliberations and, in FY 2009, delivered to the Office of the Secretary its recommendations regarding the vision, mission, overarching goals, and framework for *Healthy People 2020*. In February 2009, the Committee delivered to the Office of the Secretary its recommendations regarding the *Healthy People 2020* opportunities in the next 12 months to improve the health and economy of the Nation. In FY 2009, the Committee began its work to develop a series of recommendations to the Secretary addressing the implementation of the *Healthy People 2020*. The Committee's charter will need to be renewed by September 2009 so that it may continue to advise the Secretary.

In FY 2009, ODPHP held the 4th Annual Healthy People State Coordinators Workshop in Washington, DC. This workshop coincided with the development of *Healthy People 2020* topic areas, objectives, targets, and identification of strategies to achieve targets. Healthy People State Coordinators from across the country, the District of Columbia and U.S. Territories, discussed strategies for creating State *Healthy People 2020* plans and create a shared vision for *Healthy People 2020* use in States.

In FY 2009, began an evaluation project entitled *Evaluating the National Health Promotion and Disease Prevention Agenda for the Year 2020—Healthy People 2020—through State Action.* The purpose of the project is to assess usability in state planning processes of the *Healthy People 2020* framework—the vision, mission, goals and concepts for organizing and developing objectives. ODPHP and an advisory group of RHAs developed a request for proposal competition for states, territories, and tribes to receive funds to assess the utility and effectiveness of the early release of organizing concepts for *Healthy People 2020* in guiding and influencing state disease prevention and health promotion strategic planning. The evaluation findings from the project will help ODPHP enhance the dissemination and utilization of *Healthy People 2020* in communities.

In FY 2009, ODPHP and the Office of the Assistant Secretary for Planning and Evaluation will complete an assessment of state, local and tribal users of Healthy People. The study examines relevant issues such as: who is using *HP2010*, how and why they are using it, to what extent respondents view it as contributing to their own disease prevention and health promotion efforts, and obstacles to its use. The assessment will update findings from the 2005 Assessment in terms of the efficacy of *Healthy People 2010,* provide valuable trend information about awareness and use of *Healthy People 2010* and assess the impact of outreach efforts that HHS and its partners undertook after the earlier study. Furthermore, it will enhance understanding of how key stakeholders are carrying out the *Healthy People* program's objectives.

In FY 2009, ODPHP and the RHAs completed their collaboration to assess benefits of translating disease prevention and health promotion science into practice at the community level. The project entitled *Take Action: Healthy People, Places and Practices in Communities* provided one-year seed funding to 112 community groups to carry out projects, such as walking programs for a neighborhood or workplace, development of school lunch programs that include locally grown, seasonal fruits and vegetables, and implementation of skin cancer detection programs and smoking prevention programs. The project evaluation showed that through this project community organizations were empowered to make community health improvement inroads and positive community outcomes resulted from this micro-financing effort.

ODPHP plays a leadership role in co-coordinating the development, review and promotion of the recommendations from the *Dietary Guidelines for Americans* (Dietary Guidelines), the cornerstone of Federal nutrition policy published every five years by the HHS and the U.S. Department of Agriculture (USDA). The development of the 2010 edition of the Dietary Guidelines was initiated in FY 2009. In FY2010, the next iteration of the Guidelines will be released and ODPHP will work with other HHS offices/agencies and other departments to develop communications, educational information and resources that are research-tested, audience-appropriate and consistent.

ODPHP continues its leadership role in the development and review of Dietary Reference Intakes (DRIs) and co-sponsoring other nutrition-related studies by the Institute of Medicine (IOM). In FY 2008 and FY 2009, ODPHP is co-sponsoring a Review of the DRIs for Vitamin D and Calcium, Study on Strategies for Reducing Sodium Intake, and Reexamination of Pregnancy Weight Guidelines. In FY 2010, these efforts will continue. Support of these studies is supported by Evaluation Set Aside funding.

The *Health and Diet Survey: Dietary Guidelines Supplement* is done collaboratively with the Food and Drug Administration (FDA) to track national change of Americans' attitudes, awareness, knowledge and behavior regarding various elements of nutrition and physical activity. The baseline survey was fielded in FY 2006 and repeated in FY2008. The next iteration of the survey will occur in FY2010.

HHS produced the 2008 Physical Activity Guidelines (PAGs), an effort coordinated by ODPHP and developed in collaboration with the President's Council on Physical Fitness and Sports and the Centers for Disease Control and Prevention. Development started in FY2007, continued in FY2008, and the Guidelines were released in FY2009. In FY2010, ODPHP will continue collaboration with PSCPFS and CDC to promote the PAGs, and will continue to coordinate the voluntary review of federally-produced consumer information containing physical activity information to ensure consistency with the PAGs.

ODPHP continues to provide opportunities for professional growth and development in both prevention policy and medical education through the Luther Terry Fellowship, as well as education and training of Preventive Medicine and Primary Care resident physicians, medical and other health professions students, Emerging Leaders, Presidential Management Fellows, and public health interns as part of the Disease Prevention and Health Promotion Scholarship Program. The program is funded by ODPHP through a five-year competitive cooperative agreement, which was awarded in FY 2007.

ODPHP is congressionally mandated to provide reliable prevention and wellness information to the public through the National Health Information Center (NHIC). The office also provides leadership in innovative research in consumer health information. National Health Information Center (NHIC) supports all ODPHP Web sites including *Healthy People* and healthfinder.gov, the federal government's award-winning prevention and wellness website. In FY 2008, ODPHP launched a redesigned version of heatlhfinder.gov. The site was designed based on formative and usability research with over 800 people including those with limited health literacy. As a result, the site is more user-friendly and focuses on understandable and actionable prevention and wellness information and tools. Healthfinder.gov has several new features, for example:

- *Quick Guide to Healthy Living*—Basic, easy-to-understand information and action steps on a number of prevention and wellness topics.
- *Myhealthfinder*—A collaboration with the Agency for Healthcare Research and Quality (AHRQ) to provide the public with prevention recommendations from the U.S. Preventive Services Taskforce based on age, gender and pregnancy status.

In FY 2009, ODPHP will be increasing the number of topics and tools available through the *Quick Guide* including adding new sections for parents and older adults. Healthfinder.gov is also expanding its reach through the use of new media tools such as Twitter, e-Cards, and the ability to syndicate content to partner Web sites. ODPHP will also start the research and development process for a Spanish-language *Quick Guide to Healthy Living* in FY 2009. Through formative research and user-testing, the Spanish *Quick Guide* will be designed to be culturally relevant and appropriate for Spanish speakers with limited health literacy.

In FY2009, the NHIC will complete the development of an Online Community Prototype to encourage information sharing and networking with and among the professionals and intermediaries served by ODPHP. This online space has the potential to support ODPHP communication and interaction with partners and stakeholders in the development of prevention science, policy, communication strategies, and other ODPHP activities. The goal is to empower professionals and information intermediaries at all levels and across multiple disciplines to work collaboratively and to learn how to communicate with their constituencies more effectively about prevention. ODPHP is using a user-centered methodology in developing the Online Community Prototype, which incorporates usability, plain language, and accessibility principles. The online community will be used to assist in the launch and implementation of the *Physical Activity Guidelines for Americans*, *Dietary Guidelines for Americans*, and *Healthy People 2020.*

In FY 2008, ODPHP kicked off an evaluation set-aside pilot project called *Putting Prevention into Practice*. ODPHP is collaborating with the Middlesex Community Health Center in Baltimore to provide understandable and actionable prevention information to the public. This project utilized a community-based participatory research approach to work with Health Center staff and patients to develop and implement a cost-effective way to integrate prevention guidance into daily interactions with patients. Staff used the electronic medical record and prevention information from healthfinder.gov to support their interactions. Patients' self-efficacy in taking preventive measures, self-reported behavior change, and satisfaction with the health center visit were evaluated as outcomes of this project. Data collection for the project is complete, and in FY 2009 ODPHP will write a report and subsequent manuscripts on the findings. Lessons learned from the project will be disseminated through the Health Resources and Services Administration (HRSA) and the Agency for Healthcare Research and Quality (AHRQ) to community health centers and primary care physicians.

ODPHP measures customer satisfaction with healthfinder.gov and visits to ODPHP-supported websites through program assessment measures. In FY 2008, ODPHP exceeded the target set for visits to ODPHP-supported Web sites. ODPHP also exceeded its target satisfaction score (78) for healthfinder.gov® with a score of 79 on the American Consumer Satisfaction Index survey. ODPHP's health communication work is funded by two (competitive) contracts.

As the Departmental lead for *Healthy People 2010* Focus Area 11 - Health Communication, ODPHP identified data systems to measure all of the objectives for Focus Area 11. In FY 2009, ODPHP will sponsor a second data collection effort to measure progress toward achieving the targets of Objective 11-3, "Increase the proportion of health communication activities that include research and evaluation," and Objective11-4, "Increase the proportion of health-related web sites that disclose information that can be used to assess the quality of the site."

In support of Healthy People 2020, ODPHP is collaborating with the CDC and the Office of National Coordinator for Health IT as it envisions how health communication, health literacy and health IT can be integrated into the *Healthy People 2020* framework. This leadership team coordinates the efforts of over 60 experts in health communication and health IT across the Federal government. This group is currently providing guidance to the Federal Interagency Advisory Group for *Healthy People 2020* on the potential impact of health communication and health IT upon the determinants of health. This work will shape the development of proposed objectives for the next decade. On March 30th, the leadership team engaged private and public sector thought leaders in the field, organizing a Roundtable on Personalized Population Health. Leaders at institutions - such as Google, Intel, and Cisco - shared their insights on current and future technological trends, addressing how advances in health IT and health communication can impact and improve health disparities and health literacy.

The Office coordinates a broad-based effort in HHS to improve health literacy for all Americans. ODPHP, along with CDC, co-chairs the HHS Health Literacy Workgroup that meets every two months to share information and to identify opportunities for collaboration and coordination. The goal of the workgroup is to encourage the incorporation of health literacy in Department research, program operations, and communication with the public. ODPHP, in collaboration with the Surgeon General's Office, conducted a Workshop on Improving Health Literacy in 2006. Following the release of the Proceedings from that workshop, a series of four town hall meetings were held in FY 08 on improving health literacy. In FY 2009, science-based information and promising practices gathered from these events will be compiled and shared in a National Action Plan on Improving Health Literacy.

ODPHP underwent a program assessment in 2005. As a result of that process, ODPHP developed a long-term measure and five annual performance measures which have been incorporated into the performance analysis. ODPHP's long-term measure and annual measures relate to its mission and core activities: the *Healthy People* national health objectives, the *Dietary Guidelines for Americans,* and the National Health Information Center and related communications efforts.

Funding History

FY 2005	$7,533,000
FY 2006	$7,330,000
FY 2007	$7,305,000
FY 2008	$7,106,000
FY 2009 Omnibus	$7,232,000

Budget Request

The FY 2010 request is $7,273,000, an increase of $41,000 above the FY 2009 Omnibus Appropriations level. The increase provides funds for staff pay increases and enables the program to continue to support existing projects as described below.

In FY 2010, ODPHP will complete the development of and launch *Healthy People 2020*. Ongoing extensive Federal and public participation will be critical to the development of a set of objectives that are based on science, driven by data, and address the major health needs and priorities of the Nation. As such, in FY 2010, ODPHP will continue to support activities aimed at maximizing public input into the process. Such activities are expected to include regional public meetings, stakeholder workshops, collection of public comment via the online database, and continued participation of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, assuming its renewal.

In FY2010, ODPHP will continue to develop strategies for implementing *Healthy People 2020* and to identify interventions/activities communities can use to achieve the *Healthy People 2020* goals and objectives. In FY 2010, data will be available from ODPHP's evaluation of States' use of the *Healthy People 2020* framework. ODPHP will consider these evaluation results in developing the *Healthy People 2020* implementation strategies. Ultimately, the implementation process calls for awards to be made to states which support the development of their own disease prevention and health promotion action plans that will be modeled after the national *Healthy People 2020* objectives. This activity supports one of ODPHP's program assessment measures, "The percentage of states that use the national objectives in their health planning process."

The FY 2010 request for ODPHP also includes funding to support development, coordination, and outreach for *Dietary Guidelines for Americans, Physical Activity Guidelines for Americans,* and ongoing work of *Healthy People.* These programs all focus on promoting health and preventing obesity and related chronic diseases by addressing major risk factors (physical inactivity, poor nutrition, tobacco use, and youth risk-taking behaviors) and reducing the burden of disease through health screenings and prevention of secondary conditions. ODPHP supports the development of science-based reviews for nutrition, physical activity, and development of national health objectives. These science-based documents need to be developed into materials that can be used by public health professionals, communities, policy makers, individuals, etc. so that the scientific information is communicated to, and can be implemented by, a variety of target audiences. In addition, the FY 2010 request includes funding for the National Health Information Center which, as described above, supports healthfinder® and ODPHP-supported web sites.

In FY2010 ODPHP plans to significantly enhance the transparency of prevention science through the National Health Information Center's healthfinder.gov and health.gov. We will publish transparency guidelines for health websites and implement these guidelines as we continually improve healthfinder.gov and its new *Quick Guide to Healthy Living* and *myhealthfinder*. These guidelines are based upon 4 years of user-centered research. We will also, in collaboration with the Center for New Media in ASPA, expand the use of social media and other new tools to encourage peer to peer exchange of best prevention practices at healthfinder.gov. A Spanish version of the Quick Guide to Healthy Living is expected to be completed in 2010.

In FY2010 the Online Community Prototype will have been newly launched and in use to support the prevention learning and collaboration needs of professionals and intermediaries. Transparancy guidelines will be implemented throughout this site's design and in the learning

sessions for its users. Users will include the 2400 and growing supporters of the Physical Activity Guidelines for Americans, hundreds of stakeholders (across the Federal government and in the private sector) in health communication and health IT, members of the New Media Center, among other communities of practice.

In FY2010 the Putting Prevention into Practice will expand to additional Community Health Centers, generating additional research findings informing clinician teams regarding how to incorporate prevention into their practices.

In FY2010 ODPHP, in collaboration with the ONC and CDC's Center for Marketing, will complete the development of health communication and health IT objectives for Healthy People 2020 and will publish guidance regarding their implementation. We will continue to support the implementation of these objectives through our Online Community.

#	Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Long-Term Objective 1: Communicate strategically by increasing the reach of ODPHP disease prevention and health promotion information and communications					
1a	Awareness of Dietary Guidelines for Americans (measured at least two times between 2005 and 2010)	45% (FY 2008 exceeded)	50%	50%	---
Long-Term Objective 2: Shape prevention policy at the local, State and national level by establishing and monitoring National disease prevention and health promotion objectives					
2.a	Percentage of States that use national disease prevention and health promotion objectives in their health planning process	96% (FY2005 exceeded)	98%	98%	---
2.b	Increase the percentage of Healthy People 2010 objectives that have met the target or moving in the right direction	42.2% (197/467) FY2005 baseline	NA	60% (280/467)	---
Long-Term Objective 3: Communicate strategically by increasing the reach of ODPHP disease prevention and health promotion information and communications					
1.b	Visits to ODPHP-supported Web sites	15.03M (FY2008 exceeded)	15.5 M	15.75 M	.25M
1.c	Score on American Consumer Satisfaction Index, measured every three years at a minimum	75 (FY2008 not met)	79	80	1
1.d	Increase percentage of Healthy People 2010 focus area progress review summaries written, cleared, and posted on the Internet within 16 weeks of the progress review	92% (FY2008 exceeded)	95%	N/A	10%
Program Level Funding ($ in millions)			7,145,000	7,273,000	128,000

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

Program Data

	FY 2007 Actual	FY 2008 Enacted	FY 2010 Request
PREVENTION FRAMEWORK:			
Healthy People 2010, HealthierUS, Dietary Guidelines for Americans, Physical Guidelines for Americans outreach and coordination	$455,800	$455,800	$455,800
PREVENTION COMMUNICATION:			
National Health Information Center	1,658,000	1,658,000	1,658,000
Communication Support	700,000	700,000	700,000
SCIENCE:			
Disease Prevention and Health Promotion Scholarship Program	400,000	400,000	400,000
OPERATING EXPENSES:			
Operating Costs	3,892,200	4,018,200	4,059,200
TOTAL	$7,106,000	$7,232,000	$7,273,000

PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$1,196,000	$1,228,000	$1,241,000	$13,000
FTE	6	6	6	---

Authorizing Legislation .....Title III, Section 301 of the PHS Act
FY 2010 Authorization.....Indefinite
Allocation Method.....Direct federal

Program Description and Accomplishments

Physical activity and fitness have continued to be the major pursuit at the President's Council on Physical Fitness and Sports in the last several decades. However, evidence remains that despite the increased awareness and knowledge of the benefits of a fit and active lifestyle, the U.S. continues to be mostly a sedentary population. With enhanced national, state, and local-level partnerships and collaborations, the President's Council on Physical Fitness and Sports (PCPFS) plans to develop and disseminate creative, grassroots/community initiatives and collaborations to advance both the Department's and Administration's goals and policy recommendations for improving the health, physical activity, and fitness of Americans of all ages and abilities. PCPFS is a federal advisory committee and does not distribute grants.

The President's Council is an advisory committee of volunteer citizens who advise the President through the Secretary of Health and Human Services about physical activity, fitness, and sports in America. Through its programs and partnerships with the public, private and non-profit sectors, the Council serves as a catalyst to promote health, physical activity, fitness, and enjoyment for people of all ages, backgrounds and abilities through participation in physical activity and sports. The twenty Council members are appointed and serve at the pleasure of the President.

PCPFS creates and cultivates grassroots public and private partnerships and collaborations to raise the public's awareness about the benefits of a physically active and fit lifestyle and provides motivational, easy-to-use, adaptable tools and resources. For example, the *President's Challenge Physical Activity and Fitness Awards* program (*President's Challenge*), is a longstanding, landmark program to promote physical activity and fitness recognition for ages 6 and above. The *President's Challenge* is easily modified so organizations, schools, companies, hospitals, etc. can address specific populations - i.e. youth, adults, seniors, persons with chronic diseases or disabilities – virtually Americans of all ages and abilities – with a motivational, individual and group, physical activity and fitness tracker. PCPFS continues to establish ongoing, sustainable, interactive relationships with public and private organizations to raise the awareness of the *Physical Activity Guidelines* (PAGs) messages, as well as work towards consistency in public/private programs and materials

In addition, PCPFS provides technical assistance on diverse implementation strategies for a wide range of physical activity, fitness and health programs, and information/educational materials. The PCPFS budget request allows the PCPFS to target those most vulnerable to the consequences of sedentary living where they live, learn, work, pray, and play – a priority when considering the growing diversity of the American public and its changing demographics.

Funding History

FY 2004	$1,179,000
FY 2005	$1,247,000
FY 2006	$1,228,000
FY 2007	$1,230,000
FY 2008	$1,196,000
FY 2009 Omnibus	$1,228,000

Budget Request

The FY 2010 request is $1,241,000, an increase of $13,000 above the FY 2009 Omnibus Appropriations level. The increase provides funds for staff pay increases and enables the continued support of the existing projects as described below.

Funds in this request provide salaries and benefits, rent, travel, and other overhead costs for staff that support the President's Council as well as the activities of the Council. One of PCPFS' greatest assets is the Council which is appointed by the President. Its mandate is to meet at least once a year to generate creative ideas and initiatives to encourage and enhance physical activity, fitness and sports programs, and then to promote these ideas and plans across the nation. In-person Council meetings are the best venue to generate ideas and initiatives by this highly knowledgeable and prestigious group of volunteers, leaders in physical activity, sports, medicine, education, business, and organizations. The Council is the main advocacy and educational tool of PCPFS, and enhanced teamwork among the members increases productivity. An increased number of public speaking appearances by the Council members, the Executive Director and senior staff, and representation and participation at major physical activity conferences, will assist PCPFS to increase its effectiveness in promoting and advocating physical activity and fitness and raising awareness to diverse audiences on the Administration's and Department's initiatives.

PCPFS plans to accomplish the following objectives in FY 2010:

- Support/promote the Department's initiatives and enhance coordination and collaboration within departmental components to ensure effective and efficient incorporation of science-based physical activity/fitness strategies and messages in diverse federal, state, and local government programs and information pieces.
- Work closely with OPM on creating a healthier, more active Federal workforce (*Healthier Feds*).

- Continue to encourage and support the efforts of governors and other elected officials, and leaders in schools, hospitals, medical and allied health care organizations, industry, and voluntary organizations to adopt the motivational presidential recognition program, the President's Challenge, into their action plans.
- Develop, implement, and disseminate clear, concise synopses of the science-based *Physical Activity Guidelines* at regional and annual sports medicine, kinesiology and exercise physiology conferences and the meetings of our public/private partners. Provide technical assistance in the development and dissemination of national, state, and local implementation strategies.
- Enhance the visibility and augment options available on the *President's Challenge* for persons with special needs. Summarize lessons learned from the *I Can Do It! You Can Do It!* pilots and present adaptable alternatives to the PCPFS President's Challenge criteria. (*I Can Do It! You Can Do It!* Is the Office on Disability/HHS' National Initiative on Physical fitness for Children and Youth with disabilities.)
- Ensure the continuation of the annual Lifetime Achievement Awards and Community Leadership Awards to recognize, encourage and motivate individuals and institutions to maximize outreach to their communities by disseminating science-based programs and messages to their constituents.
- Present the annual PCPFS Honor Award to ensure continued recognition of research professionals who have advanced the science of physical activity, fitness, and sports.
- Create additional opportunities for joint program development and collaborative implementation strategies on ongoing inter-departmental MOUs – e.g., Recreation and Public Health and Healthier Children.
- As co-lead, with the Centers of Disease Control and Prevention of the Physical Activity and Fitness Focus Area of *Healthy People 2010*, and soon to be developed *Healthy People 2020*, PCPFS will collaborate with public and private organizations in the development, dissemination, and promotion of 2020 goals and subsequent implementation strategies to increase the health of Americans of all ages and abilities through the adoption and maintenance of regular physical activity.

OFFICE OF MINORITY HEALTH

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
BA	$49,118,000	$52,956,000	$55,956,000	$3,000,000
FTE	55	62	63	+1

Authorizing Legislation……..…..Title XVII, Section 1707 of the PHS Act
FY 2010 Authorization…….....Expired
Allocation Method: Direct federal; Competitive Grant/Cooperative Agreement; & Contract

Program Description and Accomplishments

The Office of Minority Health (OMH) resides within the Office of Public Health and Science (OPHS), in the Office of the Secretary of the U.S. Department of Health and Human Services (HHS). Its creation in 1986 by then-HHS Secretary Margaret Heckler was one of the most significant outcomes of the 1985 *Secretary's Task Force Report on Black and Minority Health*. OMH was subsequently established in statute by the Disadvantaged Minority Health Improvement Act of 1990 (PL 101-527), and reauthorized under the Health Professions Education Partnerships Act of 1998 (PL 105-392).

OMH's mission is "to improve the health of racial/ethnic minority populations through the development of policies and programs that help eliminate disparities."

Long-Term Problems Being Addressed by OMH

- Racial/ethnic minority health status. There is significant evidence of poor health status among racial/ethnic minority populations, with respect to preventable disease and disability as well as premature death.
- Racial/ethnic health disparities. The poor health outcomes for racial/ethnic minorities are reflected in the health status and health care disparities that are apparent when comparing health indicators for minorities against those of the rest of the U.S. population.
- Systems issues. These issues include a wide variety of conceptual, organizational, structural, and process-related variables known to influence the ability to adequately and effectively address complex problems such as the health of racial/ethnic minorities in the U.S. and racial/ethnic health disparities. Such issues reflect a compelling need for the application of a "systems approach" and systematic actions across all efforts conducted for the purpose of improving minority health and reducing health disparities. These efforts include, but are not limited to, research and evaluation initiatives to address gaps and weaknesses in science and knowledge about the nature and extent of racial/ethnic minority health problems (especially for small and hard-to-reach populations) and effective

solutions to such problems.

In many respects, racial/ethnic minority populations continue to be under-served by the U.S. health care system:

- Blacks had 90 percent more lower extremity amputations for diabetes.[1]
- Asian American/Pacific Islander women, and Vietnamese American women especially tend to have much lower rates of cervical cancer screening than other groups.[2]
- About 1 in 4 American Indian or Alaska native adults (23.8 percent) were poor compared with 1 in 5 Black adults (20.9 percent), 1 in 8 Asian adults (12.7 percent) and 1 in 11 White adults (9.0 percent).
- Hispanics had 63 percent more pediatric asthma hospitalizations.[3]
- About one-third of poor and near-poor Hispanic or Latino women experienced an unmet medical need due to cost.[4]
- Black children have a 260% higher emergency department visit rate, a 250% higher hospitalization rate, and a 500% higher death rate from asthma, as compared with White children.[5]

OMH Activities

Improving racial/ethnic minority health status and ending persistent racial/ethnic health disparities remains an important priority. OMH addresses its mandate in a manner appropriate to its role and capacity and through a number of disease prevention, risk reduction, health promotion, and service delivery strategies and activities, many of which are supported through competitive grants, cooperative agreements, contracts, technical assistance, and partnerships. The strategies and activities are categorized as follows:

- *Leadership*. As part of its efforts to effect a "systems approach" and more systematic actions to address the long-term racial/ethnic minority health problems outlined above, OMH helps establish, strengthen, and support partnerships among HHS

[1]2006 National Healthcare Disparities Report, page IV. AHRQ, 2007. http://www.ahrq.gov/qual/nhqr06/index.html

[2]Freeman G, Lethbridge-Cejku M. Access to health care among Hispanic or Latino women: United States, 2000-2002. Advance data from vital and health statistics; no 368. Hyattsville, MD: National Center for Health Statistics. 2005

[3] Barnes PM, Adams PF, Powell-Griner E. Health characteristics of the American Indian and Alaska native adult population: Unites States, 1999-2003. Advance Data from vital and health statistics; no 356. Hyattsville, Maryland: National Center for Health Statistics. 2005

[4] CDC, 2006. Access to Health Care Among Hispanic or Latino Women: United States, 2000–2002, page 6. http://www.cdc.gov/nchs/data/ad/ad368.pdf

[5] CDC 2006. The State of Childhood Asthma, United States, 1980–2005. Table B. http://www.cdc.gov/nchs/data/ad/ad381.pdf

offices/agencies, other Federal agencies, state and local agencies, tribes/tribal organizations, public and private sector interests, minority-serving organizations, and others involved in addressing the health of racial/ethnic minorities. The goal of these partnerships is to leverage different stakeholders' resources and activities in a concerted fashion to mount a multi-pronged approach toward improving minority health and eliminating health disparities. By leveraging resources, expertise, other assets and talent through partnerships, OMH can promote greater effectiveness and efficiency in individual and collective efforts.

- *Policy development and implementation*. OMH develops, disseminates, and coordinates the implementation of policies, including data policy, related to racial/ethnic minority health and health disparities. For example, OMH may issue practice guidelines, policy statements, service standards, and other similar products.

- *Education and awareness*. OMH disseminates information about disease prevention, risk reduction, health promotion, and service delivery strategies and practices that have demonstrated effectiveness, and promotes the translation of research into practice aimed at improving racial/ethnic minority health and eliminating health disparities.

- *Research, demonstration, and evaluation*. OMH supports demonstration and evaluation projects at the community, regional, tribal and national levels. These projects explore and document the effectiveness of various strategies and practices to improve racial/ethnic minority health, including efforts to increase access to and appropriate use of health care. Such projects also examine how to fill data gaps to inform planning; develop population-specific knowledge about health risks, prevention, and screening, as well as culturally and linguistically appropriate health delivery systems; promote workforce diversity and collaborations in service delivery.

In the spring of 2005, OMH underwent program assessment. The assessment cited OMH's efforts to demonstrate the returns for investment in its program. OMH is committed to creating a more results-oriented approach to its mission, grantees, and partnerships. This approach has partially entailed the planning, development, and implementation of a Performance Improvement and Management System (PIMS) within OMH. PIMS is intended to improve the work of OMH and its partners relative to program planning, performance measurement and monitoring, program evaluation, and reporting of results.

Important contributions to improve OMH efforts came from the second National Leadership Summit on Eliminating Racial and Ethnic Health Disparities (Summit) which included nearly 2,000 participants representing federal, state, tribal, and local governments; communities; institutions of higher education; health care providers; health plans; national medical and healthcare organizations; foundations; and the business sector. In direct response to feedback from Summit participants, OMH has undertaken a number of actions to effect greater results. In addition to performance improvement efforts above, OMH implemented the *National Partnership for Action to End Health*

Disparities (NPA) to guide and strengthen future actions at the community, state, tribal, regional, and national levels.

The NPA comprises a set of strategic actions that are intended to address factors at the individual, community, and/or systems level(s) that influence the health of racial/ethnic minorities, disparities that disproportionately impact such populations, and/or systems issues that may inhibit effective and efficient approaches to such problems. Actions under the NPA are organized around five related objectives:

1. Increasing awareness of health disparities
2. Strengthening leadership at all levels for addressing health disparities
3. Improving the health and health system experience
4. Improving cultural and linguistic competency
5. Improving coordination and utilization of research and outcome evaluations

All OMH grant program-related efforts and other key OMH-funded initiatives are expected to contribute to achievement of these objectives. NPA efforts are guided by a federal team that includes representatives from all HHS divisions and key Executive Branch departments/agencies.

OMH's programs directly focus on prevention and health promotion (e.g., culture of wellness, healthy choices, and medical screenings), risk reduction, healthier lifestyle choices, utilization of quality health care services, and barriers to health care for racial and ethnic minorities. They also facilitate development, implementation, and/or improvement of state/tribal government policies and programs to improve collaboration and reduce redundancy; increase availability and utilization of all forms of data and information; and improve access to, and availability of, quality health care for racial/ethnic minorities.

Recent Accomplishments

Education and Awareness

OMH continues to promote the delivery of culturally competent care to ethnically and racially diverse populations as another strategy to reduce health disparities. Specifically, OMH has developed and launched three flagship culturally competent e-learning programs targeting health professionals and health care providers. The cultural competency curriculum e-learning modules for physicians and nurses focus on increasing their competencies in serving the cultural and linguistic needs of ethnically and culturally diverse populations. The Health Care Language Services Implementation Guide is an interactive web-based tool that uses a variety of learning methods and tools to assist health care organizations and providers meet the needs of limited English proficient patients, thereby increasing timely access to health care. Breaking down cultural and communication barriers between health care organizations, providers and patients and thus increasing patient trust and compliance to treatment protocols is one of the intended outcomes of these e-learning programs. FY 2008, 55,305 continuing medical education

credits and certificates of participation were awarded to participants of the physician modules, and 29,379 continuing education credits were awarded to registered nurses.

Improved Individual and Public Knowledge and Understanding about Minority Health and Health Disparities Problems and Solutions

OMH has moved to increase awareness and understanding of the major health problems and needs of racial and ethnic minorities, and the nature and extent of health disparities between racial/ethnic groups in the U.S. through a wide range of informational and educational efforts aimed at decision-makers, health professionals, those serving racial and ethnic minority communities, and the general public. In order to assess the results of efforts by OMH and its partners on increasing public awareness of racial/ethnic minority health problems, OMH developed an annual measure on public awareness of health disparities in FY 2006 and funded a study related to this measure in FY 2007. Study instruments and methodologies are similar to those used in a 1999 study conducted by the Kaiser Family Foundation with Princeton Survey Research Associates. OMB Clearance under the Paperwork Reduction Act was received in March 2009 and preliminary results are anticipated by the summer of 2009. Annual surveys are anticipated in order to assess progress on the annual measure and identify trends that can be shared with OMH's partners and the public-at-large. In addition, grantee-specific measures related to increased participant knowledge and understanding of racial and ethnic minority health problems are incorporated into OMH evaluation planning requirements for its grants awarded during and after FY 2007.

The OMH Resource Center houses the largest specialized collection of information on minority health and disparities in the US. The Website and electronic newsletter reach thousands of users with information about HHS programs to eliminate health disparities, stories about what minority community organizations are accomplishing, and news about the expertise, educational materials and resources HHS makes available to health departments, academic institutions, community-based agencies, public health professionals, and faculty and students working on minority health. Unique visitors to OMH's Web site seeking health information are projected to increase from 395,000 in FY 2008 to 420,000 in FY 2010.

OMH also supports HIV/AIDS programs, some of which are funded by the Minority HIV/AIDS Initiative (MAI). These programs include the *Collaborative Technical Assistance and Capacity Development (CTA/CD*), a three-year grant program initiated in FY 2008 which supports 13 projects designed to develop and improve the coordination and continuum of HIV prevention, treatment and support services provided by organizations closely interfaced with targeted minority populations impacted by HIV/AIDS. In a collaborative partnership with primary care service sites and substance abuse and/or mental health treatment and prevention programs, grantees provide technical assistance and capacity building services to those organizations based on their identified needs. Grantees are expected to identify community-based, minority-serving organizations that are well linked with targeted minority populations affected by HIV/AIDS, and which have recognized needs and/or gaps in their capacity to provide a

comprehensive continuum of HIV/AIDS-related prevention and treatment services, inclusive of mental health, substance abuse and primary healthcare.

The OMH Resource Center's capacity development staff works on HIV, collaborating with CTA/CD grantees and with small and new service organizations. In FY 2009, MAI funds also support projects to: (1) improve outreach and testing for HIV, tuberculosis and sexually transmitted infections in the US Pacific Jurisdictions where it helped create a Pacific Resource and Training Center and trained health departments and CBOs, (2) strengthen CBO outreach and improve data collection and analysis on HIV infection in African immigrant communities, (3) develop a formal mentoring and training program for Latino leaders of community organizations working on HIV/AIDS, and (4) initiate a collaboration with the Indian Health Service to strengthen community-based and Tribal work on HIV/AIDS.

In FY 2009, OMH also received MAI funds for two new programs. The first, *Curbing HIV/AIDS Transmission among High Risk Youth and Adolescents by Utilizing Peer-to-Peer Interaction Using New Application Technologies (CHAT)*, is a partnership with HRSA and SAMHSA to support ongoing HIV/AIDS prevention, education and testing initiatives aimed at youth who are currently in alternative education settings; juvenile detention facilities; and alternative living arrangements ordered by the courts. The project will use innovative approaches such as texting and tweeting as a tool to support instant communication with the target population to increase access to AIDS information and prevention through these application technologies. The second is the *HIV/AIDS Health Improvement for Re-entering Ex-offenders Initiative (HIRE).* OMH, in partnership with the Substance Abuse and Mental Health Services Administration, Centers for Medicare and Medicaid Services, Administration for Children and Families, Health Resources and Services Administration, Indian Health Service, and the Department of Justice seeks to improve the HIV/AIDS health outcomes of ex-offenders re-entering the mainstream population (reentry population) by supporting community-based efforts to ensure the successful transition of ex-offenders as they complete their state or federal prison sentences and return to the community. Under a comprehensive umbrella demonstration grant, OMH will target the reentry population affected by HIV/AIDS.

Funding History

FY 2005	$50,269,000
FY 2006	$56,338,000
FY 2007	$53,455,000
FY 2008	$49,118,000
FY 2009 Omnibus	$52,956,000

Budget Request

The FY 2010 baseline budget for the Office of Minority Health is $55,956,000 which represents an increase of $3,000,000 above the FY 2009 level for health disparities comparative demonstrations. The FY 2010 request does not include one-time funded projects whose selection was incorporated into law by reference.

The FY 2010 budget request continues required enhancements to the OMH website; performance and evaluation requirements; and critical programs that target health disparities gaps and emerging issues. OMH's programs and initiatives are intended to yield outcomes that inform health policies and improve practices that prevent disease, reduce risk, promote health, and improve service delivery strategies for racial/ethnic minorities. These activities are supported through grants, cooperative agreements, and contracts.

Strengthened Community Capacity and Assets

The FY 2010 request includes $6,600,000 for the *Community Partnership to Eliminate Health Disparities Demonstration Grant Program*, an increase of $900,000 above the FY 2009 budget level. The increase allows for first-time targeted demonstrations focused on racial and ethnic minorities in rural communities. This program promotes the utilization of community partnerships with locally grounded, grassroots organizations to develop and/or implement promising practices and model programs targeting minority communities that focus on: health education promotion, disease risk reduction and increased access to and utilization of preventive health care and treatment services. The program focuses on reducing health disparities among racial and ethnic minority populations by demonstrating the effectiveness of the collaborative partnership approach. Funded organizations develop, implement and conduct demonstration projects in high-risk minority communities. These projects coordinate integrated community-based educational screening and outreach services and provide linkages for access and treatment to minorities in high-risk, low-income communities. The projects reduce social, cultural and linguistic barriers to health care and implement and/or adapt existing promising practices/model programs for targeted minority communities.

The FY 2010 request includes $2,300,000 to continue the *Bilingual/Bicultural Demonstration Grants Program* at the FY 2009 level. This program addresses the health status of limited English proficient minority populations by reducing barriers and increasing access to quality health care, increasing the diversity of the healthcare workforce, and disseminating outcomes related to culturally and linguistically appropriate services and training.

The FY 2010 request includes $1,700,000 to address increasing rates of HIV among racial and ethnic minorities, a $900,000 increase above the FY 2009 level. The increase supports limited expansion of the program to address critical gaps in HIV/AIDS

prevention through effectiveness of partnership arrangements that include national minority-serving organizations, institutions of higher education (particularly those with a history of serving minority populations, such as Historically Black Colleges and Universities, Hispanic Serving Institutions, Tribal Colleges and Universities), and organizations with access to minority populations with increasing rates of HIV/AIDS. This program promotes promising practices and model programs targeting unique minority communities. Funded organizations conduct activities such as developing, implementing and conducting HIV/AIDS demonstration projects on college campuses; coordinating educational screening and outreach services, including linkages (referral and navigation services) to improve access to enabling services and treatment; reducing social, cultural, linguistic, and literacy barriers to health care; and implementing and/or adapting existing promising practices/model programs.

The FY 2010 request includes $3,700,000 million for the OMH Resource Center, an increase of $700,000 above the FY 2009 level. The increase supports $100,000 in required enhancements to the OMH website and minimal expansion of OMH's information and capacity development services to health professionals and community organizations. Resource Center staff involvement and its information and technology infrastructure is essential to planning and implementing critical health disparities awareness programs including the Healthy Baby campaign, Minority AIDS Initiative projects in the US and US-associated Pacific jurisdictions, and the web presence for OMH and for cross-departmental activities such as the American Indian and Alaska Native Health Research Advisory Council. The Resource Center will continue its collaborations with health departments and state offices of minority health and focus on personal and community behavior related to health and the issues faced by community organizations.

The FY 2010 request for the OMH Resource Center also includes $600,000 for the *A Healthy Baby Begins with You* campaign in African American and American Indian and Alaska Native communities. Funds will be used to expand partnerships and community efforts focused on teaching principles of family health and preconception care and extending the effective campus-to-community peer training model in African American communities. Funds for the American Indian Alaska Native Campaign will be used to test and pilot outreach methods and strategies in conjunction with the Indian Health Service and Tribal community organizations.

The FY 2010 request includes $3,500,000 to support the *Youth Empowerment Program*, a reduction of $400,000 from the FY 2009 level. The reduction in the budget for this program represents one-time pilot projects funded in FY 2009 which target the identification of programmatic and policy gaps needed to improve outcomes for minority boys. This program addresses community-based interventions for reducing risky behaviors among targeted minority youth. These demonstration grants require a multi-partner approach involving institutions of higher education, primary and secondary schools, community organizations and institutions, and the community at-large. Each grantee must involve at least three formal partnerships, one of which must be with a primary or secondary school. A Youth Center must be established to provide services to

the cohort, grades 3 through 10, from the target population to participate in each of the 3 years of the project.

OMH will continue to focus on increasing the capacity of health professionals to meet cultural and linguistic health care needs of racially and ethnically diverse populations. The FY 2010 request includes $1,600,000 to continue to support the Center for Linguistic and Cultural Competence in Health Care (CLCCHC) and the Center for Emergency Preparedness for Underserved Communities (CEPUC) at the FY 2009 budget level. The CLCCHC will continue to enhance the three e-learning cultural competency programs for health care providers, including the development of evaluation protocols to assess their effectiveness. Specific activities of the CEPUC include the National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities and the Cultural Competency e-learning training program for disaster personnel.

Strengthened Infrastructure and Capacity to Address Racial/Ethnic Minority Health and Health Disparities

The FY 2010 request includes $6,600,000 for the *State Partnership Program*, an increase of $1,500,000 above the FY 2009 budget level. The increase supports grants to states not previously funded under this program in addition to first-time funding to U.S.-affiliated Pacific Basin Jurisdictions (territories). Grants under this program are competitively awarded and are designed to assist states and territories in strengthening their policies related to specific racial and ethnic health disparities; develop or adopt state/territory-wide collaborative plans for eliminating health disparities; and facilitate implementation of innovative programs that reduce disparities in health across the state/territory.

The FY 2010 request includes $2,000,000 for the *American Indian and Alaska Native (AI/AN) Partnership Program grants*, an increase of $800,000 above the FY 2009 funding level. The increase supports first-time funding for tribal epidemiology centers not previously funded under this program. Tribal epidemiology centers have been funded to work with their respective tribal leaders to better access data, engage in data development activities, and/or use a broad array of data to facilitate evidence-based health care decision-making and address health disparities planning; develop non-traditional alliances and partnerships to improve coordination/alignment of health and human services and access to quality care for their communities; and improve the diversity of the tribal healthcare, public health, and research workforce.

The FY 2010 request includes $2,725,000 to support the National Umbrella Cooperative Agreement Program, a decrease of $1,109,000 below the FY 2009 funding level. Grantees funded under this program will receive support for base projects. The National Umbrella Cooperative Agreement Program is a strategic approach to increasing the diversity of the health-related work force, reducing health disparities and improving quality of care, and improving evaluation procedures and the collection and analysis of data for targeted minority populations. The use of the cooperative agreement funding mechanism facilitates the ability of HHS to partner with other Federal agencies in working with funded national organizations to carry out a broad range of projects

addressing these issues (e.g., awareness of disparities in Lupus for racial and ethnic minorities, improvement of life outcomes for racial and ethnic minority males, increased rates of hepatitis B virus among racial and ethnic minority communities, integration of mental health and primary care, public health and emergency preparedness in minority communities, and health information technology for underserved populations). It also enables funded grantees to collaborate with non-affiliated organizations to more effectively implement projects focused on emergent issues.

Effective Leadership to End Health Disparities

In addition to implementing the *National Partnership for Action to End Health Disparities (NPA)* as a means for addressing leadership and improving nationwide coordination and collaboration for greater effectiveness, efficiency, and impact on health disparities, OMH is working with the Association of State and Territorial Health Officials and the National Association of State Offices of Minority Health to strengthen and increase state-based strategic planning and partnerships. Additional partnerships are being established to further improve efficiency of collective efforts at all levels. As part of its effort to improve leadership and coordination, OMH also will develop the first national health disparities plan in consultation with community, state, tribal, regional, and national partners.

In FY 2010, OMH will increase its focus on the use of evidence-based guidelines, strengthen collaborations with HHS agencies on health disparities projects, and establish new partnerships with public and private organizations to improve cross-sector collaborations. This FY 2010 request includes $3,000,000 for the *Comparative Health Disparities Demonstration* program that is intended to develop and assess more effective and efficient national and regional models for eliminating health disparities. A primary focus for this program is to address policy and program knowledge gaps required to effectively support health reform.

Racial and ethnic minorities experience rates of morbidity and mortality from chronic diseases, challenges to accessing quality healthcare, and rates of uninsurance that are 2 or 3 times larger than the White population. They also are underrepresented in the health care workforce, more likely to live in communities with limited or poor healthcare resources, and face language and cultural barriers to care. A recent study found that clinics with larger proportions of minority patients were four times more likely to have a chaotic work environment and that challenges in workplace characteristics exacerbate time pressures already complicated by disadvantaged patients with chronic medical and psychosocial issues[6].

[6] Varkey A, B., Manwell, L.B., Williams, E.S., Separate and Unequal: Clinics Where Minority and Nonminority Patients Receive Primary Care, Archives of Internal Medicine 2009;169(3):243-250.

A number of recommendations and proposals exist and others are being developed to reform the U.S. health system. These proposals include a focus on improving access to care (insurance or expansion of insurance coverage) and a few include provisions for eliminating disparities in health as a means for improving outcomes for racial and ethnic minorities. However, little is known—nor are substantial efforts underway to better understand—how health reform recommendations may ultimately affect the health and health outcomes of communities of color. While national healthcare experts believe that expansion of health insurance coverage is a critical component to improving health outcomes for racial and ethnic minorities, health and healthcare disparities experts caution that "no single policy – such as expanding access to health insurance – will fully address health care inequality"[7] or address the primary care service realities faced by some minority communities (e.g., physician burnout, work control measures). The Comparative Health Disparities demonstration program is intended to develop evidence about health reform strategies that have the greatest likelihood for improving outcomes for minority communities.

This FY 2010 request also supports the activities of the OMH-led American Indian and Alaska Native (AI/AN) Health Research Advisory Council (HRAC). The HRAC was established to provide a venue for consulting directly with Tribes about health research priorities and to collaborate on approaches to effectively address their health issues and needs. As an advisory body to the Department, HRAC is comprised of elected Tribal officials and serves three primary functions to: (1) obtain input from Tribal leaders on health research priorities and needs for their communities, (2) provide a forum through which HHS operating and staff divisions can better communicate and coordinate AI/AN health research activities, and (3) provide a conduit for disseminating information to Tribes about research findings from studies focusing on the health of AI/AN populations.

In 2010, OMH will have a new long-term goal based on *Healthy People 2020* goals and objectives. The proposed measure is to increase the percentage of measurable racial/ethnic minority-specific *Healthy People 2020* (*HP2020*) objectives and sub-objectives that have met the target or are moving in the right direction. These objectives are a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the second decade of this century. Created by scientists both inside and outside of government, they identify a wide range of public health priorities and specific, measurable objectives. (New measure, July 2008)

[7] KFF. Eliminating Racial/Ethnic Disparities in Health Care: What are the Options? October 2008

OFFICE OF MINORITY HEALTH

Outcomes Data

Measure	FY 2008 Preliminary	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Long-Term Goal 1: Increase the percentage of measurable racial/ethnic minority-specific *Healthy People 2010* objectives and sub-objectives that have met the target or are moving in the right direction				
Increased percentage of measurable racial/ethnic minority-specific *Healthy People 2010* objectives and sub-objectives that have met the target or are moving in the right direction. (2005 Baseline: 62.4%)	NA	NA	68.6%	NA
Long-Term Objective: Increase individual and public knowledge and understanding about racial/ethnic minority health and health disparities problems and solutions				
Increased knowledge and understanding of the nature and extent of racial and ethnic health disparities in the general population (1999 Baseline: 47.5%)	Expected by 9/09	51.8%	52.8%	NA
Annual Efficiency Measure: Increase the average number of persons participating in OMH grant programs per $1 million in OMH grant support				
Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support (2006 Baseline: 18,960)	18,253 in 2008(did not meet target)	20,922	21,550	NA
Program Level Funding ($ in millions)		$52.956	$55.956	$3.000

OFFICE OF MINORITY HEALTH

Program Data Chart

Activity	FY 2008 Enacted	FY 2009 Level	FY 2010 Request
CONTRACTS:			
OMH Resource Center	$3,000,000	$3,000,000	$3,700,000
Logistical Support Contract	1,000,000	1,300,000	1,400,000
Center for Linguistic and Cultural Competency in Health Care	1,500,000	1,600,000	1,600,000
Evaluation	0	300,000	700,000
Other Contracts & IAAs	3,029,000	3,898,630	4,879,000
Subtotal, Contracts	8,529,000	10,098,630	12,279,000
COOPERATIVE AGREEMENTS:			
Male Health	900,000	900,000	1,000,000
HIV/AIDS Coop Agreements	800,000	800,000	1,700,000
Umbrella Cooperative Agreements	2,300,000	3,834,000	2,725,000
Subtotal, Coop Agreements	4,000,000	5,534,000	5,425,000
DEMONSTRATION PROJECTS:			
Bilingual/Bicultural Demonstrations	2,300,000	2,300,000	2,300,000
Health Disparities Program:			
State Partnership Grants	5,900,000	5,100,000	6,600,000
American Indian/Alaska Natives Partnership Grants	1,800,000	1,200,000	2,000,000
Community Partnership Grants	6,000,000	5,700,000	6,600,000
Comparative Demonstrations	0	0	3,000,000
Youth Empowerment Program	2,735,000	3,900,000	3,500,000
Conference Support Program	0	400,000	350,000
Subtotal, Demonstration Projects	18,735,000	18,600,000	24,350,000
Health Disparities – Mississippi	5,000,000	5,283,000	0
Specified Project – Lupus	0	1,000,000	0
Specified Project – St. Francis Hospital	565,000	0	0
Operating Expenses	12,289,000	12,440,370	13,902,000
TOTAL	**$49,118,000**	**$52,956,000**	**$55,956,000**

OFFICE ON WOMEN'S HEALTH

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$31,033,000	$33,746,000	$33,746,000	---
FTE	39	43	43	---

Authorizing Legislation .....Title III, Section 301 of the PHS Act
FY 2010 Authorization.....Indefinite
Allocation Methods.....Direct federal; Competitive grants; Contracts

Program Description and Accomplishments

The Office on Women's Health (OWH) was established in 1991 to improve the health of American women and girls by advancing and coordinating a comprehensive women's health agenda throughout HHS. The program has four goals: 1) Develop and impact national women's health policy; 2) Develop, adapt, and evaluate and/or replicate model programs on women's health; 3) Educate, influence and collaborate with health organizations, health care professionals, and the public; and 4) Increase OWH's capacity to achieve maximum operational performance and objective documentation of accomplishments. The program provides leadership to promote health equity for women and girls through sex/gender-specific approaches and fulfills this mission through competitive contracts and grants to an array of community, academic and other organizations at the national and community levels. National educational campaigns provide information about the important steps women can take to improve and maintain their health. OWH provides Departmental leadership on women's health, while developing partnership opportunities across agencies and with the private sector. This approach maximizes efficiency and minimizes costs. OWH has experienced success in all of its program goals.

OWH underwent program assessment in the spring of 2004. The assessment cited OWH's ability to disseminate credible scientific health information to women and girls as a strong attribute of the program. In response to the assessment and findings, OWH undertook a strategic planning process to define its four major as described above. OWH continues to identify gaps and influence changes in healthcare for women and girls. OWH's annual and long-term outcome measures link to the program's mission and make it possible to measure progress in achieving long-term performance goals.

During FY 2008, OWH drafted a Strategic Plan for FY 2010 - FY 2015, which became effective in October 2008. Under this new plan, OWH began funding evidence-based interventions to acknowledge women's health areas that are not currently addressed at the national level by any other public or private entity. These programs focus on disparities in women's health, in which minority status, disabilities, geography, family history, low socioeconomic status (SES), chronic conditions, and infectious diseases are contributing risk factors. OWH utilizes Quick Health Data Online as a primary source to identify health disparities. Evidence-based strategies from AHRQ, CDC, and other sources are required to justify all programs.

Leadership and management of the Chronic Fatigue Syndrome Advisory Committee (CFSAC) were transferred to OWH from the Centers for Disease Control and Prevention (CDC) as of November 1, 2008. CFSAC will meet May 27-28, 2009, with a focus on children with CFS as well as ongoing research issues with CDC and NIH.

FY 2008 Appropriations Language directed OWH to fund the Institute of Medicine to conduct a study of progress in women's health research. The Committee will hold its third meeting May 7-8, 2009, including a public session the afternoon of May 7. Details of the study, the committee membership, and related materials can be found at http://www8.nationalacademies.org/cp/projectview?key=49029. Results are expected in early 2010.

Model Programs on Women's Health

Model Programs on Women's Health focus on developing and replicating innovative programs in women's health. The OWH model program, *Advancing System Improvements to Support Targets for Healthy People 2010* (ASIST 2010), provides three years of funding to support public health systems and/or collaborative partnerships that emphasize gender-specific approaches to 7 of the 28 Focus Areas of *Healthy People 2010*. Evidence-based programs support the grantees' performance objectives. OWH monitors the progress of grantees in reaching the *Healthy People 2010* goals throughout their grant period.

In FY 2008, OWH began a national external evaluation of the ASIST 2010 program. This evaluation assessed the effectiveness of the surveillance system in supporting the operations of the public health system/collaborative partnership, its ability to track changes within the system and the sex and gender focus, examine the ability of different public health systems/collaborative partnerships to effectively deliver sex and gender-based care, and the sustainability of the data collection effort.

In FY 2009, OWH began an evaluation of its former multidisciplinary model in women's health programs in an effort to identify the characteristics of programs that have sustained themselves after federal funding has expired. Most importantly, the evaluation generated examples of acceptably sustained federal programs and guidelines for sustaining a federal program that could be included in future grant/contract announcements.

One model program planned for FY 2010 is a multi-agency program to reduce smoking rates in young, low socioeconomic status (SES) women, 40 percent of whom are now smoking. These women will be reached at three levels: clinical interventions during pregnancy and one year after delivering a child, quitlines with free incentives, and media campaigns. OWH and NCI met with 15 other federal agencies, to design and plan this comprehensive initiative. A panel of outside experts convened in FY 2009 to provide further advice for this comprehensive program. HRSA has agreed to place all materials developed through this joint effort in every federally funded community health center. These centers are the primary healthcare providers for the target population.

In late FY 2009, OWH will convene a multi-day interactive HIV/AIDS Gender Forum that supports the exchange of concepts and best practices in serving women. The 2009 Gender Forum will focus on ensuring that public health initiatives, programs, prevention and care services demonstrate competency in serving women. In addition, for the fourth year, OWH will facilitate a national response to the impact of HIV/AIDS on women and girls by promoting observance of the National Women and Girls HIV/AIDS Awareness Day.

In FY 2008, OWH piloted a violence against women prevention, education and awareness program that promoted safety and nonviolence on college and university campuses. The initiative is based upon recommendations provided in the *Toolkit To End Violence Against Women* developed by the National Advisory Council on Violence Against Women in 2001.

Evaluation findings of the *Heart Truth* Provider Campaign revealed that primary care providers seem to be the least aware of women's heart issues. In FY 2008, OWH launched its initiative for primary care partnerships to prevent heart disease in women, targeting physicians and nurses. This three year project is designed to encourage medical and nursing organizations to educate and encourage health care professionals to learn about these issues and successfully intervene through the dissemination of the *Heart Truth* Provider Continuing Medical Education (CME), case-studies, and slide presentations. Interventions were funded in three of the top 15 states for heart disease mortality in women: Delaware, Ohio and New York.

Education/Collaboration/Coordination on Women's Health

OWH has strengthened HHS prevention efforts by communicating strategically to the public and health care professionals and by providing prevention information tailored to women and girls.

OWH maintains www.womenshealth.gov, which provides health information and referrals to consumers of health care services, health professionals, researchers, educators, and students. OWH also maintains the www.girlshealth.gov website, and it had 933,999 user sessions from January 1 – July 31, 2008. Additionally, for this same period there were over 15,460 phone calls.

Early in FY 2009, OWH released a comprehensive women's health resource guide. *The Healthy Woman* is sold nationwide, on a cost-recovery basis, and is available for download at no cost on womenshealth.gov. The book can also be purchased at Borders, Amazon.com, and numerous other retailers.

OWH's www.girlshealth.gov website is the #1 Google return when searching on "girls health." The site motivates girls ages 10-16 to choose healthy behaviors by providing information on fitness, nutrition, stress management, relationships with friends and family, peer pressure, suicide, drugs, and self-esteem.

Two key programs focus on girls health and are the backbone of OWH efforts. The *BodyWorks* toolkit for the prevention of obesity focuses on the family as the most important environment to prevent obesity in girls and the rest of the family. The toolkit helps parents and caregivers of young adolescent girls (ages 9-13) improve family eating and activity habits. Evaluation of the

program was completed in early FY 2009. Preliminary responses of trainers and families have been enthusiastic; currently there are over 1,600 trainers and 800 families throughout the country who have participated in the program. The Spanish version of the *BodyWorks* toolkit was released in the Fall of 2008. In addition, OWH awarded a contract to develop culturally appropriate materials for low literacy and economically disadvantaged parents to enhance their communication on important life skills with their teen daughters.

OWH has integrated the *Powerful Bones, Powerful Girls* (PBPG) osteoporosis prevention campaign into its adolescent girls' programming to improve efficiency and reduce redundancy. OWH plans to continue its progress with the National Bone Health Campaign (NBHC). This multi-year national education campaign promotes optimal bone health in girls 9-14 years old, and thus reduces their risk of osteoporosis later in life. The goal is to educate and encourage girls to establish lifelong healthy habits, especially increased calcium consumption and weight-bearing physical activity to build and maintain strong bones. The overarching goal of the campaign is to use social marketing principles and practices to change the nutritional and physical activity behaviors of girls by establishing lifelong healthy habits, especially an increase in both consumption of foods with calcium and weight bearing physical activity.

OWH contributes to, and expects to continue, several nationwide women's heart health initiatives. Recent data show that the percentage of women who know that heart disease is the number one killer of women has doubled in the last 6 years. As a founding sponsor (with the National Institutes of Health's National Heart, Lung, and Blood Institute) of the *Heart Truth Campaign*, OWH is disseminating health professional educational modules on the science behind the campaign's messages. OWH also supports the *Heart Truth Champions* program in several cities to deliver educational messages. In addition, OWH supports the *Sister to Sister Everyone Has a Heart* Foundation's annual *Women's Heart Day Campaign* every February.

In FY 2009, OWH collaborated with HRSA to continue the four-year *National Business Case for Breastfeeding Campaign* to encourage businesses to offer lactation support for mothers who return to work. The goal of the program is to increase support to sustain breastfeeding for six months by women who return to work. Ten State Breastfeeding Coalitions were selected for training and implementation of the program using FY 2007 funds: California, Connecticut, Georgia, Hawaii, Indiana, Louisiana, Oregon, Rhode Island, Texas, and Utah. Ten more states were selected in FY 2008: Alaska, Arizona - Navajo Nation, Iowa, Kansas, Michigan, New York, Pennsylvania, South Carolina, Vermont, and West Virginia. The *Business Case for Breastfeeding Kit* is available in hard copy though the HRSA Resource Center and on line at the breastfeeding webpage at www.womenshealth.gov/breastfeeding. Over 2000 businesses were contacted in FY 2008. The document was also translated into Spanish in FY 2008 - FY 2009. OWH is partnering with CDC and the Surgeon General's office to update the blueprint for action on breastfeeding. It has been 10 years since this document was last published. The new document will reflect the latest science related to breastfeeding.

On March 31, 2009, OWH and the Advertising Council launched the first ever *National Lupus Awareness Campaign*. This campaign is dedicated to increasing awareness of lupus to improve early diagnosis and treatment among those who are at increased risk for this disease. The campaign, targeted toward young minority women who are most impacted by lupus, will provide

them and their family members with information to help them take action if they have symptoms. The campaign includes TV and radio public service announcements (PSAs), a website (www.couldihavelupus.gov), bulletin boards and other media tools. The campaign will also generate long overdue public attention for lupus and raise recognition of the disease as a significant national public health problem.

Quick Health Data Online is a dynamic and comprehensive database system that provides state and county level data for women and men from all 50 states, the District of Columbia, and the US territories. Database elements include demographics, mortality, access to care, reproductive health, infectious and chronic disease, maternal health, mental health and violence and abuse. OWH modified and expanded this data warehouse in FY 2009 and updates the data annually. In FY 2008, an update of the Women's Health and Mortality chartbook appeared on the website, showing states' ranking on 25 key health indicators. It will be updated on the website in May 2009. The health disparities profiles examine data for racial and ethnic populations, focusing on twenty-one key health indicators. User sessions average 9,000 per month.

Building on the success of the 2008 National Women's Health Week (NWHW), OWH led HHS' planning for the May 2009 event. In FY 2008, more than 1,000 events and outreach activities occurred in all 50 states and some territories, and about 100 proclamations were issued. OWH also conducted the WOMAN (*Women and girls Out Moving Across the Nation*) Challenge. Over 42,000 women signed up to increase their physical activity to recommended levels, and the Surgeon General's radio interviews generated over 18 million audience impressions. National Women's Checkup Day is the day after Mother's Day, on which OWH encourages women to schedule preventive checkups they often postpone. Hundreds of providers and organizations offered free or reduced rate screenings on the 2008 Checkup Day.

In FY 2010, OWH will continue to provide general support to the ten Regional Offices on Women's Health. A contractor will manage regional women's health projects and activities and provide logistical support and travel arrangements for select meetings with women's health partners. The implementation of this contract will allow OWH regional coordinators to devote additional time and efforts to OWH programs and to enhance regional partnerships and collaborations among various organizations who work on improving women's health across the US.

Funding History

FY 2005	$28,641,000
FY 2006	$28,205,000
FY 2007	$28,219,000
FY 2008	$31,033,000
FY 2009 Omnibus	$33,746,000

Budget Request

The FY 2010 request is $33,746,000, the same as the FY 2009 Omnibus Appropriations level. FY 2010 funding enables the continued support of the existing projects. At this level of funding,

OWH will maintain programs at the FY 2009 level. The program data chart submitted below provides a display of activities to be supported.

As part of the process of implementing OWH's strategic plan, OWH has identified several programs whose funding periods end in 2009. These programs may be re-announced based on evaluation findings. Alternatively, OWH may redirect some or all of the funds to an array of new activities addressing gaps, or funds may be used to enhance current programs shown to be working but in need of larger-scale efforts to demonstrate effectiveness. The funds are identified in the program data chart as "program opportunity funds", and a process is under way in the third quarter of FY 2009 to determine how those funds will be distributed into programs.

Model Programs on Women's Health

In FY 2010, the OWH Coordinating Committee on Women's Health will continue to engage a diverse group of stakeholders to assist with identifying opportunities and implementing an action agenda that will advance the conceptual picture of "women's health" in concert with the release of the framework for *Healthy People 2020*. This effort will culminate with the Women's Summit in July 2009 where the *Action Agenda for Women's Health and Beyond 2010* will emerge.

In FY 2010, OWH plans to continue its initiative for primary care partnerships to prevent heart disease in women, targeting physicians and nurses. Evaluation findings of the *Heart Truth* Provider Campaign revealed that primary care providers seem to be the least aware of women's heart issues.

In FY 2010, OWH will continue targeting young women attending minority academic institutions with HIV/AIDS prevention education. These young women are community leaders and the OWH programs provide them with the prevention information they need not only for themselves, but for all the young people they influence. Today, women represent a larger share of new HIV infections compared to earlier in the epidemic. Women of color are particularly affected. Black women accounted for two thirds (65%) of new AIDS case among women in 2007; Latinas represented 15% and white women, 17%. In 2006, teen girls represented 39% of AIDS cases reported among 13-19 year olds. Black teens represented 69% of cases reported among 13-19 year olds; Latinas represented 19%. OWH is working in partnership with CDC to develop a gender toolkit for capacity building for community-based organizations providing HIV/AIDS prevention education and services targeting women and girls. The gender toolkit is a resource guide for community-based organizations that serve women.

In FY 2010, OWH plans to broaden the Women and Mental Health initiative's span to include specific materials on depression, trauma, and other unique mental health challenges for women. Assessment and evaluation of the *Action Steps to Improving Women's Mental Health* and consumer companion booklet, *Women's Mental Health: What It Means to You,* was implemented in the fall of 2008. Likewise, a release and evaluation project has been established for a Spanish version of the booklet, and a similar booklet targeted for girls and young women.

Education/Collaboration/Coordination on Women's Health

In FY 2009, OWH planned a new *Violence Against Women* initiative that targets adolescent relationship violence. This effort will build on a joint HHS-Department of Justice (DOJ) FY 2008 invitational meeting to explore research outcomes and programmatic needs. In FY 2010, OWH plans to continue this violence initiative to educate young women about domestic violence.

The National Breastfeeding Initiative program will continue through FY 2010. The goal of the program is to increase support to sustain breastfeeding for six months by women who return to work. Ten State Breastfeeding Coalitions will be selected for FY 2009.

One of the OWH program assessment measures is to increase the percentage of women who are aware of the eight warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911. In order to reach this goal, OWH has been working with CDC staff to develop a three-year national media PSA campaign regarding this issue. It is likely that TV, radio, new media, airport ads, and print media will be used to disseminate this message nationally. This campaign will continue through FY 2011.

OFFICE ON WOMENS HEALTH
Outcome Data

Measure	Most Recent Results	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Long-Term Objective 1: Increase the percentage of women-specific Healthy People 2010 objectives and sub-objectives that have met their target or are moving in the right direction				
1.1 Increase the percentage of women-specific *Healthy People 2010* objectives and sub-objectives that have met their target or are moving in the right direction.	69.5% (exceeded target, 67.5% - FY 2007)	72.5% (245/338)	74.0% (250/338)	1.5% (5/338)
Long-Term Objective 2: Increase the percentage of women-specific Healthy People 2020 objectives and sub-objectives that have met their target or are moving in the right direction				
2.1 Increase the percentage of women-specific *Healthy People 2020* objectives and sub-objectives that have met their target or are moving in the right direction.	*Healthy People 2020* baseline derived in 2010	NA	Baseline	NA
Long-Term Objective 3: Increase heart attack awareness in women				
3.1 Increase the percentage of women who are aware of the eight early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911. (baseline: FY05 54.5%)	65.8% (exceeded target, 60% - FY 2007)	67.5%	NA	NA
Note: This is a separate measure—not part of of "911" measure 3.2 Annual number of visitors to OWH websites (e.g., womenshealth.gov website; and girlshealth.gov website).	28.4mSessions (exceeded target, 24.5m – FY 2007)	34.5m sessions	37.5m sessions	3.0m sessions
Note: This is a separate measure—not part of the "911" measure3.3 Number of girls ages 9-17 and women ages 18-85+ that participate in OWH-funded programs (e.g., information sessions, web sites, and outreach) per million dollars spent annually.	1,006,45 (exceeded target, 813,904 – FY 2007)	1,220,591	1,326,729	106,138
Program Level Funding ($ in millions)		$33.746	$33.746	$0.000

OFFICE ON WOMEN'S HEALTH
Program Data

Activity	FY 2008 Actual	FY 2009 Enacted	FY 2010 Estimate
ASIST 2010	5,134,791	4,932,059	0
Sustainability of Federal Programs	500,000	150,000	0
Adolescent Health & Osteoporosis	2,425,000	3,150,000	3,150,000
Cardiovascular Disease Programs	1,050,000	1,302,393	1,250,000
Workplace Breastfeeding	300,000	415,000	415,000
Quick Health Data	411,000	411,000	450,000
Mental Health	400,000	100,000	0
Regional Women's Master Contract	1,000,000	1,206,376	1,500,000
Concept Mapping/Analysis - 2010	300,000	0	0
SG's Conference on Pre-Term Birth	125,000	0	0
HIV/AIDS in Minority Communities	1,872,000	1,125,000	1,300,000
Program Opportunity Fund (see narrative)	0	0	8,606,000
Lupus	608,711	1,392,228	0
Minority Women's Health	175,000	200,000	200,000
Violence Against Women	625,000	2,325,000	625,000
Nat'l Women's Hlth Info Center	3,200,000	3,200,000	3,200,000
Print Materials (incl mini calendars)	1,000,000	1,000,000	1,000,000
Communications Outreach	300,000	300,000	300,000
National Women's Health Week	250,000	250,000	250,000
2008 Woman Challenge	116,400	0	0
IOM Congressional Earmark	1,000,000	0	0
Co-sponsorships (incls IAAs & others)	500,000	500,000	500,000
Meeting Logistics Contract	500,000	1,200,000	1,000,000
Operating Expenses	9,240,098	10,586,944	10,000,000
TOTAL	**$31,033,000**	**$33,746,000**	**$33,746,000**

OFFICE FOR HUMAN RESEARCH PROTECTIONS

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$6,710,000	$6,959,000	$7,048,000	$89,000
FTE	31	33	33	---

Authorizing Legislation .....Title III, Section 301 of the PHS Act
FY 2010 Authorization .....Indefinite
Allocation Method .....Direct federal, Contracts, and Other

Program Description and Accomplishments

The Office for Human Research Protections (OHRP) was created in June 2000 in order to fulfill the Department of Health and Human Services (HHS) responsibilities set forth in the Public Health Service Act. OHRP supports, strengthens and provides leadership to the nation's system for protecting volunteers of research conducted or supported by HHS. OHRP provides clarification and guidance to research institutions, develops educational programs and materials, and promotes approaches to enhancing human subject protections. To carry out their research mission, more than 10,000 universities, hospitals, and other research institutions in the U.S. and abroad have formal agreements ("assurances") with OHRP to comply with the regulations pertaining to human subject protections. OHRP is organized into three functional Divisions and headed by the Office of the Director (OD). Each Division contributes to these responsibilities in numerous ways. The following narrative provides a brief description of each organizational component and some of OHRP's recent accomplishments and future expectations.

Office of the Director (OD) – The OD supervises and manages the development and promulgation of policies, procedures, and plans for meeting the responsibilities set forth above and the activities of the Divisions as described below. Specific responsibilities and accomplishments include:

- Serves as Executive Secretary of Secretary's Advisory Committee on Human Research Protections (SACHRP) and co-chair of Human Subject Research Subcommittee (HSRS) of the National Science and Technology's Committee on Science. In FY 2008, the OD: supported three SACHRP meetings; supported two subcommittees, six subcommittee meetings, and one ad hoc working group; and led six meetings of the Human Subjects Research Subcommittee and gave two presentations to the Committee on Science. In FY 2009, the OD will: support three SACHP meetings, will support approximately four SACHRP subcommittee meetings; and will lead approximately six meetings of the Human Subjects Research Subcommittee.
- Manages its International Activities Program which provides leadership for HHS in the global effort to improve human research protections through developing policies, procedures and practices for the monitoring and protection of human research participants in studies conducted outside the US, and to enhance the global capacity

for protecting human research participants. In FY 2008, the OD participated in several international meetings designed to expand technical support for human subject protection programs in developing countries and enhance international capacity for ethical review of human subject research. This activity is expected to continue in FY 2009.

- Coordinates responses to requests for OHRP documents and information under the Freedom of Information Act.
- Supports and increases public understanding of the role of human subject protections in advancing biomedical and behavioral knowledge, by providing information and clarification to reporters who disseminate this knowledge to the research community and the general public. In FY 2008, OHRP responded to 134 reporter requests and distributed both English and Spanish versions of its public information brochures to research institutions throughout the country. In FY 2009, OHRP intends to build on this solid foundation by increasing usability of its website as well as supplementing the distribution of its brochures through coordination with the Division of Education's training opportunities.

Division of Policy and Assurances (DPA) – DPA prepares policies and guidance documents and interpretations of requirements for human subject protections and disseminates this information to the research community. The Division also organizes and coordinates consultations with experts for certain research involving children, pregnant women, fetuses, neonates and prisoners. In addition, DPA negotiates assurances of compliance with research institutions and administers and maintains a registration system for institutional review boards. Specific responsibilities and accomplishments include:

- Maintains, develops, promulgates and updates policy and guidance documents regarding regulatory requirements and ethical issues for biomedical and behavioral research involving human subjects. DPA also coordinates appropriate HHS regulations, policies and procedures with other Departments and agencies in the Federal government, organizes and coordinates consultations with panels of experts for certain research involving pregnant women, fetuses, and neonates; prisoners; and, children, when required by HHS regulations for the protection of human subjects at 45 CFR 46.207, 46.306 and 46.407, respectively. DPA coordinates responses to requests for information, technical assistance, and guidance from Congress, other HHS agencies, other Federal agencies, and non-governmental entities.
- Negotiates Assurances of Compliance with research entities; registers Institutional Review Boards (IRBs); provides liaison, guidance, and regulatory interpretation to research entities, investigators, Federal officials, and the public; maintains and modifies existing assurance mechanisms, as necessary; operates and maintains a registration system for institutional review boards; provides technical support to SACHRP and its subcommittees; reviews and approves certifications for HHS conducted or supported research involving prisoners; develops *Federal Register* notices, including notices related to the issuance of OHRP guidance, requests for information, advance notices of proposed rulemaking (ANPRM), notices of proposed rulemaking (NPRM), and final rules; prepares submissions to the Office of Management and Budget (OMB) for forms that need to be approved by OMB under the Paperwork Reduction Act; and develops and implements new procedures to

ensure that HHS' human subjects protection regulations are appropriately and effectively applied to the changing needs of the research community.
In FY 2008, DPA:

- Issued three *Federal Register* notices related to issuance of guidance and four notices related to obtaining OMB approval under the Paperwork Reduction Act (PRA). In FY 2009, DPA plans to issue up to four notices related to issuance of guidance and up to four notices related to the PRA.
- Took action on more than 100 prisoner certification requests and expects this level to be sustained in FY 2009.
- Approved new, renewed or updated Assurances of Compliance (4,487), and IRB registrations (3,024). DPA expects to process the same volume of Assurances and IRB registrations in FY 2009.

Division of Compliance Oversight (DCO) – DCO evaluates all written substantive indications of non-compliance with HHS regulations—title 45, Part 46, Code of Federal Regulations (45 CFR part 46). Specific responsibilities and accomplishments include:

- Conducts inquiries and investigations into alleged non-compliance with the HHS regulations for the protection of human subjects. These activities include conducting and preparing investigative reports, and recommending remedial or corrective action as necessary. In FY 2008, DCO opened nine new compliance oversight investigations and closed 16 compliance oversight investigations. So far in FY 2009, DCO has opened four new compliance oversight investigations and closed seven compliance oversight investigations. OHRP has reduced the volume of open compliance oversight investigations to about 11.
- Conducts a program of not-for-cause surveillance evaluations of institutions. This program provides an important complement to the performance-based quality improvement programs described below. DCO conducted four not-for-cause compliance oversight evaluations in FY 2008. DCO has conducted three not-for-cause compliance oversight evaluations so far in FY 2009, and will do one more.
- Receives, reviews, and responds to incident reports from Assured institutions. These reports include reports of suspensions or terminations of institutional review board (IRB) approval of research, serious or continuing non-compliance, and unanticipated problems involving risks to subjects or others. DCO reviewed and closed 924 incident reports in FY 2008. DCO has so far reviewed and closed about 606 incident reports in FY 2009.

Division of Education and Development (DED) – Education is recognized universally as one of the most important elements in improving protections for human research subjects. DED provides guidance to individuals and institutions conducting HHS-supported human subject research; conducts national and regional conferences; participates in professional, academic, and association conferences; and develops and distributes resource materials in an effort to improve protections for human research subjects. OHRP also helps institutions assess and improve their human research protection programs through quality improvement consultations and workshops.
DED:

- Develops and conducts education conferences, gives presentations, develops other training tools, and carries out quality improvement activities to help ensure human

research subjects protections. In FY 2008, DED helped organize three OHRP Research Community Forums, gave approximately 100 presentations, conducted three Quality Assurance (QA) consultations, eight regional one-day QA workshops, and nine half-day QA workshops. In FY 2009, DED:

  - Helped organize three OHRP Research Community Forums attended by about 1,000 people from across the country and abroad,
  - Gave approximately 80 presentations,
  - Conducted seven regional one-day QA workshops for institutions with a FWA utilizing an internal IRB, as part of the OHRP quality improvement program, and
  - Conducted seven half-day regional QA workshops for institutions with a FWA utilizing only an external IRB,

- Provides liaison to Federal officials and guidance and regulatory interpretation to research entities, investigators, and the public regarding ethical issues in biomedical and social/behavioral research involving human subjects.
- Provides technical assistance to institutions engaged in HHS-conducted or sponsored research involving human subjects; maintains, promulgates, and updates educational guidance materials related to protection of human research subjects; and conducts public outreach and education or information programs to promote and enhance public awareness of the activities of OHRP and human subject protections.
- In FY 2009, DED finalized two training videos for posting on the OHRP website and has 4 additional videos in various stages of production; it is working to further develop and refine these videos prior to posting in late FY 2009 or FY 2010. OHRP continues distribution of its tri-fold public education pamphlet for English- and Spanish-speaking audiences via the OHRP website and in hard copy. These pamphlets provide advice to potential volunteers in under-represented communities to aid in their consideration of participation in research. Also, in FY 2009 DED completed its formal the education evaluation project. The evaluation showed excellent support for DED programs.

The activities of OHRP contribute directly to Goal 4 of the HHS Strategic Plan, which is to *Advance scientific and biomedical research and development related to health and human services.* Scientific and biomedical research will only continue so long as the rights and welfare of human subjects in scientific and biomedical research are protected, so that people continue to trust the research community and agree to participate in research in sufficient numbers. Advancing scientific and biomedical research in turn supports Goals 1, 2, and 3 of the HHS Strategic Plan, since the findings of scientific and biomedical research enable us to improve health care (Goal 1), prevent or control medical conditions and protect public health (Goal 2), and promote the economic and social well-being of individuals, families, and communities (Goal 3).

OHRP supports the OPHS/HHS strategic goals by contributing to the following measures:

- Increase the number of local, state, and national health policies, programs, and services that strengthen the public health infrastructure, and the number of policies in research institutions that improve the research enterprise.
- Increase the reach and impact of OPHS communications related to strengthening the public health and research infrastructures.
- Increase the number of substantive commitments to strengthening the public health and research infrastructure on the part of governmental and non-governmental organizations.
- Increase knowledge about the public health and research infrastructure, including research needs, and improve data collection needed to support public health decisions.

Funding History

FY 2005	$7,380,000
FY 2006	$6,921,000
FY 2007	$6,897,000
FY 2008	$6,710,000
FY 2009 Omnibus	$6,959,000

Budget Overview and Supported Activities

The FY 2010 request is $7,048,000, an increase of $89,000 above the FY 2009 Omnibus Appropriations level. The increase provides funds for staff pay increases and enables the continued support of the existing projects as described below.

Funds are used to support program activities including: maintaining a database for assurances and IRB registration; conducting advisory committee meetings; collaborating with other institutions to co-sponsor regional forums; and travel costs associated with educational events, public outreach, leadership activities, and compliance oversight evaluations. At this level, OHRP expects to maintain its current level of policy and assurance activities, compliance oversight activities, and will seek to maintain the current level of educational activities. OHRP expects to realize increased efficiencies that will result from an enhanced electronic system for submitting assurances and IRB registrations. OHRP does expect a significant increase in the International Activities Program related to making determinations of equivalent protections for institutions in foreign countries that conduct HHS-funded human subject research. Organizationally, OHRP has established the following goals for its individual components:

Office of the Director (OD): In FY 2010, the OD will support two SACHRP meetings and approximately four SACHRP subcommittee meetings. The OD will also lead six HSRS meetings.

Division of Policy and Assurances (DPA): In FY 2010, DPA plans to develop up to four guidance documents, as well as issue up to four *Federal Register* notices related to guidance. DPA expects to continue the attained level of 100 prisoner certifications as well as the similar volume of Assurances of Compliance (4,487) and IRB registrations (3,024).

Division of Compliance Oversight (DCO): In FY 2010 DCO anticipates maintaining the number of not-for-cause compliance oversight evaluations as performed in prior years, including the international area, at up to four per year.

Division of Education and Development (DED): In FY 2010, OHRP will strive to continue its education and quality improvement program. DED plans to give approximately 75 presentations at various meetings; conduct two to three regional forums; and conduct up to six QA workshops. These QA workshops provide attendees with the necessary information to assess their institution's human subject protections program and offer tools to facilitate improvement. In FY 2010 DED will continue the production of additional on-line training videos. These videos will provide a free educational resource to all members of the research community.

COMMISSIONED CORPS INITIATIVES: TRANSFORMATION, READINESS AND TRAINING

	FY2008 Appropriation	FY2009 Omnibus	FY2010 President's Budget Request	FY2010 +/- FY2009 Omnibus
BA	$4,119,000	$14,813,000	$14,813,000	---
FTE	26	31	31	---

Authorizing Legislation….Title III, Section 301 & Title XXVIII, Section 206 of PHS Act
FY2010 Authorization…….....Indefinite
Allocation Method……..……...….Direct federal; Contracts

Program Description and Accomplishments

This item supports the transformation of the Commissioned Corps, and Readiness and Response activities.

Transformation: To protect the health and safety of the American people, the U.S. Public Health Service Commissioned Corps (the Corps) is transforming into a force that is ready to respond rapidly to the most dramatic public health challenges and health care crises that can result from natural disasters (including infectious disease epidemics), technological catastrophes, terrorist attacks, and other extraordinary needs. In its day-to-day role, the Corps will remain an essential national resource within HHS to meet mission critical requirements and to address health care needs in isolated, hardship, hazardous, and other hard-to-fill positions. Activities will increase the capability and effectiveness of the Corps by contributing to the growth of the Corps' active duty force, ensuring adequate training of officers when called to active duty and at critical stages in their career progression, as well as creating and maintaining systems and programs whereby the Corps can readily support the critical missions of the Department.

An important component of the effort involves increasing the size of the Active Duty force. More officers on extended active duty will better enable the Corps to meet its agency-based and response missions. In FY 2008, the Office of Commissioned Corps Operations' Division of Commissioned Corps Assignments restructured work processes to increase the effectiveness and efficiency of application processing and call-to-active duty processes. This effort created numerous system improvements which have contributed to an increase of more than 260 officers from the beginning of FY 2008. The Corps' estimated target is 6,228 officers by the end of FY 2009 and 6,308 officers by the end of FY 2010.

One of the key Corps missions is to provide public health and clinical services to underserved populations. Historically, positions established to fulfill this mission are difficult to fill because they involve significant hardship for the incumbent and his/her family. Often, these positions are in remote locations and/or are performed under hazardous working conditions. In FY 2008, under the authorities of 37 U.S.C. 303a and 307a, policies were developed to create an Assignment Incentive Pay (AIP) program, to provide pay incentives to officers who accept

assignments at hard-to-fill duty stations. The OPDIVs/programs determine which assignments are eligible for AIP. Prior to AIP being approved, the Office of Commissioned Corps Force Management (OCCFM) reviews OPDIV requests for AIP to ensure adherence to established policy. If approved by OCCFM, the officers are paid out of OPDIV/program funds. As of April 7, 2009, 212 AIP assignments have been approved by the Office of Commissioned Corps Force Management (77% of which are classified as Isolated/Hardship or Hazardous Duty assignments, the remaining 23% are either other Critical Public Health or Physician/Dentist assignments). Additionally, the Corps is examining programs that will provide assistance to dependents for childcare, employment and relocation.

A robust, flexible and efficient IT system is essential to supporting the broad range of Corps activities. Throughout FY2007 and FY2008, the Corps has partnered with the U.S. Coast Guard (CG) in the consolidation of three Uniformed Services personnel systems into a single system maintained by the CG called Direct Access. Direct Access has managed the personnel actions for more than 50,000 users each year. Performance testing has been completed and user acceptance testing will be complete in April 2009 for management of the first phase of migrating Corps data to Direct Access. All performance issues for this phase that have been identified have been resolved. In May 2009, the Corps will begin migrating personnel systems to Direct Access. By retiring the current archaic and inefficient IT systems, Direct Access will enhance the overall efficiency and effectiveness of emergency deployments and facilitate increasing the size of the Corps.

In addition to the current human resources data captured on each Corps officer, new billet descriptions are being created for all billets encumbered by Corps officers, an Officer Profiles system is being populated with validated data on each officer's competencies, certifications, training/education, licensure, *etc*. This information will be imported to Direct Access to assist with the force management objectives of the Corps. In FY2009, the Corps' existing HR data will be imported, this includes information such as current billets, license information, assignment histories, awards, etc. It is anticipated that in FY2010, additional information will be populated that includes the new billets and Officer Profiles data. The data in the Officer Profiles system will mirror the information in the billet descriptions and will be used to match officers with vacancies.

The PHS Officer Basic Course (OBC) has provided orientation to the Corps and uniformed service to nearly 900 officers who have entered on active duty over the past 18 months (as of April 2009). It is anticipated that 540 officers will attend the OBC in both FY2009 and FY2010. This is the first in the continuum of officer training courses to be institutionalized by the Corps. In FY2009, the development of a PHS Officer Intermediate Course will provide additional leadership training and experiences for officers entering into the mid-career ranks and taking on additional supervisory and response leadership roles. A pilot Officer Intermediate Course is anticipated in July 2009.

Readiness and Response: All Commissioned Corps officers are deployable assets and must meet requirements for physical fitness, height and weight standards, immunizations, basic life support certification, and the completion of training related to emergency response and humanitarian assistance. The Office of Force Readiness and Deployment (OFRD), a division in the Office of

the Surgeon General, was established to manage the Commissioned Corps Readiness and Response Program.

The mission of the Commissioned Corps Readiness and Response Program is to provide a timely, appropriate, and effective response by U.S. Public Health Service officers to:

- public health and medical emergencies,
- urgent public health needs and challenges, and
- National special security events.

OFRD executes this program by ensuring that individual Corps officers are appropriately trained for deployment, and that the Corps deploys the appropriate team or individual(s) in a timely and effective manner.

As a result of the Katrina Lessons Learned Report (February 2006), the Corps now consists of an organized, tiered response structure. The teams and the magnitude of the response are tailored to the severity of the event and the specialties required. The Corps has organized and trained five Rapid Deployment Force (RDF) teams that can respond within 12 hours of an event. Regional and national incident support teams function as liaisons for the initial assessment and ongoing coordination of responses to public health emergencies. OFRD has coordinated five specialized teams of Applied Public Health professionals to deploy to affected communities to provide basic public health functions such as infrastructure assessments, vector control, food and water sanitation and environmental health in the wake of a complex disaster. When the situation on the ground warrants, teams of mental health professionals are deployed to provide clinical services to the affected populations and responders. Five teams designed to facilitate patient repatriation and access to human services, case management and psychosocial care have also been developed by OFRD. Each of these Tier 1 and Tier 2 teams are augmented by officers from the remainder of the Corps who all meet readiness standards and comprise Tier 3. A limited number of officers whose duties are deemed by the Agency Head to be critical to achieving the agency's mission will be exempt from deployment. A summary of the Corps' pre-configured response teams is in the following table:

Team	Arrival On Scene	Deployment Duration
Rapid Deployment Force (RDF) (Corps Tier 1)	<24 Hours	15-30 days
National Incident Support Teams (NIST((Corps Tier 1)	<24 Hours	15-30 days
Regional Incident Support Teams (RIST) (Corps Tier 1)	<24 Hours	1-3 days
Applied Public Health Teams (APHT) (Corps Tier 2)	<48 hours	15 days
Mental Health Team (MHT) (Corps Tier 2)	<48 Hours	15 days
Services Access Teams (PAT) (Corps Tier 2)	<48 Hours	15 days
Corps Augmentation Staff (Corps Tier 3)	<72 hours	15 days

In addition to the use of this tiered approach for responding to public health emergencies, OFRD deploys pre-positioned teams of officers and individuals for National Special Security Events and high-profile mass gatherings. Recent examples include the Republican and Democratic National Conventions, Papal Visit, Presidential Inaugurations and State of the Union Addresses.

OFRD also supports U.S. Government inter-service, interagency initiatives such as those missions taking place aboard US Navy ships in the Caribbean and the Pacific by rostering and deploying officers who provide clinical services and serve as public health subject matter experts to the mission. These missions are designed to increase the operational capacity of U.S. Government personnel to deliver humanitarian assistance, perform public health assessments, conduct public health infrastructure repair and provide health care training of indigenous health care workers. In FY2008, OFRD deployed officers to support such humanitarian assistance missions aboard USS Boxer (Western Central America), USS Kearsarge (Eastern Central America/Caribbean) and USNS Mercy (Pacific Partnership). In addition, the deployment of the USNS Comfort to support humanitarian operations in the Republic of Georgia required support from the Corps. The Corps currently has officers deployed on the USNS Comfort in support of Continuing Promise 2009 and will have officers on the USS Dubuque in support of Pacific Partnership 2009. Plans have been made to collaborate with the U.S. Southern Command (US SOUTHCOM) in conducting Medical Readiness and Training Exercises (MEDRETE) in Central and South America. The Corps has entered into a Memorandum of Understanding with US SOUTHCOM in FY2009 and the Corps is ready to begin participation in MEDRETEs when notified by SOUTHCOM. However, since SOUTHCOM leads this activity, the Corps must await their direction, which may occur in late FY2009 or FY2010.

Performance: As a proxy for evaluating the readiness and response of Corps, the Office of Force Readiness and Deployment (OFRD) underwent a program assessment in 2006. Knowledge gleaned from the assessment was used by OFRD to develop a series of improvement plans and seven ambitious annual measures designed to stimulate and monitor the efficiency of program activities and the appropriateness, timeliness and effectiveness of team and individual deployments. At the end of FY 2008, OFRD met or exceeded all seven of its assessment measures.

Performance goals, measures and targets have been established within the Corps to also assure progress is made in achieving the sizing and operational goals established by the Secretary. These goals define the Corps' staffing requirements, readiness, public health, isolated/ hardship and other clinical requirements, as well as its management, research, and other functions. The established performance goals have already facilitated the following:

- Collaborative arrangements with a broad variety of federal and private partners to obtain readiness training at no-cost or low-cost, including Advanced Cardiac Life Support, training on the Federal Medical Station platform, and humanitarian assistance training
- For the past three years, OFRD has successfully and dramatically increased the readiness numbers and standards of Corps officers and teams to match performance. In FY2008, the percent of officers meeting readiness standards *exceeded* the target, as did the percentage of officers that are were fully deployable, and the percentage of both deployed officers and teams that met timeliness, appropriateness and effectiveness. Furthermore, OFRD exceeded it's efficiency measure: the target cost per officer to attain or maintain readiness requirements was $100, and the actual cost to OFRD was $93.87.
- Development and application of deployment assessment tools to effectively assess performance measures for timeliness, effectiveness and appropriateness of activations and deployments.

Funding History

FY2005	$4,177,000
FY2006	$4,155,000
FY2007	$9,926,000
FY2008	$4,119,000
FY2009 Omnibus	$14,813,000

Budget Request

The FY2010 request is $14,813,000, the same as the FY2009 Omnibus Appropriations level. FY2010 funding enables the continued support of the following activities:

- The Corps will complete the migration of most all of its current HR data to Direct Access in FY2009 and will begin the migration of legacy systems/processes in the spring of FY2009 with the majority of the systems migrations taking place throughout FY 2010 in phases. Prior to the migration of the systems and data, the data must be formatted properly and securely to be interpreted by the Direct Access system. Once the data have been migrated, the functionality of the system(s) must be independently verified and validated.
- All relevant personnel data will be warehoused on Coast Guard servers or secure interfaces between HHS data warehouses and the Direct Access system will have to be established. In order to coordinate the management of the Corps' personnel data and activities at the Coast Guard, two Corps officers may be detailed to the Coast Guard Headquarters.
- IT systems will be developed that will support personnel management activities that include Billets, Officer Profiles, Assignments, Readiness, Awards, and Leave. Throughout FY 2010, existing data will be formatted in order to be properly interpreted by the Direct Access system, and new data will be collected to augment the Officer Profiles system that will be used in a variety of force management activities (*e.g.*, force strength analyses/projections, recruitment planning, retention programs, deployments, training, matching officers with vacancies).
- Building on the FY 2009 development and pilot testing of the PHS Officer Intermediate Course (OIC), FY 2010 funds will be used to develop the next courses in the training continuum. These courses will be called the PHS Officer Advanced Course (OAC) and the Officer Executive Course (OEC). OIC is designed for officers who are entering into positions with increased leadership responsibilities (whether at their duty station or in their deployment role). The OAC and OEC will be offered to officers who are entering into senior leadership positions within the Corps and their respective agencies. The learning objectives, course design, and course materials will be developed in FY 2010 and a pilot of the OAC will be offered in late FY 2010. Learning objectives and course design for OEC will be developed in FY 2010 and begin development of the course materials with an eye toward implementing the pilot course in FY2011.
- Management of Corps officers' careers, personnel actions, evaluation, awards, *etc*. are unique within the Department and non-HHS agencies to which our officers are assigned.

It is important that the supervisors of Corps officers understand the processes and procedures for processing each of these activities. A web-based resource for supervisors (Corps or civilian) called the Corps Awareness Program for Supervisors (CAPS) will provide answers to common questions, links to important forms and personnel INSTRUCTIONS and presentations on how to complete these actions. The CAPS resource is rudimentary at present, and FY 2010 funds will be used to further develop the CAPS program, market it to all stakeholders and refine it in response to feedback that is received from the end users.

- FY 2010 funds will support independent evaluations of programs that have been implemented since FY2007. Evaluations may include the following programs: the Officer Basic Course, Officer Intermediate Course (design and course materials), Assignment Incentive Pay, Career and Assignment Manager roles and business processes, migration to Direct Access and program development in light of responses received from officer surveys.

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
6.1.1: Increase the percentage of Officers that meet Corps readiness requirements, thus expanding the capability of the individual Officer. (Baseline – 2004: 50%) *(Outcome)*	FY 2008: 89.4% (Target Exceeded)	90%	92.5%	+2.5
6.1.2: Increase the percentage of Officers that are deployable in the field, thus expanding the capability of the Corps. (Baseline - 2005: 40%) *(Outcome)*	FY 2008: 75.4% (Target Exceeded)	77.5%	80%	+2.5
6.1.3: Increase the percent of individual responses that meet timeliness, appropriateness, and effectiveness requirements.(Baseline - 2007: 77%) *(Outcome)*	FY 2008: 89.3% (Target Exceeded)	90%	92.5%	+2.5
6.1.4: Increase the percent of team responses that meet timeliness, appropriateness, and effectiveness requirements.(Baseline - 2007: 89%) *(Outcome)*	FY 2008: 93.2% (Target Exceeded)	95%	97.5%	+2.5
6.1.5: Increase the number of response teams formed, thus enhancing the Department's capability to rapidly and appropriately respond to medical emergencies and urgent public health needs. (Baseline - 2005: 0) *(Outcome)*	FY 2008: 26 (Target Met)	36	36	Maintain
6.1.6: Increase the number of response teams which have met all requirements, including training, equipment, and logistical support, and can deploy in the field when needed as fully functional teams, thus enhancing the Department's capability to appropriately respond to medical emergencies and urgent public health care needs. (Baseline - 2006: 0) *(Outcome)*	FY 2008: 20 (Target Met)	20	26	+6
6.1.7: Cost per Officer to attain or maintain readiness requirements. *(Efficiency)*	FY 2008: $93.87 (Target Exceeded)	$100	$100	Maintain
Program Funding Level ($ in millions)	NA	$14.813	$14.813	

COMMISSIONED CORPS INITIATIVES
Program Data

	FY 2008 Actual	FY 2009 Enacted	FY 2010 Estimate
Transformation	$2,926,000	$8,123,000	$8,118,090
OFRD	1,193,000	6,690,000	6,694,910
Total	$4,119,000	$14,813,000	$14,813,000

NATIONAL VACCINE PROGRAM OFFICE

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$6,790,000	$6,879,000	$6,896,000	$17,000
FTE	10	17	17	---

Authorizing Legislation…….Title XXI of the Public Health Service Act
FY 2010 Authorization……...…….....Expired
Allocation Method……..……Direct federal; Contracts

Program Description and Accomplishments

The National Vaccine Program Office (NVPO) was created by Congress in 1987, to provide leadership and coordination among Federal agencies as they work together to carry out the goals of the National Vaccine Plan. The development of this plan was mandated in P.L. 99-660. The Plan includes values, goals, objectives, and strategies for pursuing the prevention of infectious diseases through immunization. The four goals of the National Vaccine Plan are to:

- Develop new and improved vaccines;
- Ensure the optimal safety and effectiveness of vaccines and immunization;
- Better educate the public and health professionals about the benefits and risks of immunizations; and
- Achieve better use of existing vaccines to prevent disease, disability, and death.

NVPO coordinates interaction between the Department of Health and Human Services (HHS) agencies and interacts with stakeholders in these areas through regular communication on issues including vaccine safety, vaccine supply, vaccine coverage, vaccine adverse events, vaccine financing, and international vaccine and immunization issues. NVPO advances the Secretary's priority on prevention from the work done to promote safe and effective vaccines, and enhance delivery of these preventive medical services, as well as being deeply involved in pandemic influenza preparedness, thereby contributing to the Secretary's priority on preparedness. Highlights include:

- *Updating the National Vaccine Plan.* The National Vaccine Plan identifies priority activities to improve the safety and effectiveness of disease prevention through immunization. The initial plan, published in 1994, is being evaluated and revised to redefine the current actions that can be taken to improve the vaccine enterprise and set a vision for the future. NVPO is coordinating the revision with all relevant agencies and offices in HHS, and with the Departments of Defense and Veterans Affairs, and the U.S. Agency for International Development. Input

is also being obtained from the Institute of Medicine, interested stakeholders, and the general public.

- *Overview of the National System for Immunization Safety*. The safety of vaccines is an issue that affects all children and families in the United States. The National Vaccine Program Office coordinates an interagency group that reviews the Federal system to anticipate, detect, and understand adverse events following immunization and improve the safety of vaccines that are used in the United States. As a result of this review, NVPO has completed a comprehensive review of the immunization safety system that describes the Federal vaccine safety system and provides specific examples of the many types of activities conducted by HHS, DoD and the VA in the area of immunization safety. The report includes vaccine research and development, laboratory studies, clinical trials, the licensure process, post-licensure surveillance, clinical assessment, and risk communication. This report will serve as the basis for communications with healthcare providers and the public to maintain and enhance confidence in the safety of the nation's vaccine program.
- *Pandemic Influenza Preparedness.* NVPO provides scientific direction to HHS pandemic influenza planning and preparedness activities coordinating with the Office of the Assistant Secretary for Preparedness and Response (ASPR), HHS OPDIVS, and other Federal agencies. Key activities include developing national guidance on prioritization of pandemic and pre-pandemic influenza vaccines, guidance on antiviral drug use strategies, and coordination in updating the HHS pandemic influenza preparedness and response plan.
- *National Vaccine Advisory Committee*. NVPO serves as Executive Secretariat for the National Vaccine Advisory Committee (NVAC) which advises and makes vaccine-related recommendations to the Assistant Secretary for Health. NVAC meets at a minimum of three times per year and is funded through the NVPO budget. In 2007-2008, NVAC focused on a number of areas relevant to the National Vaccine Plan such as:
    - Improving immunization information systems - NVAC's recommendations of the immunization information system report include steps to ensure privacy protections and information security, improve provider participation, appropriate functionality, and secure funding;
    - Adolescent immunization programs - NVAC's report on adolescent vaccination highlights the new opportunities presented by licensure and recommendation of new adolescent vaccines and the challenges posed in achieving high levels of disease prevention in this age group. Recommendations focus on strategies to improve vaccination coverage, surveillance, and program financing;
    - Vaccine Finance - efforts are currently focused on deliberating issues and developing recommendatoins to address adult financing. This workgroup coordinates with the Adult Immunization workgroup in discussing financing-related issues. NVAC will be publishing the Committee's work on pediatric and adolescent recommendations. These recommendations focus on a broadspectrum of issues targeting

the underinsured population and the reimbursement of the vaccine administration fee – both in the public and private sectors.

- Adult Immunization - NVAC established an Adult Immunization workgroup to "...assess public health adult immunization activities in HHS programs, identify gaps, and recommend improvements, particularly in program implementation, coordination, evaluation and collaboration across agencies, that will lead to improved vaccination uptake in adults in these programs." In 2009, this Working Group will join with the Vaccine Financing Working Group to review the financing of vaccines for adults in the United States.
- Vaccine Safety - NVAC's Vaccine Safety workgroup is reviewing CDC's Immunization Safety Office research agenda and providing guidance on content and prioritization. Additionally, the workgroup is looking at the federal immunization safety system more broadly and developing a white paper outlining what the optimal immunization safety system would look like to detect and prevent vaccine adverse events and maintain and improve public confidence in vaccines.

- *Strategic Issues in Vaccine Research (SIVR) Program*. Through a competitive process, with input from NVAC, NVPO's *Strategic Issues in Vaccine Research* (SIVR) program allocates funds to meet needs that emerge outside of traditional budget cycles and to initiate and stimulate priority vaccine and immunization-related projects. The *Strategic Issues in Vaccine Research* program has led to significant advances in vaccine safety, development and use while building capacity within HHS and leveraging agency resources to support follow-on activities. Examples of SIVR key program accomplishments include:
  - Improving the safety of new vaccines by developing methods to detect potential contaminants of vaccine substrates;
  - Developing improved methods to produce and evaluate candidate pandemic influenza vaccines; and
  - Evaluating the impacts of influenza vaccination in children leading to expansion of vaccination recommendations.

Funding History

FY 2005	$7,133,000
FY 2006	$7,004,000
FY 2007	$6,980,000
FY 2008	$6,790,000
FY 2009 Omnibus	$6,879,000

Budget Request

The FY 2010 request is $6,896,000, an increase of $17,000 above the FY 2009 Omnibus Appropriations level. The increase provides funds for staff pay increases and enables the continued support of the existing projects as described below.

In FY 2010, NVPO will continue to:

- Coordinate and integrate activities of all Federal agencies involved in vaccine and immunization efforts. NVPO hosts a biweekly interagency teleconference to coordinate current vaccine-related activities;
- Assess, evaluate, and fund *Strategic Issues in Vaccine Research* (SIVR) projects. SIVR also will support NVPO goals through the support of public engagement activities to enhance understanding of public values and perspectives on vaccine safety and the vaccination program, improving decision making and program acceptability;
- Enhance interagency collaboration, so that vaccine and immunization-related activities are carried out in an efficient, consistent, and timely manner. NVPO uses the monthly Flu Risk Management Meeting (FRMM) and weekly Departmental Influenza Conference Call to specifically coordinate influenza information across the Federal government;
- Contribute to pandemic preparedness by finalizing national guidance on the use of medical countermeasures, supporting other vaccine and pandemic preparedness initiatives, and coordinating an update of the HHS Pandemic Influenza Preparedness and Response Plan;
- Complete the Revised National Vaccine Plan;
- Work with Agencies to develop and implement strategies for achieving the highest possible level of prevention of human diseases through immunization and the highest possible level of prevention of adverse reactions to vaccines; and
- Work to minimize gaps that may exist in Federal planning of vaccine and immunization activities.
- Enhance coordination of federal vaccine safety activities.
- Enhance the effectiveness and value of NVAC by supporting their efforts in authoring timely and topical recommendations on critical vaccine policy issues.

PUBLIC HEALTH REPORTS

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$443,000	$450,000	$453,000	$3,000
FTE	2	2	2	---

Authorizing Legislation……Title III, Section 301 of the Public Health Service Act
FY 2010 Authorization…….Indefinite
Allocation Method……..Direct federal; Contract, Cooperative agreement

Program Description and Accomplishments

The journal Public Health Reports (PHR), the oldest journal of public health in the U.S., has been published continuously since 1878. PHR is the public health journal of the U.S. Public Health Service and the Surgeon General, and is produced in collaboration with the Association of Schools of Public Health. For 129 years this peer-reviewed journal has been a highly respected vehicle for public health academicians, practitioners, planners, legislators, and students. It is the venue of choice for many to publish their original work and acquire much of their knowledge and skills on innovative public health theory, research, and practice activities.

Public Health Reports brings important research and discussion of key issues to the public health community. Each bi-monthly issue examines subject matter needed to understand the issues of public health and disease prevention of the Nation. In addition to the six regular issues, two or more supplemental and/or special issues are published annually. Science-based webcasts are also produced. Each issue includes columns such as the *Surgeon General Perspective*, *International Observer*, *Law and the Public's Health*, *Public Health Chronicles*, and *From the Schools of Public Health* that address important national and international public health issues. The special commentary column from the Surgeon General, *Surgeon General Perspective*, highlights and discusses timely and emerging public health issues that align with the Surgeon General's priorities.

The Journal also has a special interest articles in emphasizing public health history. For example, *Public Health Reports: Historical Collection 1878-2005* is a text with 35 semiannual articles that have appeared over the years. *Vaccination*, is a history of vaccine use in the America from the 18th century to the present day which explores the history of this essential public health tool through an audio presentation with timelines, photographs, and archived articles. Recently, the entire set of PHR journal articles from 1878 has been digitalized and is currently available to the public via the internet at no charge. The URL is: http://www.pubmedcentral.nih.gov/tocrender.fcgi?journal=333&action=archive

End-of-year	# of Manuscript Submissions
2001	177
2002	227
2003	257
2004	253
2005	320
2006	323
2007	416
2008	410

PHR supports the OPHS strategic goals by contributing to the measures that increase the reach of OPHS prevention communications. In addition, PHR supports Secretarial goals to (1) prevent and control disease, injury, illness, and disability of Americans and (2) protect the public from occupational, environmental, and terrorist threats to the Nation's health by publishing articles and targeted columns that provide information to guide scientific and programmatic research in these areas.

Funding History

FY 2005	$463,000
FY 2006	$463,000
FY 2007	$455,000
FY 2008	$443,000
FY 2009 Omnibus	$450,000

Budget Overview and Supported Activities

The FY 2010 request is $453,000, an increase of $3,000 above the FY 2009 Omnibus Appropriations level. The increase provides funds for staff pay increases and enables the continued support of the existing projects.

The goal of PHR is to provide research and discuss key public health issues. Each issue of PHR examines subject matter needed to understand health promotion and disease prevention issues of the Nation's population. This goal is achieved through regular publishing of a scholarly journal as well as offering supplements, webcasts and special project products.

OFFICE OF RESEARCH INTEGRITY

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA*	$8,571,000	$8,909,000	$9,118,000	$209,000
FTE	21	24	24	---

*ORI is funded by NIH dollars, which are reflected as non-add

Authorizing Legislation ..... Title III, Section 301 and Title IV Section 493 of the PHS Act
FY 2010 Authorization ..... .Indefinite
Allocation Method ..... Direct federal; Contracts; Grants

Program Description and Accomplishments

The mission of the Office of Research Integrity (ORI) is to promote integrity in the research programs of the Public Health Service (PHS), both intramural and extramural, including responding to allegations of research misconduct. To accomplish this mission, ORI engages in research and evaluation, education, oversight of institutional and HHS investigations, collaboration with external partners, including scientific societies and associations, and research institutions and other activities intended to promote integrity, reduce misconduct, and maintain the public confidence in science-based medicine.

In recent years, ORI has placed greater emphasis on education, research, evaluation, and prevention activities. In response to these changes, ORI adopted an action plan, approved by the Assistant Secretary for Health (ASH), to increase resources in these areas. A key part of this plan was the establishment of a research program to study the factors influencing research integrity, an education program on the responsible conduct of research, and ongoing collaborations with ORI's research partners, including the Association of American Medical Colleges, the Council of Graduate Schools, other research associations, academic and scientific societies, numerous individual institutions, and others.

ORI's budget, resources, and programs are directly relevant to the Department's interest in the prevention of disease and promotion of health. ORI's overall mission supports the integrity of research and the public confidence in such research. Since clinical trials, human studies, animal studies, and basic research lead to new drugs, devices, and medical interventions, confidence in the science base which leads to such improvements in health is closely intertwined with the beneficial products of the research. ORI is also emphasizing prevention in its programs by developing educational resources to support best practices and by supporting extramural studies through its research program on the indicators of research integrity and the causes of misconduct. Only through the development of this science base can PHS identify effective and cost efficient means of promoting integrity and preventing misconduct. ORI's mission to identify and take action in response to research misconduct also provides primary and secondary prevention by

removing from research those who commit misconduct and reinforcing the scientific norms of honest scientists who conduct research responsibly. ORI responds to research misconduct and promotes research integrity, thereby directly supporting HHS and OPHS objectives to advance science and medical research, improve the quality of health care (through science-based medicine), and strengthen prevention. ORI efforts to prevent misconduct and promote integrity and responsible research practices strengthen the integrity of the science base, which supports the progress in new health care products and treatments which can prevent disease and illness. ORI also supports the public health infrastructure by helping ensure a trustworthy science database, upon which decisions are made and which support public confidence in utilizing science based medical discoveries.

Over the past three years, ORI has accomplished the following:[1]

- Reviewed 800 allegations of misconduct, opened over 80 formal inquiries and investigations, and made 29 findings of research misconduct.
- Reviewed over 100 institutional policies and procedures for regulatory compliance and responded to over 15 incidents of possible retaliation against good faith whistle blowers or non-compliance with regulatory requirements.
- Sponsored or participated in over 20 workshops and conferences with research institutions, scientific societies, and others on research misconduct, the responsible conduct of research, and the promotion of research integrity.
- Engaged in the development in over 10 educational products in Responsible Conduct in Research (RCR).
- Funded 15 grants to support research on misconduct, education in research integrity, conflicts of interest, and institutional practices that affect the integrity of the research environment.
- Provided on-site or telephonic technical assistance to approximately 150 research institutions in handling allegations of misconduct.
- Received and managed the Annual Report on Possible Research Misconduct for approximately 5000 institutes per year.
- Adopted a sample misconduct policy in 2007 to assist institutions in implementing the new PHS misconduct regulation, 42 CFR Part 93, Subpart E, that requires the accused scientist to provide specific factual evidence to demonstrate his/her innocence.
- Funded 39 awards to 33 societies through a cooperative agreement with Association of American Medical Colleges (AAMC). This resulted in 20 products related to research integrity and the responsible conduct of research.
- Funded the development of model RCR programs at leading research universities.

ORI supports the following OPHS performance measures:

- Increase the number of substantive commitments to prevention on the part of governmental and non-governmental organizations

[1] All ORI data are reported on a calendar year, rather than fiscal year, basis.

- Increase knowledge about disease prevention and health promotion, including effective interventions and research needs
- Increase the reach and impact of OPHS communications related to strengthening the public health and research infrastructures
- Increase knowledge about the public health and research infrastructure, including research needs, and improve data collection needed to support public health decisions

Funding History

FY 2005	$8,213,000
FY 2006	$8,172,000
FY 2007	$8,172,000
FY 2008	$8,571,000
FY 2009 Omnibus	$8,909,000

Budget Request

The FY 2010 request is $9,118,000, an increase of $209,000 above the FY 2009 Omnibus Appropriations level. The increase provides funds for staff pay increases, and enables the continued support of the existing projects as described below.

In FY 2010, ORI plans to:

- Continue a major new initiative to train institutional research integrity officers (RIOs) in handling and managing allegations for research misconduct. Ultimately, ORI plans to train all RIOs at the top 100 research institutions and to expand to the next 100 as resources permit.
- Continue work with the academic societies to develop and disseminate model RCR programs at an institutional level.
- Continue the support of ORI's RCR Resource Development Program and Conference Programs to provide educational resources for the research community.
- Continue to support the ORI/NIH extramural research program to engage researchers in the study of research integrity.
- Collaborate with the Office of Human Research Protections (OHRP) to maximize resources and speakers at workshops and conferences on human subjects, research misconduct, and research integrity. This will facilitate the communication of a common message by two Federal offices that have responsibility for research integrity issues, thus benefiting both the Federal government and OHRP's extramural partners.
- Collaborate with the NIH regional seminars by making presentations related to research misconduct, the responsible conduct of research, and the promotion of research integrity.
- Facilitate collaborations between academic societies in order to achieve broad cost-effective programs for the research community.
- Provide technical assistance to at least 20 institutions which conduct investigations into alleged misconduct and need assistance.
- Assess 225 potential allegations of misconduct.
- Complete assessments and closure of approximately 50 Pre-Inquiry Assessments.

- Take final actions on 10 or more findings of research misconduct involving PHS funding.
- Effect ten or more articles that misrepresent research results to be corrected or retracted.
- Issue charge letters and defend ORI authorities and actions in specific cases before the Departmental Appeals Board and in civil litigation.
- Respond to five or more whistle blower complaints of retaliation and institutional compliance problems.
- Assist the research community with the development of educational resources to enhance research practices.

Workload Data

Calendar Year	Misconduct Cases	Whistleblower Compliance/ Cases	Judicial Litigation
2006	Queries 266 Cases opened 29 Cases closed 35 Assessments underway 32 Current cases 53	Carried into 2006 3 Opened 12 Closed 8 Current 7	Opened 4 Closed 1 Current 4
2007	Queries 217 Cases opened 9 Cases closed 11 Assessments underway 34 Current cases 51	Carried into 2007 7 Opened 2 Closed 1 Current 8	5 pending civil cases No pending criminal cases
2008	Queries 198 Cases opened 13 Cases closed 17 Assessments underway 58 Current cases 34	Carried into 2008 8 Opened 8 Closed 4 Current 12	5 pending civil cases 2 pending criminal cases.

EMBRYO ADOPTION AWARENESS CAMPAIGN

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$3,930,000	$4,200,000	$4,200,000	---
FTE	---	---	---	---

Authorizing Legislation……Public Health Service Act, Section 1704
FY 2010 Authorization…….…….Indefinite
Allocation Method……..Competitive grants, Contract

Program Description and Accomplishments

The purpose of the campaign is to educate Americans about the existence of frozen embryos--created through in-vitro fertilization (IVF)--which may be available for donation/adoption for family building. The most recent studies suggest that there are at least 400,000 frozen embryos stored in fertility clinics in the United States. Of this number, it is estimated that approximately 88 percent are still being considered for future use by the creating couple in their own family building efforts. Many of the remaining 48,000 embryos might be made available for donation if the creating couples were educated about the alternative of releasing the embryos for adoption by other infertile couples.

Funded projects focus on educating couples who have frozen embryos who may choose to donate them. The program also functions to inform infertile couples about the availability of embryos for adoption. Information and educational activities are specifically directed at potential donors and recipients, as well as professionals (e.g., physicians, IVF clinic personnel, attorneys, and/or social workers) involved with the process of embryo donation and/or adoption.

With the passage of P.L. 107-116 (the fiscal year 2002 Departments of Labor, Health and Human Services, Education and Related Agencies Appropriations Act), Congress authorized the Department to launch a public awareness campaign about the existence of frozen embryos available for adoption. In FY 2008, Congress increased funding for the program from the FY 2007 level of $1,980,000 to $3,930,000 and included permissive authority to expend funds for medical and administrative services related to embryo adoption, stating, "*That funds provided in this Act for embryo adoption activities may be used to provide to individuals adopting embryos, through grants and other mechanisms, medical and administrative services deemed necessary for such adoption: Provided further, That such services shall be provided consistent with 42 CFR 59.5 (a) (4).*" This language was also attached to the FY 2009 Omnibus Appropriation Act which provides $4.2 million for the program.

In FY 2008, the Office of Population Affairs issued a competitive contract to explore the questions associated with funding medical and administrative services related to embryo donation/adoption. The contractor is also examining options for the design and development of

performance measures for the entire frozen embryo donation/adoption program. This process will help ensure that the funds are being targeted in the most efficient and effective manner possible. The results of this study, which are due in March 2010, will be used to inform future program efforts.

The core focus of the program is on information and education activities that contribute to increasing public awareness and understanding of embryo donation and adoption. A key challenge is to help couples with the decision-making process that is necessary to release frozen embryos for adoption. Funded projects have used both traditional and cutting-edge public information techniques to reach the general public as well as IVF professionals. The outreach to professionals is based on the concept that the understanding they acquire will be transmitted to their clients and hence to the general public. These projects have equipped professionals with the knowledge, skills and abilities necessary to provide useful and verifiable information and effective education to their clients.

By educating Americans about this family building option, the program supports the Department's Strategic Goal 3, which seeks to protect life, family, and human dignity by promoting the economic and social well-being of individuals, families, and communities; enhancing the safety and well-being of children, youth, and other vulnerable populations; and strengthening communities.

Funding History

FY 2005	$ 992,000
FY 2006	$1,979,000
FY 2007	$1,980,000
FY 2008	$3,930,000
FY 2009 Omnibus	$4,200,000

Budget Request

The FY 2010 request is $4,200,000, the same as the FY 2009 Omnibus Appropriations level. FY 2010 funding enables the continued support of the existing projects. These projects focus on public awareness information and education activities to help couples with making decisions regarding the process necessary to release frozen embryos for adoption.

Embryo Adoption Awareness	FY 2007	FY 2008	FY 2009 (est.)	FY 2010 (est.)
Total Number of Grants	6	8	8	8
New Grants	3	5	5	5
Continuation Grants	3	3	3	3

HIV/AIDS IN MINORITY COMMUNITIES

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	$50,984,000	$51,891,000	$51,891,000	---
FTE	---	---	---	---

Authorizing Legislation .....Title III, Section 301 of the PHS Act
FY 2010 Authorization .....Indefinite
Allocation Methods.....Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

In 1999, the Congressional Black Caucus initiated a partnership with the Department of Health and Human Services (HHS) to significantly increase the national response to the HIV/AIDS epidemic in racial and ethnic minority communities since they are disproportionately impacted by this epidemic. The partnership identified the following issues as priorities:

- developing more effective prevention education interventions;
- increasing access to HIV counseling and testing services; and
- ensuring that comprehensive and quality health care and drug abuse treatment services are available in these communities.

Since FY 1999, Congress has appropriated $50 million or more each year to support the Minority AIDS Initiative. Utilizing these funds, significant steps have been taken to respond to this unfolding crisis through capacity enhancements to mount a community-based response, delivering prevention and treatment services, and providing guided and informed technical assistance and research. A sustained commitment to these goals will ensure a durable response – with a flexible resource pool that can be quickly targeted to respond to newly emerging problems – and to capitalize on lessons learned. Since most minority communities have disproportionately high rates of HIV/AIDS infection, these targeted investments have been successful in identifying and addressing key barriers to allowing the Department's programs to effectively reach and serve minority communities.

Funds received by the Office of the Secretary for the MAI are disbursed to the Public Health Service agencies in HHS, as well as the Centers for Disease Control and Prevention; the Health Resources and Services Administration; the Substance Abuse and Mental Health Services Administration; and the Indian Health Service, on a competitive basis. Project proposals are subject to three levels of review, including peer review by fellow agency representatives who comprise the MAI Steering Committee; secondary review committee of senior OPHS staff lead by the Director of OHAP; and final review team comprised of the Assistant Secretary for Health (ASH) and a few of his key advisors. Following approval from the ASH, agencies then award the funds through

grants, cooperative agreements, and/or contracts to support hundreds of organizations and entities across the country.

Following are the four categories of programs and activities that have been funded in the past few years.

Outreach and Partnership Building. An integral part of OPHS' national prevention strategy is to educate, motivate and mobilize local and national minority leaders in the fight against HIV/AIDS. The goal is to leverage the credibility and influence of community leaders, and to place resources (information and technical) in the hands of those who know and can reach vulnerable racial and ethnic communities. This strategy also hopes to improve health outcomes in general for these populations, while promoting HIV testing and early medical treatment for those who are HIV-infected. Several efforts are underway which have facilitated the creation of new partnerships and initiatives. At the national level, dialogues with the YWCA and the National Medical Association have resulted in these organizations adopting HIV awareness, education and/or prevention activities which target their employees, clients and members.

Concurrently, the HHS Regional Health Administrators have reached hundreds of faith and community-based groups and leaders in first-time engagements with HHS on HIV/AIDS awareness and education. Some of these groups have now become advocates of HIV prevention education, while others have stepped forward to become providers of HIV/AIDS services. Grants for outreach and partnership activities are awarded to not-for-profit community-based and faith-based organizations, local health departments and clinics, health care providers, and universities and colleges, including historically black colleges and universities (HBCUs), Hispanic serving colleges (HSCUs) and universities, and Tribal colleges and universities (TCUs), research institutions, local government agencies, tribal government and for-profit organizations and companies. With the awarding of these grants, many influential and well-positioned entities educate and mobilize local communities through a variety of venues and mediums to engage the HIV epidemic. From sponsoring health fairs to town hall meetings and prayer breakfasts, local leaders become federal partners. Similarly, through the use of their own internal publications, training, listserves and e-mail blasts, community leaders provide additional mediums for outreach.

Technical Assistance and Training Activities. MAI funds are being used to expand technical assistance and capacity building activities for organizations serving racial and ethnic minorities disproportionately impacted by HIV/AIDS. Grants are awarded to not-for-profit community-based and faith-based organizations, local health departments and clinics, health care providers, and universities and colleges, including HBCUs, HSCUs, and TCUs, research institutions, local government agencies, tribal government and for-profit organizations and companies.

Training centers from the Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), and Office of Population Affairs (OPA) have

continued a formal partnership to collaborate among these providers. These collaborative efforts have significantly reduced duplication of efforts, and have fostered more rigorous and comprehensive training both across and within the areas of HIV/AIDS prevention, care and treatment. Currently, training centers in the HHS regions are developing curricular and training modules that reflect the many advances in preventing and treating HIV, as well as aiding HHS in activities which promote and support the Department's policies.

Prevention. With a focus on at-risk and high risk ethnic and racial minority populations, the CDC, SAMHSA, IHS, and several OPHS offices receiving MAI funds continue to make HIV testing central to their prevention efforts. Routine HIV testing and rapid HIV testing have been consistently integrated in the kinds of programs and activities developed over the last few years to reach youth, ex-offenders, rural and frontier populations, immigrants, college students, MSM, and substance abusers. For example, OPA, through its Title X-funded Family Planning Clinics, continues to provide rapid HIV testing as part of its HIV prevention services which includes funding for the HIV test, as well as counseling and referral services. The Family Planning Clinics provide comprehensive family planning, counseling and prevention services. Rapid HIV testing is also being provided in many SAMHSA-funded/ State-run and private-sector facilities and institutions that provide substance abuse prevention treatment. The CDC has increased its efforts to implement acute HIV screening among MSM. The Office on Women's Health has focused attention on female youth at greater risk for juvenile delinquency. In all cases the funding provided by the MAI has made rapid testing a reality in these expanded opportunities to conduct critical HIV testing.

In general, grants to fuel prevention work have been awarded to not- for-profit community-based and faith-based organizations, local health departments and clinics, health care providers, and universities and colleges, including HBCUs, HSCUs, and TCUs, research institutions, local government agencies, tribal government and for-profit organizations and companies. Multi-ethnic evidence based behavioral interventions remain essential to the MAI prevention efforts. The Office of Minority Health's Pacific Project and African Immigrant Project are just two examples of that expanded prevention effort.

Assessment and Evaluation. In 2007, the MAI Fund underwent a program assessment OHAP coordinated the data and responses to this assessment and was responsible for its completion. As a result of this assessment, OHAP developed and has begun to implement an improvement plan for the MAI Fund. The plan consists of improving four performance objectives and one management objective. Specifically, the improvement plan consists of: (1) establishment of baselines and ambitious targets for long-term performance measures; (2) development of a comprehensive evaluation plan for MAI Fund activities; (3) development of a formal process to document the use of performance information in managing the MAI Fund and making funding allocation decisions; (4) establishment of procedures that get grantees to commit to measures and report on performance related to the program's goals; and (5) arrangement for the inventory of

programs with related missions or activities and document their complimentary relationship to the activities of the MAI Fund.

By working with the MAI Steering Committee, OHAP has integrated or will soon integrate the entire set of improvement objectives outlined in the Improvement Plan. All process or procedural fixes are now in place and the establishment of baselines and ambitious targets are complete. An eighteen month evaluation of the MAI Fund began in the fall of 2008 and will conclude in FY 2010. Performance measures have been included as one of the variables to consider when assessing the merit of new proposals, and most agencies have quickly aligned their proposals to our efforts to increase testing and knowledge of HIV status; decrease new HIV infections; delay the onset of an AIDS diagnosis; decrease AIDS mortality; and improve the cost efficiency of both HIV testing and the training of clinical staff.

MAI Accomplishments in FY 2008 and FY 2009

Through the National HIV Testing Mobilization Campaign we have provided outreach to over 5 million Americans through direct contact and social marketing activities. Memorandums of Agreement have been established with 7 national HIV/AIDS organizations across a broad spectrum of HIV/AIDS demographics to expand HIV testing. The final assessment report and legacy document on the Campaign are nearing completion. In addition, the document, *HIV/AIDS: What You and Your Community Can Do*, *a* resource primer, will be completed shortly.

Through the MAI, a number of projects are designed to promote increased access to, continuity of, and quality of care, including: expanded recruitment and training of clinical staff; refining referral and linkage strategies; development of chronic care initiatives; promotion of telemedicine; and exploration of additional retention and patient navigation programs.

Through the AIDS.gov portal and the use of new media tools we have significantly broadened the outreach capacities of all of the HHS agencies and offices with HIV portfolios. MAI-funded projects have increasingly integrated new media tools and strategies in their activities.

An assessment and evaluation on MAI Fund activities and projects over the past three years is in process, as well as a comprehensive inventory of all MAI activities and programs over the last three years. Both reports will contribute significantly to our understanding of the important work being accomplished by the MAI.

Funding History

FY 2005	$ 52,415,000
FY 2006	$ 51,855,000
FY 2007	$ 51,891,000
FY 2008	$ 50,984,000
FY 2009 Omnibus	$ 51,891,000

Budget Request

The FY 2010 request is $51,891,000, the same as the FY 2009 Omnibus Appropriations level. FY 2010 funding enables the continued support of the Minority AIDS projects at the same level as in FY 2009.

Capacity Development in Rural and Moderate Incidence Areas

One of the keys to having an impact on this epidemic is to provide sustainable capacity development in rural and moderate incidence areas where an HIV/AIDS infrastructure may be weak or non-existent. Given these infrastructure challenges, its incumbent upon federal agencies to think creatively about what will work and how best to move these areas forward. The MAI Fund in FY 2010 represents an important opportunity to provide indigenous organizations within these communities the capacity development around service delivery and the management of HIV/AIDS. During times of tightened resources but and unwavering epidemic, our sustainable and proactive efforts are desperately needed. From the rural South to tribal country to some small cities in the Midwest and southwest, there are places where carefully targeted resources from the MAI Fund could have significant impact on the local epidemic.

Technical Assistance and Training Activities

Innovations in technology and new media or new perspectives on the use of old media, has broadened our understanding of how the federal government can provide invaluable technical assistance and training to organizations and other entities. From pod casts to text messaging to PSAs, there's a new and exciting way the MAI Fund can provide the tools to our local partners to assist them to carry awareness and prevention messages to their constituents, encourage HIV testing or refer for treatment and care. With our recognized challenges to reach youth and other populations detached from traditional public health campaigns and messages, its' important we use every tool we have in our arsenal to make a dent in this epidemic. Creative use of the MAI Fund in FY 2009 and beyond can be the vanguard of such efforts.

Prevention

In 2010, these funds will be used to continue our expansion of HIV testing opportunities as the cornerstone of prevention and our efforts to find the more than 250,000 individuals who are positive but don't know their status. Part of our prevention efforts must also involve getting those who test positive in care and returning to care those that have left.

There remains strong evidence that those individuals who know their positive status and in care are more likely to take steps to modify unsafe behaviors. Finally, prevention can't lose sight of the majority of Americans who are negative and the segment of those who are at great risk. Whether its high risk youth, women, or minorities, our prevention efforts must continue to evolve and stay relevant and appropriate. The MAI Fund provides the funding vehicle for agencies to be innovative and to test new approaches on a short-term basis.

Outreach and Partnership Building

In FY 2010, these funds will be used to continue our outreach and partnerships with non-traditional and under-served community-based and faith-based entities. While certain focus will be on those communities and populations that are disproportionately impacted by HIV/AIDS, we will continue to try to stay ahead of the epidemic and target resources to those emerging communities that have lower incidence levels but are ripe for a much larger problem. Outreach to youth and those individuals over 50 will play an increasingly important role as the rates of infection rise among both segments. Within our partnerships we will explore new ways to communicate and forge relationships through the use of innovative technology and new media.

#	Measure	FY 2007 Actual	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1	By 2010 increase the number of ethnic and racial minority individuals surviving 3 years after a diagnosis of AIDS	85.0% (FY 2007)	86.75%	87.75	TBD
2	Reduce percentage of AIDS diagnosis within 12 months within 12 months of HIV diagnosis among racial and ethnic minority communities.	38.0% (FY 2007)	36.25%	35.25	TBD
3	Reduce the rate of new HIV infection among racial and ethnic minorities in the U.S.	February 2009	50%	48.4%	TBD
4	Increase the number of African American individuals surviving 3 tears after a diagnosis of AIDS	82.0% (FY 2007)	87%	88%	TBD
5	Increase the number of Latino/Hispanic individuals surviving 3 tears after a diagnosis of AIDS	88.0% (FY 2007)	90%	90%	TBD
6	Increase the number of Asian/Pacific Islander individuals surviving 3 tears after a diagnosis of AIDS	90.0% (FY 2007)	92%	93%	TBD
7	Increase the number of American Indian / Alaskan Native individuals surviving 3 tears after a diagnosis of AIDS	75.0% (FY 2007)	79%	80%	TBD
8	Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among African American communities.	38.0% (FY 2007)	35%	34%	TBD
9	Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Latino/Hispanic communities.	42.0% (FY 2007)	39%	38%	TBD
10	Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Asian/Pacific Islander communities.	38.0% (FY 2007)	36%	35%	TBD
11	Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among American Indian/Alaskan Native communities.	39.0% (FY 2007)	37%	36%	TBD
12	Increase the number of individuals who learn their HIV status for the first time through MAI Fund programs.	139,750 (FY 2007)	158,172	167,662	TBD
13	Maintain the actual cost of MAI Fund HIV testing clients below the medical care inflation rate.	$94.64 (FY 2006)	$98.29	$101.71	TBD
14	Maintain the actual cost per MAI Fund physician and other clinical staff trained below the medical care inflation rate.	$795.70 (FY 2006)	$1280.57	$1,670.78	TBD

	Program Level Funding ($ in millions)		$51.891	$51.891	$0.000

* Newly developed target for FY 2010

HIV/AIDS IN MINORITY COMMUNITIES
FUNDING ALLOCATION
(Dollars in thousands)

Agency	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY08	FY09 1/
CDC	$15,641	$15,641	$10,500	$9,850	$8,500	$8,745	$7,875	2,740
SAMHSA	12,000	12,000	11,000	11,345	9,500	$10,235	8,735	9,600
HRSA	6,200	5,600	6,900	8,205	8,637	$8,641	7,190	5,348
NIH	—	—	—	—	—	—_	—_	—
IHS	1,450	1,450	1,500	2,096	1,963	1,913	2,300	3,210
OS	14,700	13,363	18,554	19,661	22,090	21,192	23,723	21,465
OPHS:								
OHAP	*3,200*	*1,863*	*2,914*	*2,956*	*6,335*	*3,932*	*2,523*	3,500
OMH	*7,900*	*7,900*	*8,000*	*7,650*	*7,000*	*6,760*	*8,800*	8,900
OPA	*3,000*	*3,000*	*6,000*	*6,000*	*6,100*	*6,500*	*7,100*	8,070
OWH	*600*	*600*	*1,640*	*3,055*	*2,655*	*4,000*	*4,000*	6,125
RHA	—	—	—	—	—	—_	*1,300*	1,780
Eval Set-aside	—	1,021	1,090	1,258	1,165	1,165	1,160	1,160
TBD	—	—	—	—	—	—	—	1,458
TOTAL	**$49,991**	**$49,075**	**$49,544**	**$52,415**	**$51,855**	**$51,891**	**$50,984**	**$51,891**

1/ Allocation to be determined.

HEALTHCARE-ASSOCIATED INFECTIONS

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
BA	---	$5,000,000	$5,000,000	---
FTE	---	---	---	---

Authorizing Legislation……...…
FY 2010 Authorization……...Indefinite
Allocation Method……..Direct federal

Program Description and Accomplishments

Healthcare-associated infections (HAI) are infections that patients acquire while receiving treatment for medical or surgical conditions. HAI are among the top ten leading causes of death in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths in 2002. The financial burden attributable to these infections is staggering. HAI resulted in an estimated $28 billion to $33 billion in excess healthcare costs each year.

Successful infection prevention and elimination efforts have been underway for years across the various HHS agencies. However, in 2008, HHS began a Department-wide effort to address the issue by establishing the senior-level Steering Committee for the Prevention of Healthcare-Associated Infections in order to improve and expand prevention efforts.

The Steering Committee is chaired by the Principal Deputy Assistant Secretary for Health within the Office of Public Health and Science (OPHS) and is primarily charged with developing and implementing the HHS Action Plan to Prevent Healthcare-Associated Infections. The initial version of the Action Plan focused on infections occurring in hospitals and was released in January 2009. The overall plan established national goals and outlined key actions for enhancing and coordinating HHS-supported activities and outlined opportunities for collaboration with external partners.

OPHS will continue to provide leadership and oversight of the overall Departmental HAI prevention effort. With the $5 million in funding provided to the HHS Office of the Secretary in the Fiscal year 2009 Omnibus Bill, OPHS plans to expand the valuable work of the Steering Committee. The Steering Committee will have the continued responsibility for coordinating implementation of the Action Plan, monitoring progress in achieving the national goals outlined in the plan, and leading the next tier's efforts. In addition, the Steering Committee is coordinating the use of HAI-related American Recovery and Reinvestment Act of 2009 funds provided to the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services.

OPHS will lead the development and implementation of a national public awareness campaign to raise awareness of the importance of addressing HAI with a variety of audiences, including healthcare providers, institutions, and consumers. The most important objective for the HAI public awareness campaign is to ensure people who enter the hospital do not acquire an HAI. The campaign will ensure consumers understand how an HAI is acquired. The campaign will also educate healthcare providers on how to communicate some of the risks associated with hospital stays. It will take into consideration the important balance that must be met – educating and empowering the consumer without scaring them away from visiting their healthcare provider or from entering a hospital. By educating consumers before they enter the hospital on the potential risks of HAIs and how they can be prevented, the consumer will be empowered to take a more active role in his or her healthcare.

In FY 2009, OPHS will also support a variety of inter-agency projects linked to the Action Plan, including:

- Implementation of basic science research projects aimed at filling gaps in the existing knowledge base of infection control;
- Coordination with healthcare provider educational institutions in order to incorporate augmented infection control training into curriculums;
- Outreach to external organizations and individual healthcare consumers to garner input on enhancement of the Action Plan; and
- Development and implementation of an information systems project designed to support a standards-based solution for integrating data collection across specific HHS data systems with the intent of using interoperability standards to reduce "siloed" Departmental data systems and reduce data collection and reporting burdens for healthcare facilities.

Funding History

FY 2005	---
FY 2006	---
FY 2007	---
FY 2008	---
FY 2009 Omnibus	$5,000,000

Budget Request

The FY 2010 request is $5,000,000, the same as the FY 2009 Omnibus Appropriations level. FY 2010 funding enables the continued support of the existing projects as described above, specifically staff support for the Steering Committee and the continuation of the public awareness campaign. In FY 2010, the Steering Committee will begin its second tier efforts on the ambulatory surgical care setting. Ambulatory Surgical Centers have been the fastest growing provider type participating in Medicare.

The Steering Committee will also have the responsibility for monitoring the Department's progress in reducing and preventing HAI. Measures for assessing progress and five-year prevention targets have been established in the Action Plan. Information systems needed to supply measurement data have also been identified in the Action Plan. In addition, the Steering Committee is currently investigating the best means of measuring performance and is tentatively planning on establishing a framework for evaluating the effort as implementation of the Action Plan begins.

RENT AND COMMON EXPENSES

	FY 2008 Enacted	FY 2009 Omnibus	FY 2010 Request	FY 2010 +/- FY 2009
Rent:				
GDM	$11,792,000	$10,504,000	$10,470,000	-34,000
OGC	2,108,850	2,151,027	2,194,048	+43,021
OPHS	7,941,870	7,877,611	8,035,163	+157,552
IGA	602,000	675,000	689,000	+14,000
DAB	440,000	312,000	312,000	-
Total	22,884,720	$21,519,638	21,700,211	+180,573
Operations and Maintenance:				
GDM	2,446,000	3,375,000	3,375,000	-
Related Services:				
GDM	2,874,000	3,122,000	3,090,000	-32,000
OGC	345,000	351,900	358,938	+7,038
Total	3,219,000	3,473,900	3,448,938	-24,962
Subtotal, GDM only	*$17,112,000*	*$17,001,000*	*$16,935,000*	*-66,000*
Common Expenses:				
GDM	2,450,000	2,692,000	2,560,000	-132,000
OGC	2,156,790	2,199,926	2,243,924	+43,998
OPHS	1,700,388	1,915,490	1,941,105	+25,615
Total	6,307,178	6,807,416	6,745,029	-62,387
Service and Supply Fund:				
GDM	8,851,000	9,878,000	11,960,000	+2,082,000
OGC	971,040	990,461	1,010,270	+19,809
OPHS	8,771,678	9,695,031	9,985,881	+290,850
Total	18,593,718	20,563,492	22,956,151	+2,392,659
Subtotal, GDM only	*$11,301,000*	*$12,570,000*	*$14,520,000*	*+1,950,000*
Totals:				
GDM	28,413,000	29,571,000	31,455,000	+1,884,000
OGC	5,581,680	5,693,314	5,807,180	+113,866
OPHS	18,413,936	19,488,132	19,962,149	+474,017
IGA	602,000	675,000	689,000	+14,000
DAB	440,000	312,000	312,000	-
Total	$53,450,616	$55,739,446	$58,225,329	+2,485,883

Program Description and Accomplishments

Rent/Operations and Maintenance and Related Services.

The Office for Facilities Management and Policy (OFMP), in the Office of the Assistant Secretary for Administration and Management, administers both Rent/Operations and Maintenance (O&M) and Related Services funds for all headquarters facilities occupied by the Office of the Secretary. OFMP provides stewardship and fiscal responsibility in managing the Department's real property assets, monitors the amount and type of space occupied by each STAFFDIV, and coordinates efforts to achieve the most efficient use of space, while maintaining a quality work environment.

Descriptions of each area follow:

- *Rental payments (Rent)* to the General Services Administration (GSA) include funds to cover the rental costs of office space, non-office space, and parking facilities in GSA-controlled buildings.

- *O&M* (formerly known as Delegated Authority) includes funds to cover the operation, maintenance and repair of buildings for which management authority has been delegated to HHS by GSA; this includes the HHS headquarters, the Hubert H. Humphrey Building (HHH). Note: All Rent amounts are shown in object class 23.1, Rental Payments to GSA; however, O&M amounts are spread across other object classes.

- *Related Services* include funds to cover non-Rent activities in GSA-controlled buildings (e.g., housekeeping, guard services, other security, and building repairs and renovations).

    - Provides mission-enabling facilities and a safe, secure and healthy work environment for the Southwest Complex and the Humphrey Building.
    - Implements and maintains HSPD-12 Badging Program for SW Complex.

- *Building Management* – OFMP is committed to a high level of performance in the management of the HHH Building.

    - Implements and maintains traffic and security improvements to control access to the Humphrey building.
    - Modernizes lighting, resulting in improvements in energy efficiency and costs.
    - Completes other Humphrey Building improvement projects.

In FY 2001-FY 2008, all performance targets in this area were achieved. OFMP's current practices and procedures adhere to GSA guidelines that building services complaints are responded to within 72 hours of receipt. To verify performance, an independent analysis of computer-generated data from the contractor's service call system is regularly performed. In order to ensure accuracy, individual work orders (issued as a result of estimates for service) are manually pulled on a random and periodic basis, and performance verified. These reviews have consistently supported the automated reports.

Common Expenses/ Service and Supply Fund (SSF) Payment

Common Expenses include funds to cover administrative items and activities which cut across and impact all STAFFDIVs under the GDM appropriation. The major costs in this area include:

- Worker's Compensation
- Federal Employment Information and Services
- Records storage at the National Archives and Records Administration
- Radio Spectrum Management Services
- Federal Executive Board in Region VI
- Telecommunications (e.g., FTS and commercial telephone expenses)
- CFO and A-123 audits
- Federal Laboratory Consortium
- Postage and Printing
- Unemployment Compensation

Payments to the SSF are included in the overall Common Expenses category, but are broken out separately here for display purposes. These payments cover the usage of goods and services provided through the SSF:

- Personnel and Payroll Services
- Finance and Accounting activities
- Reprographics
- Electronic communication services (e.g., voice-mail and data networking)
- Unified Financial Management System (UFMS) Operations and Maintenance

NOTE: In FY 2009, funding to pay for computer service charges were moved from the Common Expenses account to the individual STAFFDIV budgets, to ensure accountability in ordering services and in paying these bills.

Funding History

FY 2005	$27,278,000
FY 2006	$27,912,000
FY 2007	$31,989,000
FY 2008	$28,413,000
FY 2009	$29,571,000

Budget Request

The FY 2010 request for the consolidated GDM Rent and Common Expenses account is $31,455,000, an increase of $1,884,000 over the FY 2009 Omnibus level. These funds are necessary to cover centralized payments for Rent/O&M, Related Services, Common Expenses, and the Service and Supply Fund. These payments are made from centrally-managed accounts on behalf of all GDM accounts except the Office of Public Health and Science (OPHS), the Office of the General Counsel (OGC), the Office of Intergovernmental Affairs (IGA – ten Regional

Directors offices only), and the Departmental Appeals Board (DAB); the costs for these accounts are included in their individual sections of the budget. The SSF payment, which now includes UFMS, accounts for nearly the entire increase.

The majority of the increase in the SSF payment ($2,000,000) is for necessary improvements to the Office of the Secretary (OS) websites. These websites are managed by the Assistant Secretary for Public Affairs' Web Communications Division, which is funded through the SSF. These funds will be used to support significant new activities – including the transparency of Recovery Act reporting, the President's Health Reform plan, the Children's Health Insurance Program, and the Prevention and Health Information Technology initiatives – and to enhance the accessibility of OS content, including Spanish language presentation and Section 508 compliance. In addition, funds will be used to implement new Web 2.0 social media applications, to interactively deliver content and involve the public in a more open government process via the Web.

PHS EVALUATION SET-ASIDE

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
Reimb. Authority	44,600,000	46,756,000	59,756,000	+13,000,000
ASPE	41,243,000	41,243,000	41,243,000	0
Health Reform	--	1,000,000	12,500,000	+11,500,000
OPHS	4,510,000	4,010,000	4,510,000	+500,000
ASRT	1,153,000	503,000	1,503,000	+1,000,000
FTE	126	131	142	+11

FY 2010 Authorization……...Indefinite
Allocation Method……...Direct federal; Grants; Contracts

Program Description and Accomplishments

HHS' Public Health Service (PHS) Evaluation Set-Aside program is authorized by section 241 of the US Public Health Service Act. Through the systematic collection of information on program performance, this program has a significant impact on the improvement of activities and services provided by HHS. Projects support by PHS Evaluation funds traditionally serve decision-makers in both the public and private sectors of public health research, education and practice communities, by providing valuable information regarding how well HHS programs and services are working.

The FY 2010 request for the PHS Evaluation Set-Aside in GDM includes funding for programs in three offices: The Assistant Secretary for Planning and Evaluation (ASPE), the Office of Public Health and Science (OPHS), and the Assistant Secretary for Resources and Technology (ASRT). Descriptions of these office's PHS Evaluation programs follows.

Assistant Secretary for Planning and Evaluation

The Assistant Secretary for Planning and Evaluation (ASPE) serves as the principal policy advisor to the Secretary of HHS on issues related to health, disability, aging, human services, and science. ASPE conducts research and evaluation studies; provides critical policy analysis, development, and advice; provides policy planning, coordination, and management; conducts research, evaluation, and data collection; and estimates the costs and benefits of policies and programs under consideration by HHS or the Congress. ASPE has a long history of leading special initiatives on behalf of the Secretary (e.g., health care and welfare reform), and provides direction for HHS-wide strategic, evaluation, legislative and policy planning.

Four policy offices within ASPE (Health Policy, Science and Data Policy, Human Services Policy, and Disability and Long Term Care Policy) perform these functions with a focus on their primary population or issue of interest. ASPE develops and reviews issues with a perspective that is broader in scope than that of any one Operating Division (OPDIV) or Staff Division

(STAFFDIV). When appropriate, ASPE divisions collaborate with HHS OPDIVs and STAFFDIVs, as well as other federal agencies, state and local partners, and non-governmental groups, in performing these functions. Working with these partners enables ASPE to leverage available resources more effectively, achieve efficiencies, and assist the translation of research into practice. ASPE also coordinates and manages data and information policy within HHS, and coordinates crosscutting policy-related activities within, and sometimes outside, HHS.

ASPE's contributions provide objective and reliable information for policy development and program decision-making. ASPE's policy analysis, evaluation and policy development activities in health, long-term care, science, and human services have contributed substantial information to senior policy makers in HHS and throughout the federal government.

ASPE continues to build a strong analytical capacity, including making substantial investments in the creation and analysis of nationally representative data to inform critical policy issues. Policy support services provided include micro simulation modeling, statistical analysis, actuarial support and other technical and analytic services. These services support internal HHS-wide coordination in data policy, including interagency data collection and data standards, and collaborative efforts between HHS, the health industry, and the non-profit and philanthropic sectors.

In addition to the activities of the four policy offices, ASPE also performs the following primary activities:

- Data Collection Coordination – ASPE leads the coordination of data collection and statistical policy across HHS. To promote HHS-wide planning and coordination for data collection investments, ASPE co-chairs the HHS Data Council that is comprised of senior executives and managers from all HHS OPDIVs and STAFFDIVs. The Council promotes HHS-wide communication and planning for data collection from a collective, HHS-wide perspective, assures coordination and cost efficiencies in addressing interagency data needs and issues, stresses efficient and effective approaches to data collection, and serves as a forum to address priority interagency, HHSal and national data needs in a coordinated fashion.

- Research Coordination – ASPE also has the lead role in ensuring that the HHS' investment in health and human services research supports the Secretary's priorities in the most efficient and effective manner. ASPE continues to work to achieve efficient leveraging of the HHS' health and human services research portfolio by identifying areas where efficiencies could be achieved through collaboration, and by identifying better ways to translate the findings of research into practice.

- Research and Evaluation – ASPE's policy research and evaluation program has a significant impact on the improvement of policies, programs and services of the HHS, through the systematic collection of information on program performance; gauging program effectiveness, improving performance measurement, performing environmental scans and assessments, and providing program management.

ASPE Budget Request

The FY 2010 request for ASPE is $53,743,000 (excluding the Children's Health Insurance Program discussed below) an increase of $11,500,000 over the FY 2009 level. This increase will provide funds to support the President's Reforming Health Care initiatives, including policy research, analysis, micro simulation modeling, actuarial, public health, and economic analyses, and to fund an additional ten FTE on-board in FY 2009. The FY 2010 funding level will also allow ASPE to continue a variety of independent policy research and evaluation activities across the spectrum of the HHS's programs, with particular attention to crosscutting initiatives.

ASPE's Research and Evaluation program, funded under section 241 of the U.S. Public Health Service Act, has a significant impact on the improvement of HHS policies, programs and services. Set-aside funds are used to conduct research and evaluation studies; collect data; and estimate the costs, benefits and impacts of policies and programs under consideration by HHS or the Congress. ASPE's work directly supports the HHS's mission and achievement of the Strategic Goals. In FY 2010 ASPE will conduct the following activities in support of HHS's four Strategic Goals.

Goal 1: Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care. Priority projects for FY 2010 under this goal include health care reform initiatives, promoting health information technology; modernizing Medicaid; and strengthening and improving Medicare.

- Health Reform**.** Provide policy research, economic, actuarial and technical analyses in support of the President's health reform and health policy initiatives.
- Improve health care quality. Continue to research, develop, and analyze policy options to improve the quality of health care for all Americans. Conduct an assessment of the methodology used to develop estimates of the number of medical errors and preventable deaths that occur each year.
- Quality Measurement. Work with internal partners to foster the use of Medicare data to support efforts of local quality measurement.
- Health information technology. Continue policy analysis and evaluation efforts for improving the effectiveness and efficiency of the health system through the accelerated adoption of health information technology. Continue ASPE's leadership role in evaluating activities to support the President's priority to accelerate the development and use of information technology in health care, long-term care, and public health. Areas of focus include developing a framework and pathway for Medicare EHR incentives, safety net providers, physician adoption, personal health records demonstrations and evaluations, Health IT for public health and improving the tools for communicating patient information during transitions from hospitals to nursing homes and post-acute care settings.
- Health care marketplace competition. Investigate the impacts of health care marketplace competition, and research the effects of health care spending on the economy.
- Long-term care needs and services. Continue research efforts to study, analyze, and evaluate consumer-driven options for organizing, delivering, and financing home- and community-based support for people who use long-term care services. Develop and analyze policy options and identify barriers, with the goal of expanding long-term care planning

opportunities for individuals.

- Strengthen health professions workforce. Support new and ongoing research activities to address the recruitment and retention of a qualified, stable frontline workforce to provide long-term supports in institutional and community settings, including strengthening the basic data infrastructure and partnering with the HHS of Labor to promote career ladders for paraprofessional workers in long-term care settings.
- HIV/AIDS prevention and treatment. Continue to work on issues related to the implementation of the Ryan White HIV/AIDS Modernization Act of 2006, and work with HRSA and ASL to respond to inquiries from Congress about progress implementing new provisions of the Act.
- Independent living supports. Support survey research and analysis on home modifications that enable older individuals with disabilities to live in their homes more safely for longer periods of time.
- Advance directives and hospice services. Continue to support research on advance directives and hospice services, to provide policymakers with sound information on death-and dying-related issues, and to promote awareness and planning by consumers.
- Disability in the aging population. Develop and analyze policy options and data sources for measuring and describing the aging of the population and the incidence and prevalence of disability in the aging population.

Goal 2: Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats. Priority projects for FY 2010 under this goal include improving food and medical product safety, promoting emergency preparedness, response and recovery planning efforts; preventing chronic disease and promoting healthy behaviors; and reducing health disparities.

- Food and Medical Product Safety. Conduct research and analyses to strengthen FDA's food safety capacity, and post market drug and medical product surveillance.
- Chronic Disease Prevention and Health Promotion. Conduct cost-benefit analyses of a variety of evidence-based clinical and community-based preventive services. Conduct evaluation and policy development efforts in chronic disease prevention and health promotion, with a focus on increasing physical activity, preventing obesity, preventing costly falls among the elderly, and addressing the long-term care needs of chronically ill individuals with impairments.
- Retail clinic industry. Conduct an assessment of the policy implications of continued expansion of the retail clinic industry. This includes an assessment of applicability of this service delivery site for the Medicare population.
- HIV/AIDS prevention and treatment. Examine HIV disease management programs that serve Medicaid enrollees and other low-income populations.
- Performance measurement. Conduct research to develop measures and metrics for assessing the performance of the health system at national, state and local levels.
- Public Health and Emergency preparedness. Work closely with other agencies on the implementation of the Emergency Preparedness Plan and Pandemic Flu Plan, with special attention to evaluation, data and policy analysis.
- Conduct policy research, evaluation and data development for assuring and assessing prevention, preparedness, and response capabilities for planning, preparing, and responding

to a variety of public health threats, such as bioterrorism, natural disasters, and a potential disease pandemic. Conduct research to understand how states and localities plan for the needs of vulnerable populations in their emergency preparedness plans.
- Mental health and substance abuse programs. Conduct evaluation efforts targeted at the effectiveness of mental health and substance abuse programs.
- Assessing and addressing disparities in health. Continue to research, develop and analyze policy options to identify, assess and reduce racial and ethnic health disparities.

Goal 3: Promote the economic and social well-being of individuals, families and communities. Priority projects for FY 2010 under this goal include promoting economic independence and social well-being of individuals and families; protecting the safety and fostering the well-being of children and youth; and addressing the needs of other vulnerable populations, including human trafficking victims.

- Economic Opportunity and Support. Conduct research, evaluation and analyses on poverty; low-wage workers; welfare; and child support enforcement. Continue research on policies to help low-income Americans succeed in the workforce, ensure access to other safety net programs such as TANF, enhance the well-being of vulnerable families and their children, foster self-reliance and reward work, support capacities for ownership, and improve strategies for helping the hard-to-employ. Continue support for the Poverty Research Centers to examine causes, consequences, and remedies of poverty.
- Fathers and families. Conduct research on healthy families and responsible fatherhood to promote economic security, family stability, child well-being, and public health. Continue to build the knowledge base about family structure and function, the contributions of fathers, and effective family strengthening services by specific subgroups. Continue to analyze child support enforcement, including ARRA investments, and its contribution to child health and economic wellbeing. Continue to evaluate programs for incarcerated and re-entering fathers and their partners.
- Healthy youth development. Promote healthy youth development through research and data on positive youth development and risk-based adolescent behaviors, support interdepartmental collaborations to assist at-risk youth, and continue to build evaluation capacity to assess effectiveness and improve programs.
- Early childhood development and child well-being. Continue to examine programs and policies that affect child well-being, early childhood development, early childhood education, and coordination across programs. Continue to model eligibility for and use of child care subsidies.
- Child Welfare. Examine ways to improve permanency planning for at-risk children and assess child welfare financing issues.
- Homelessness. Continue to coordinate the HHS' activities related to homelessness, including chairing the HHS' internal Homelessness Work Group and serving as the liaison between the HHS and the U.S. Interagency Council on Homelessness. Continue to support research and evaluation to improve programs and services for homeless persons, with a special focus on the impact of homelessness on children.
- Vulnerable Populations. Continue research and analysis on policies and strategies for vulnerable populations including Native Americans and immigrant and refugee families.
- Faith-Based and Neighborhood Partnerships. Conduct analysis in support of the President's

initiative to maximize effective partnerships, and contribute to overall understanding of the role these organizations play in social services delivery.
- Worksite wellness. Explore the types and comprehensiveness of worksite wellness programs. Examine the effectiveness and cost benefit of these types of programs.

Goal 4: Advance scientific and biomedical research and development related to health and human services. Priority projects for FY 2010 under this goal include conducting research and evaluation efforts and translating them into practice, especially in the areas of food, drug and medical product safety, and personalized health care.

- Innovation. Conduct policy analysis and research relating to the research, development, adoption and technology innovation cycle in health care, including genomics, drugs, biologics and devices in support of prevention and treatment.
- Genomics and health care. Support policy research and analytical efforts to further the concept of personalized health care by building upon existing efforts, providing leadership and program and policy coordination across HHS, and carrying out a program of policy research, analysis and evaluation.
- Food, drug, and medical product safety. Conduct evaluation and analytical efforts and support policy research and analytical efforts in issues related to national vaccine policy; food, drug, and medical product safety; national prescription drug policy including pharmaceutical economic, drug cost, and utilization studies; international drug studies; and pharmaceutical research and development issues.
- Risk assessment and management. Conduct evaluation and analytical efforts in risk assessment, risk management, risk communication, regulatory science, and the impact of biomedical investment and related issues in science and technology policy.

ASPE Grant Awards Table

Description	FY 2008	FY 2009	FY 2010
Number of Awards	5	5	5
Average Award	$555,000	$550,00	$565,000
Range of Awards	$350,000 - $800,000	$350,000 - $789,000	$350,000 - $850,000

ASPE maintains a grants program to support academically based research centers. ASPE has a long history of supporting research and evaluation of important and emerging social policy issues associated with income dynamics, poverty, individual and family functioning, marriage and family structure, transitions from welfare to work, child well-being, and special populations. Federal support for the poverty center program has been continuous since 1968. Federal support for a marriage research center was instituted by ASPE in FY2007.

ASPE's academic research center grants provide funding for five research institutes with funding levels ranging from $350,000 per year to $850,000 per year - The national poverty center conducts a broad program of policy research to describe and analyze national, regional and state environment (e.g., economics, demographics) and policies affecting the poor, particularly those families with children who are poor or at-risk of being poor. In addition, support 3 smaller research centers that maintain a more focused agenda on expanding our understanding of the

causes, consequences and effects of poverty in local geographic areas, especially in states or regional areas of high concentrations of poverty. The national marriage research center works to improve our understanding of how family structure and function affect the health and well-being of children, adults, families and communities. All these centers develop and mentor social science researchers whose work focuses on these issues.

Health Reform Activities

HHS' Supporting Role for Policy Development and Advancement: As the lead health agency, HHS will play a central role in designing and implementing health reform. Once health reform legislation is enacted, HHS will take a lead role in developing specific policies to implement it. Most past pieces of health legislation deferred a number of issues for policy or rulemaking (e.g., what is a prescription drug benefit region; how should bidding for the drug plans be structured; what crowd-out and premium assistance guidance should be used in CHIP). Thus, HHS is planning for a major and intense policy development role for rulemaking, program guidance, and administrative actions to implement health reform legislation.

The Staff Divisions within the Office of the Secretary that will play a lead role in HHS reform activities are the Assistant Secretary for Planning and Evaluation; Office of Public Health and Science including the Office of Minority Health and Office on Women's Health; and the Office on Disability.

The below cost categories provide a description of key activities and budget justification for the FY 2010 Budget. Costs may shift among categories depending upon the timing of legislation and the needs of the Secretary, Executive Office of the President, and the Congress.

- Modeling to estimate costs and savings of health reform: The Office will contract with organizations to support micro-simulation models to estimate the effects of different components and sets of policies being considered in developing health reform plans. Contract costs include data acquisition and modeling services. ($1.5 million)

  In FY 2010, the Office will also build an internal modeling capacity that is integrated with the Office of the Actuary in CMS to facilitate the provision of estimates on health policy changes. This effort will entail hiring economists and programming staff; preparing papers on the options for assumptions, data, and potential output from the model; and hosting meetings and an advisory group to oversee its development. Staffing costs include three senior economists, two senior programmers, three mid-level staff, and two consultants. ($2 million)

- Studies to aid in development and implementation of reform: HHS's current role in producing studies will be rapidly expanded to meet multiple, concurrent requests for analyses from the Secretary, and the Executive Office of the President. Resources will mostly be contracts with some staff support.

- Internal policy development and technical assistance projects: HHS will also continue to serve as a source of information and data to other parts of the Federal government. HHS data sets will be used to inform the debate as well as track changes once policies are

implemented. Reviews, data analysis, and options papers will be developed to support all aspects of health reform. Supplemental surveys and other extensions of existing datasets will be funded to answer relevant policy questions, as will links to external datasets where relevant.

- Engaging the public and supporting the White House: The President is committed to making health reform inclusive. This involves outreach to the public in the form of community discussions, web-based listening sessions, surveys, events, and other means of soliciting input and guidance. HHS will continue to support these forums and other events to meet the President's commitment to an open and inclusive process. HHS will also continue to support the White House Office of Health Reform, as appropriate.

- Implementing Health Reform: HHS expects to have an important role in implementing policies immediately and subsequent to the passage of comprehensive health reform legislation. This could involve developing and implementing policies and/or regulation for the Secretary and Administration. Policy development will primarily be supported Federal staff.

Office of Public Health and Science

The Office of Public Health and Science (OPHS) exhibits an essential role in the Public Health Evaluation Set-Aside program at HHS. Within OPHS, the Immediate Office of the Assistant Secretary for Health (ASH) coordinates the Evaluation Set-Aside program for the ASH. Each fiscal year, OPHS program offices submit proposals in an effort to improve and evaluate programs and services of the U.S. Public Health Service, and identify ways to improve their effectiveness. Studies supported by these Set-Aside funds serve decision makers in federal, state, and local government, and the private sector of the public health research, education, and practice communities by providing valuable information about how well programs and services are working. Projects that were approved for 2009 evaluation funds are listed below by HHS Strategic Goal:

Effectiveness of Programs and Strategies

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.

- Evaluate the National Blood Collection and Utilization Survey (NBCUS), a unique bi-annual industry-wide survey of 3,000 blood collection facilities and blood centers. Data collection of more than 325 data elements for blood, plasma, tissue, and cellular products are analyzed to determine the current trends in blood safety and availability, cellular therapies, and tissue transplantation. The NBCUS data and analysis survey report draws evaluative data for policy and program effectiveness. The report is also essential to the Advisory Committee on Blood Safety and Availability in assessing past and future recommendations.

- Evaluate of the Dietary Guidelines Supplement of 2009 designed to inform the American

public about the 2005 Dietary Guidelines of Americans. The baseline survey was conducted in December 2004 to collect important data on public awareness, familiarity, understanding, and application of the guidelines' principles before and after the release of the new dietary guidelines in January 2005. A follow-up survey was conducted approximately one year following the fielding of the baseline survey in December 2005 and again in December 2007. This information will be used to assess the impact of current HHS-wide nutrition communication/education efforts and aid in planning future activities.

- Evaluate HIV Prevention Programs for Young Women Attending Minority Institutions. In 2003, the OWH through the Minority AIDS Initiative initiated HIV Prevention for Young Women Attending Minority Institutions program. OWH believes these programs are an innovative approach to HIV prevention for young women and will help to reduce the risk and spread of HIV among women in the U.S. This evaluation should provide OWH with an understanding of effective gender-specific interventions, both process and outcome. This is the final year of this project.

Strategic Goal 3: Human Services – Promote the economic and social well-being of individuals, families and communities.

- Evaluate the Title XX Adolescent Family Life Program. The purpose of this project is to conduct a cross-site evaluation of the AFL demonstration program to both describe its implementation and to evaluate its impact on desired outcomes, completing a long-term effort, on the part of OPA, to plan and conduct such an evaluation. This project presents a unique opportunity to evaluate the effectiveness of a multi-site funding program to prevent adolescent premarital sexual activity and to improve the outcomes for pregnant and parenting adolescents and their children. This is the fourth and final stage of this project.

Environmental Assessments

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.

- Complete a community assessment of Rosebud Sioux Tribe Suicide Prevention Initiatives. Evaluate prevention strategies and tribal policies on reservation communities, such as Rosebud Sioux, which has epidemic levels of suicide. This project will assess the extent to which recent suicide prevention initiatives have influenced community awareness and perceptions of suicide risk, and access to services, in local communities. This formative evaluation will be the first community-based approach aimed at providing tribal officials with feedback on measurable progress toward the reduction of suicide.

Improving Program Management

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.

- Evaluate the Integration of Preparedness Indicators throughout Healthy People 2020. This project will evaluate proposed public health preparedness indicators for Healthy People 2020. The Mid-Atlantic Public Health Preparedness Coalition will serve as a technical consultant on choosing an appropriate set of preparedness indicators. This project will evaluate the utility at state and local levels for program development and strategic planning for statewide preparedness and response. It will also evaluate the utility of these indicators for assessing state and local preparedness.

- Create the Spanish edition of the Quick Guide to Healthy Living. The Office of Disease Prevention and Health Promotion (ODPHP) seeks to conduct formative research, and develop and evaluate a comparable version of healthfinder.gov's Quick Guide to Healthy Living, including a mobile phone application for Spanish speakers with limited health literacy. ODPHP is congressionally mandated to connect the public and professionals to important health information. Over 30 million U.S. residents speak Spanish in the home. This would expand the reach to Spanish-speaking communities on these important OPDHP initiatives.

- Implement the Building a Healthier Heartland (BHH) program. BHH will evaluate, further develop and enhance a multi-stakeholder community collaboration that can amplify a consistent health message across four key community channels (Business, Schools, Organizations, Government) and model it around chronic disease risk factors (poor nutrition, physical inactivity, tobacco use). Programs would focus on such actions/issues as: Coalition Building, Measurement, Education, Messaging, Policy Change, and Social Networking. BHH strives to develop a coalition of local and national stakeholders working to strengthen partners' efforts to promote the health of Kansas City Metropolitan Area residents and employees. The goals of BHH are to improve nutrition, increase physical activity, and reduce exposure to tobacco and secondhand smoke.

Supporting an Evaluation Infrastructur**e**

Strategic Goal 4: Scientific Research and Development - Advance scientific and biomedical research and development related to health and human services.

- Develop, implement, and evaluate a Web-Based Performance Information Management System (PIMS). This project, led by OMH, will implement Phase II, and is intended to primarily support implementation, further integration, and evaluation of the effectiveness of system components, including use of performance and evaluation tools and resources by broader audiences in the longer term. The purpose of PIMS is to improve the Office's ability to demonstrate meaningful results in return for the public's investment in OMH-funded programs. The result of this initiative will enable OMH and its partners within OPHS, HHS, and across the Nation to more effectively and efficiently produce and demonstrate more meaningful progress towards the health of racial/ethnic minorities and reduction of racial/ethnic health disparities.

- Improve medication assisted substance abuse treatment in the U.S. Caribbean jurisdictions.

Puerto Rico and the Virgin Islands requested assistance from SAMHSA for technical assistance to improve their drug treatment programs. SAMHSA has gathered partners from a variety of federal programs that may be able to serve as an advisory group to seek broader assistance. There is significant substance abuse treatment health gap within the territories, which this project seeks to provide strategies to ameliorate. The goals of the project are to develop a long term strategy for capacity and infrastructure development with specific actionable goals, map deliverables for SAMHSA and other Federal partners, and to establish reasonable performance metrics for system improvement.

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.

- Develop health indicators for the nation. Evaluate the current and past Healthy People objectives and implementation activities that will help ensure that the next generation of objectives, Healthy People 2020, represents national health priorities, reflects extensive stakeholder input, and is relevant to a wide variety of users. The project will reach beyond the traditional public health sector to engage stakeholders from other areas not directly connected with health. This input will be gathered, evaluated, and synthesized.

Assistant Secretary for Resources and Technology

The PHS FY 2010 evaluation request for the Office of the Assistant Secretary for Resources and Technology (ASRT) is $1,503,000, which is $1,000,000 over the FY 2009 level. This funding request will return the funding level to that of FY08. The FY 2010 request will be used to fund increasing program evaluation activities within the ASRT Office of Budget. These funds will cover additional staff focused on program evaluation activities (such as PART) in the PHS agencies in the preparation of the Performance and Accountability Report. Funds will also go towards the continued development and operation of an electronic performance tracking system for HHS programs, similar to systems used by a number of other Federal agencies.

Overall PHS Eval Set-Aside Budget Request

The total FY 2010 request for the GDM PHS Evaluation program is $59,756,000, an increase of $13,000,000. Beginning in FY 2008, these PHS Evaluation amounts reflect the transfer of funding for ASPE from the GDM direct appropriation; all funding for ASPE operations is now centralized in PHS Evaluation funds.

The FY 2010 request for ASPE is $41,243,000, the same as the FY 2009 enacted level. This funding level will allow ASPE to continue a variety of independent policy research and evaluation activities across the spectrum of the Department's programs, with particular attention to specific crosscutting initiatives, the breadth and depth of which are described in this submission.

The FY 2010 request for Health Reform activities is $12,500,000, an increase of $11,500,000. This level will allow HHS to play a central role in designing and implementing health reform as described above. The funds will primarily support the Office of the Assistant Secretary for Planning and Evaluation. Funds may also be used to support activities required of the Office of Public Health and Science, including the Office of Minority Health and Office on Women's Health; and the Office on Disability.

The FY 2010 request for OPHS is $4,510,000, an increase of $500,000. This level will allow OPHS to continue conducting evaluation projects.

The FY 2010 request for ASRT is $1,503,000, an increase of $1,000,000. This level will allow ASRT to fund increasing program evaluation activities within the ASRT Office of Budget. These funds will cover additional staff focused on program evaluation activities (such as PART) in the PHS agencies in the preparation of the Performance and Accountability Report. Funds will also go towards the continued development and operation of an electronic performance tracking system for HHS programs, similar to systems used by a number of other Federal agencies.

OTHER FUNDING SOURCES

	FY 2008 Appropriations	FY 2009 Appropriations	FY 2009 Recovery Act	FY 2010 President's Budget	FY 2010 +/- FY 2009
FMAP BA	0	0	$5,000,000	N/A	N/A
CHIPRA BA	0	$15,000,000	0	N/A	N/A
FTE		4	4		

Authorizing Legislation .....Unauthorized

Program Description and Accomplishments

Federal Medical Assistance Percentage Implementation Funding (FMAP)
The Recovery Act provides $5 million to the Secretary to implement the temporary increase in the Federal Medical Assistance Percentage (FMAP) provided by the Recovery Act. These funds will be used by CMS and ACF to fund administrative activities related to the implementation of this provision. Some portion of these funds may also be utilized by the Office of the Secretary to implement these provisions.

Evaluation of Express Lane Eligibility Option under CHIP
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 created a new option for States to rely on a finding made by an Express Lane agency when determining eligibility for medical assistance, through September 30, 2013. Each State must annually provide an eligibility error rate on children enrolled in Medicaid or CHIP using these findings. If a State's error rate exceeds three percent, corrective actions will be undertaken and continued noncompliance may lead to a reduction in payments. The Secretary must conduct an evaluation of the effectiveness of this option and report to Congress by the end of FY 2012. The Assistant Secretary for Planning and Evaluation will be conducting this evaluation. CHIPRA appropriated $5 million for this evaluation for fiscal years 2009 through 2012.

Updated Federal Evaluation of CHIP
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 requires the Secretary to conduct a new evaluation of ten States with approved child health plans under the Children's Health Insurance Program (CHIP). A similar evaluation was conducted in 2000. This updated evaluation will be conducted by the Assistant Secretary for Planning and Evaluation and must be submitted to Congress by December 31, 2011. CHIPRA appropriated $10 million for FY 2010 for this evaluation, to remain available until FY 2012.

Funding History

FY 2009	$10,000,000
FY 2010	$10,000,000

Budget Request

There is no FY2010 funding request for this activity.

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT
(Excluding Service and Supply Fund)

	FY 2008 Enacted	FY 2009 Omnibus	FY 2010 Request
Immediate Office of the Secretary	67	73	73
Public Affairs	27	32	38
Legislation	26	27	30
Planning and Evaluation	120	128	137
Resources and Technology	149	166	193
Administration and Management	114	125	134
Intergovernmental Affairs	33	36	39
General Counsel	389	397	414
Departmental Appeals Board	65	70	74
Office on Disability	4	5	6
Secretarial Initiatives and Flexibility	0	0	27
Global Health Affairs	30	32	32
Public Health and Science	301	411	418
President's Council on Bioethics	10	10	0
Center for Faith-Based Initiatives	6	7	7
CHIPRA and FMAP	0	8	8
Total, GDM	1,341	1,527	1,630

Average GS Grade

2006	GS-12/2
2007	GS-12/2
2008	GS-12/4
2009	GS-12/4
2010	GS-12/4

DETAIL OF POSITIONS

	FY 2008 Enacted	FY 2009 Enacted	FY 2010 Estimate
Executive Level I	1	1	1
Executive Level II	1	1	1
Executive Level III	–	–	–
Executive Level IV	9	9	9
Executive Level V	–	–	–
Subtotal	11	11	11
Total – Executive Level Salaries	$1,704,500	$1,752,500	$1,788,000
SES Subtotal	94	99	99
Total – ES Salaries	$13,473,000	$14,562,000	$14,854,000
GS-15	186	194	210
GS-14	264	280	302
GS-13	325	335	362
GS-12	267	276	298
GS-11	112	118	128
GS-10	7	8	8
GS-09	96	107	116
GS-08	43	43	46
GS-07	36	40	43
GS-06	10	9	10
GS-05	4	4	4
GS-04	2	2	2
GS-03	–	–	–
GS-02	–	–	–
GS-01	–	–	–
Subtotal	1,353	1,415	1,528

	FY 2008 Enacted	FY 2009 Enacted	FY 2010 Estimate
Commissioned Corps	85	129	133
Ungraded	86	87	87
Total positions	1,628	1,741	1,859
Total FTE usage, end of year	1,341	1,527	1,630
Average ES salary	$143,334	$147,094	$150,036
Average GS grade	GS-12/4	GS-12/4	GS-12/4
Average GS salary	$76,742	$80,409	$82,018
Average Special Pay (Commissioned Corps)	$75,136	$78,066	$80,330

SIGNIFICANT ITEMS IN APPROPRIATIONS COMMITTEE REPORTS

FY 2009 L/HHS Appropriations Committee (ARRA and H.R. 1105)

Item

Healthcare -Associated Infections National Action Plan - According to the Centers for Disease Control and Prevention (CDC), healthcare-associated infections (HAIs) are one of the top ten leading causes of death in the United States, accounting for an estimated 99,000 associated deaths and $20 billion in excess healthcare costs annually. HAIs are largely preventable. HHS is commended for its work in developing a national action plan with five year targets for reducing HAIs. The Department is directed to continue the HHS Steering Committee for the Prevention of HAIs, and associated workgroups that it has established to coordinate prevention and implementation, research, information systems and technology, compliance and oversight, and public and provider outreach activities across the operating divisions of the Department.

Action Taken or to be Taken

The Office of Public Health and Science (OPHS) within the Office of the Secretary (OS) of the Department of Health and Human Services (HHS) is continuing the work of the Steering Committee for the Prevention of Healthcare-Associated Infections and its working groups.

Consistent with its leadership role in developing the action plan ("HHS Action Plan to Prevent Healthcare-Associated Infections"), OPHS will provide the necessary leadership, coordination, and infrastructure for supporting the Steering Committee's activities. The Steering Committee will have the continued responsibility for coordinating implementation of the Action Plan across the Department and monitoring and tracking progress in achieving the national goals outlined in the plan, as well as for commencing its next tier efforts.

In addition, the Steering Committee is coordinating the use of HAI-related American Recovery and Reinvestment Act of 2009 funds provided to the Office of the National Coordinator for Health Information Technology (OS/ONC), Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), and Centers for Medicare and Medicaid Services (CMS).

Item

Healthcare -Associated Infections National Education Campaign - Increases include $5,000,000 within OS, $7,500,000 within CDC and $9,304,000 within the Agency for Healthcare Research and Quality (AHRQ). The Office of the Secretary shall use the additional $5,000,000 to develop and implement a national campaign to empower consumers to be active participants in preventing HAIs; perform a comprehensive inventory of HAI data and databases; enhance prevention, surveillance, and research activities;

improve integration of data across HHS systems; expand measures in CMS' Hospital Compare and improve regulatory oversight of hospitals and the hospital accreditation program; provide management support to t he HHS Steering Committee for the Prevention of HAIs; and conduct other priorities related to reducing HAIs. A description of how the funds provided to CDC and AHRQ shall be used is included in the explanatory statement under those operating divisions.

Action Taken or to be Taken

With the $5 million in funding provided to the HHS/OS in the Fiscal Year 2009 Omnibus Bill, OPHS will support a variety of inter-agency projects linked to the HHS Action Plan to Prevent Healthcare-Associated Infections, including:

- Infrastructure and management support for the senior-level HHS Steering Committee for the Prevention of Healthcare-Associated Infections and its working groups;
- Development and implementation of a national public awareness campaign to raise awareness of the importance of addressing HAI with a variety of audiences, including healthcare providers, institutions, and consumers; The portion of the campaign aimed at healthcare consumers will seek to empower consumers to be active participants in their own healthcare, specifically in preventing HAIs;
- Implementation of basic science research projects aimed at filling gaps in the existing knowledge base of infection control;
- Coordination with healthcare provider educational institutions in order to incorporate augmented infection control training into curriculums;
- Outreach to external organizations and individual healthcare consumers to garner input on enhancing the Action Plan; and
- Development and implementation of an information systems project designed to support a standards-based solution for integrating data collection across specific HHS data systems with the intent of using interoperability standards to reduce "siloed" Departmental data systems and reduce data collection and reporting burdens for healthcare facilities.

Additional projects, as described in the Action Plan, are in discussion.

Item

HIV/AIDS Strategy - HHS is encouraged to develop and implement a single national AIDS strategy to promote coordination among Federal agencies and State and local governments, set clear goals and benchmarks, and provide a basis for ensuring accountability.

Action Taken or to be Taken

The FY 2009 Omnibus Appropriations Bill provides an allotment for the development of the National Strategic Plan. At this time no decisions have been made regarding the specific use of these funds. Pending further instructions from the White House Office of national AIDS Policy, OHAP will begin a series of discussions with principals from across HHS with HIV/AIDS portfolios. These discussions will be used to assess the compliment of data

systems, review of programs and activities which may be pertinent to the Plan.

Item

Minority HIV/AIDS - The Office of the Secretary is expected to support activities that are targeted to address the growing HIV/AIDS epidemic and its disproportionate impact upon communities of color, including African Americans, Latinos, Native Americans, Asian Americans, Native Hawaiians, and Pacific Islanders, at no less that last year's funding level.

Action Taken or to be Taken

OMH supports HIV/AIDS programs, some of which are funded by the Minority HIV/AIDS Initiative (MAI). These programs include:

The Collaborative Technical Assistance and Capacity Development (CTA/CD) grant program which is designed to develop and improve the coordination and continuum of HIV prevention, treatment and support services provided by organizations closely interfaced with targeted minority populations impacted by HIV/AIDS.

Curbing HIV/AIDS Transmission among High Risk Youth and Adolescents by Utilizing Peer-to-Peer Interaction Using New Application Technologies (CHAT), is a partnership with the Office of HIV/AIDS Policy, Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration to support ongoing HIV/AIDS prevention/education and testing initiatives aimed at youth who are currently in alternative education settings, juvenile detention facilities, and alternative living arrangements ordered by the courts.

HIV/AIDS Health Improvement for Re-entering Ex-offenders Initiative (HIRE) is an OMH partnership with the Office of HIV/AIDS Policy, Substance Abuse and Mental Health Services Administration, Centers for Medicare and Medicaid Services, Administration for Children and Families, Health Resources and Services Administration, Indian Health Service, and the Department of Justice that seeks to improve the HIV/AIDS health outcomes of ex-offenders re-entering the mainstream population. OMH, utilizing case management strategies, will target the reentry population with special focus on substance abusers, MSM, and individuals impacted by mental health disorders

FY 2009 House Report No. 110-XXX

Item

Healthcare-Acquired Infections (HAI) - The Committee believes that combating HAIs is an urgent public health issue that demands greater attention. The Committee includes $1,000,000 within the Office of the Secretary to ensue that HHS engages in a stronger, coordinated effort, involving CDC, the Centers for Medicare and Medicaid Services (CMS), and the Agency for Health Research and Quality (AHRQ), to reduce HAIs. The Committee expects the Secretary to use these funds to collaborate with outside experts, as well as

experts within at CMS, CDC, and AHRQ, to conduct a thorough review of HAI activities across the Department and to develop an action plan for reducing HAIs in the U.S. This action plan shall identify data deficiencies, additional activities needed for a strengthened, coordinated public health response, timelines and benchmarks for approved outcomes, new enforcement mechanisms that may be needed and short- and long-term budget estimates for carrying out the action plan. This information will be critical for the Committee to make an informed, appropriate response to this urgent problem. (p. 18/19)

Action Taken or to be Taken

In order to improve and expand HAI prevention efforts, HHS established the Steering Committee for the Prevention of Healthcare-Associated Infections in the summer of 2008. The Steering Committee included senior-level representatives from the Offices and Operating Divisions of HHS, including AHRQ, the Office of the Assistant Secretary for Public Affairs, the Office of the Assistant Secretary for Planning and Evaluation, CDC, CMS, the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and OS/ONC.

The Steering Committee is chaired by the Principal Deputy Assistant Secretary for Health within OPHS. The HHS Deputy Secretary charged the Steering Committee with developing the Action Plan to Prevent Healthcare-Associated Infections. This plan established national goals and key actions for enhancing and coordinating HHS-supported efforts. In addition, the plan outlined opportunities for collaboration with external partners.

A critical step in the Action Plan development process was the identification of priority measures and five-year national prevention targets for assessing progress in HAI prevention. The targets serve to enable HHS to evaluate progress and focus prevention efforts in order to achieve the goals outlined in the Action Plan.

The initial version of the Action Plan focused on infections occurring in hospitals and was released in January 2009. HHS is in the process of synthesizing the comments received from the public and revising the Action Plan. In addition, HHS is planning public engagement meetings for the summer of 2009 to solicit feedback from the public on establishing priorities for HAI prevention. HHS intends to maintain the Action Plan as a "living document" and further revise the document to incorporate new science or knowledge related to infection control.

Item

Health Disparities - The Committee commends OMH for it's efforts to partner with our nation's historically black medical schools, including expanding opportunities for biomedical research and supporting residency training faculty. The Committee also encourages OMH to continue its leadership I defining the opportunities at minority health schools to resolve health disparities. (p. 219)

Action Taken or to be Taken

OMH is committed to improving the health status of minorities and disadvantaged people and increase the diversity of the health-related workforce. Specific efforts include:

Morehouse School of Medicine (MSM) has the only legislatively mandated National Center for Primary Care in the United States. MSM, through its National Center for Primary Care, conducts training programs, quality improvement programs, and real-world practice-based research in partnership with approximately 150 community and migrant health centers in eight Southeastern states. The MSM focuses on enhancing faculty and leadership development through cultivating diverse research investigators; develops a non-traditional pipeline approach involving a network of academic/community partnerships to guide students from underserved communities into careers in the health professions, focusing on the mission of eliminating health disparities; and implements and manages additional projects that will assist in fostering partnerships with the nation's minority-serving health professions schools to support faculty in residency programs, meet the challenges of providing academic opportunity for disadvantaged students, and improve health care services in underserved communities.

Morehouse College, through a consortium of HBCUs (Morehouse College, Bowie State University, Lincoln University, Wilberforce University, and Morgan State University), administers the National Minority Male Health Project (NMMHP) that promotes healthy lifestyles among minority males through a comprehensive program of research, service, and education at the local level. The outcomes of the NMMHP will be used to develop other national efforts to address health disparities among racial and ethnic minority populations. Each institution is required to implement the following core activities: (1) health screenings, (2) on-campus male centered wellness centers, (3) health education programs, and (4) clinical partnerships. In addition, the consortium plans to conduct two sets of research projects, the first will focus on risk factor research and includes two projects to identify modifiable risk factors for unhealthy lifestyles for minority males. The focus of the second project is efficacy/effectiveness research that includes several evaluations of current youth health and risk interventions that are underway in Atlanta, GA and Baltimore, MD. The New Minority Male Health project will include Hispanic Serving Institutions and Tribal Colleges and Universities as members of the consortium because many of the health disparities that plague African-American males also affect Hispanic and American Indian and Alaska Native males.

FY 2009 Senate Report No. 110-410

Item

Family Planning - The Committee remains concerned that programs receiving title X funds ought to have access to these resources as quickly as possible. The committee again instructs the Department to distribute to the regional offices all of the funds available for family planning services no later than 60 days following enactment of this bill. The Committee intends that the regional offices should retain the authority for the review, award and administration of family planning funds, in the same manner and timeframe as in fiscal year 2006. The Committee intends that at least 90 percent of funds appropriated for title X

activities be for clinical services authorized under section 1001 of the act. The Committee further expects the Office of Family Planning to spend any remaining year-end funds in section 1001 activities. (p. 59)

Action Taken or to be Taken

The PHS Regional Offices will receive their funding distribution for Title X family planning services within 60 days following enactment of this bill. At least 90 percent of the funds appropriated for Title X activities will be distributed to service grantees for clinical services authorized under section 1001 of the Act. Additionally, any year-end funds will support section 1001 activities.

Item

Physical Activity Guidelines - The Committee is aware that the Secretary of Health and Human Services is scheduled to release physical activity guidelines for all Americans in the fall of 2008. The Committee urges the Secretary to release these guidelines in a timely manner and promote these guidelines to the general public and in each Federal agency. It is especially important that these guidelines be used when carrying out any Federal health program. In addition, the Committee recognizes the need to keep the guidelines current and up to date and therefore, encourages the Secretary to update the physical activity guidelines **every 5 years** based on the latest scientific and medical knowledge available at the time the report is prepared. (p. 168)

Action Taken or to be Taken

The first edition of the ***Physical Activity Guidelines for Americans*** was released by HHS in October 2008. The Guidelines provide a comprehensive set of science-based physical activity recommendations for all Americans aged six (6) and older, with additional information tailored for specific population groups such as older adults, children, and women during pregnancy and the post-partum period.

The development of the Physical Activity Guidelines was achieved through a Federal Advisory Committee (FACA) process; the Committee members performed literature reviews and scientific analysis of current data to develop their report. The first FACA meeting was held in June 2007 and the report of the Advisory Committee was presented to the Secretary in June 2008. From June 2008 until October 2008 the *Physical Activity Guidelines for Americans* was produced by HHS, using the FACA report as well as input from federal scientists and members of the public.

In an effort to ensure consistency with the *Physical Activity Guidelines for Americans*, HHS-ODPHP is finalizing a formal review process for all HHS consumer publications that include information on physical activity. Once the review process is solidified within the Department, HHS will distribute an invitation for materials review to all relevant Federal agencies.

HHS is using partnership and expanded outreach strategies to promote the new Physical

Activity Guidelines. A partnership strategy was selected to leverage resources and to support the efforts of physical activity information. Expanded outreach will supplement the reach of partners in raising awareness among consumers about the amount of physical activity they need.

ODPHP, in collaboration with the President's Council on Physical Fitness and Sports, offers organizations the opportunity to register as a Physical Activity Guidelines Supporter and receive a toolkit of resources for their use in disseminating information about the Guidelines and encouraging their members and constituents to get the physical activity they need. To date, more than 2,850 organizations have registered as Supporters. Supporters may share ideas and best practices for promoting the Guidelines through the ongoing forum of the Physical Activity Guidelines Supporter Network. ODPHP will make available an online collaborative workspace for peer-to-peer collaboration and interactive tools to encourage physical activity as part of the ODPHP eHealth Research and Development project.

In addition to the toolkit, a consumer booklet, *Be Active Your Way*, designed according to health literacy principle, was introduced at the launch of the *Physical Activity Guidelines for Americans.* The Get Active section of the newly redesigned healthfinder.gov site was updated to be in alignment with the Guidelines, providing users with easy to use an actionable guidance. Outreach plans for 2009 include disseminating e-marketing tools for professionals, requesting and highlighting personal stories from the public, and outreach to Hispanic Audiences. ODPHP will continue to collaborate with the President's Council on Physical Fitness and Sports and the Centers for Disease Control and Prevention to promote the *Physical Activity Guidelines for Americans*.

Item

Minority Health - The Committee is encouraged by the progress the Office of Minority Health is making in fiscal year 2008 on the multi-year effort to address health disparities issues in the rural areas and minority populations of the gulf coast region, and looks forward to further progress in this area in fiscal year 2009. The Committee commends OMH for its efforts to partner with our Nation's historically black medical schools, including expanded opportunities for biomedical research and support for residency training faculty. The Committee also encourages OMH to continue its leadership in defining the opportunities at minority health schools in resolving health disparities. (p. 170)

Action Taken or to be Taken

The Meharry Medical College (MMC) program strengthens the nation's capacity to prepare health professionals from disadvantaged backgrounds to serve minority populations and to develop a national model for improving health care delivery to indigent and underserved citizens. The MMC has:

- Increased the number of residents of other area health professions institutions into the in-patient and ambulatory care services of Nashville General Hospital at the Meharry campus for the purpose of providing those residents experience in working with and increasing available services to minority and disadvantaged populations;

- Continued its collaborative relationship with Vanderbilt University Medical Center (the Meharry-Vanderbilt Alliance) to further expand collaborative research and research training initiatives at MMC (particularly addressing health disparities) through collaborative research projects, increase the number of shared clerkships, and expand primary care experiences for students from both institutions through the joint residency program;
- Implemented an Office of Educational Development and Support designed to support students identified as being at-risk by providing workshops to improve test-taking and time/stress management skills, application and interview skills workshops, primary care exposure and U.S. Medical Licensure Examination review;
- Established a program to track students' progress and ultimate process of the program in improving the number of physicians practicing in minority and medically underserved areas;
- Expanded the MMC Clinical Skills Assessment Center and provided enhanced training in cultural competency so that students will demonstrate improvement in their cultural awareness, attitude, knowledge and skills;
- Expanded health disparity research and research training activities through the development and implementation of a library modernization plan that expands library resources to community-based providers, enhances biomedical informatics services, and increases behavioral and population-based research resources; and
- Provided a report of the initial practice locations of MMC medical and dental graduates for each of the past 10 years and the number of students completing their education during the project period that were assisted by this program.

Item

Office of Women's Health - The Committee is aware of the problem of female genital cutting (FGC) in the United States, which potentially impacts nearly 228,000 women and girls nationwide. The community outreach and education initiative that were called for under the Federal Prohibition of Female Genital Mutilation Act of 1995 have been limited by the absence of resources needed to support these efforts. The Committee recognizes the importance of community-centered programs to address FGC. Community ownership of the issue is critical and is achieved by engaging local organizations that have earned the community's trust through their existing work with refugee and immigrant women and girls. The Committee therefore encourages the Office of Women's Health to support FGC-related programs implemented by ethnic community-based organizations. (p. 171)

Action Taken or to be Taken

The Office on Women's Health has worked with the National Center for Trauma-Informed Care and its host HHS agency, the Substance Abuse and Mental Health Services Administration, to establish a listserv among a group of community organizations founded by and serving immigrant women from high-prevalence countries. The listserv provides a platform for information exchange, and over the past year we have established several promising alliances. OWH proposes to convene these organizations, other professional partners and HHS agencies to explore potential FY 2010 activities to address FGC in the United States.

CENTRALLY-MANAGED PROJECTS

The GDM Staff Divisions are responsible for administering certain centrally-managed projects on behalf of all Operating Divisions in the Department. Authority for carrying out these efforts is authorized by either specific statute or general transfer authority (such as the Economy Act, 31 USC 1535). The costs for centrally-managed projects are allocated among the Operating Divisions in proportion to the estimated benefit to be derived.

Project	Description	FY 2009 Funding
CFO Audit of Financial Statements	These funds cover the costs of auditing the HHS financial statements annually (as required by the CFO Act of 1990), producing the Department-wide financial statements, and coordinating the HHS audit process.	$13,746,000
Bilateral and Multilateral International Health Activities	These funds support activities by the Office of Global Health Affairs to develop and coordinate the Department's crosscutting interactions with multilateral organizations and foreign governments, necessitated by the increasing intersections between domestic health priorities and international engagement.	$5,811,000
President's Council on Bioethics	The Council was created in 2001 to advise the President on bioethical issues related to advances in biomedical science and technology. The Council's charter is currently scheduled to expire on September 30, 2009. Funding for the Council (including 18 members and 10 staff) comes entirely from HHS.	$2,300,000
HSPD-12 Implementation	These funds are used to fund the HHS Program Management Office for Homeland Security Presidential Directive 12 (HSPD-12), which requires Federal agencies to issue and maintain PIV-2 compliant ID cards to all HHS contractors and employees.	$1,700,000
Media Monitoring	These funds permit the Office of the Assistant Secretary for Public Affairs to provide a coordinated, succinct daily monitoring service of all agency-relevant media coverage for the entire Department, thus preventing duplication and overlap by the individual Operating Divisions.	$488,000

Project	Description	FY 2009 Funding
Electronic and IT Access for Persons with Disabilities	These funds ensure that HHS complies with the requirements of Section 508 of the Rehabilitation Act Amendments, and that a comprehensive program is implemented which becomes a part of the HHS infrastructure – in the same manner that EEO requirements and programs have.	$199,000
HHS Health and Wellness Center	These funds are used to provide a portion of the ongoing operating costs of a health facility which promotes physical fitness for all HHS employees located in the Southwest DC complex.	$147,000
Motor Vehicle Management Information System (MVMIS)	MVMIS funds are used to support a web-based tool which allows the Department to manage its motor vehicle fleet and be in compliance with all applicable Federal and HHS policies, laws and regulations.	$64,000
TOTAL		$24,455,000

SPECIAL REQUIREMENTS

FY 2010 HHS Enterprise Information Technology Fund and e-Government Initiatives

Allocation Statement:

Departmental Management (DM) will contribute a total of **$509,430** from its FY 2010 budgets to support the Department's Enterprise Information Technology (EIT) initiatives, as well as E-Government initiatives. Similar contributions from all HHS Operating Divisions are combined to create an EIT Fund that finances both specific HHS information technology (IT) initiatives identified through the Department's IT Capital Planning and Investment Control process, and the Expanding E-Government initiatives. All HHS enterprise initiatives must meet cross-functional criteria and be approved by the HHS IT Investment Review Board, based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$122,943** is allocated to support inter-agency E-Government initiatives in FY 2010**,** as follows:

FY 2010 HHS Contributions to e-Gov Initiatives*	DM
Line of Business - Geospatial	$1,040
Line of Business - Federal Health Architecture (FHA)	$77,351
Line of Business - Human Resources	$2,878
Line of Business - Grants Management	$4,841
Line of Business - Financial Management	$3,351
Line of Business - Budget Formulation and Execution	$2,229
Line of Business - IT Infrastructure	$3,755
Disaster Assistance Improvement Plan	$27,500
Total, e-Gov Initiatives	**$122,943**

*The total for all HHS FY 2010 inter-agency E-Government and Line of Business contributions for the initiatives identified above, and any new development items, is currently projected by the Federal CIO Council to not increase above the FY 2009 aggregate level. Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Line of Business - Geospatial: Promotes coordination and alignment of geospatial data collection and maintenance among all levels of government: provides one-stop web access to geospatial information through development of a portal; encourages collaborative planning for future investments in geospatial data; expands partnerships that help leverage investments and reduce duplication; and, facilitates partnerships and collaborative approaches in the sharing and stewardship of data. Up-to-date accessible

information helps leverage resources and support programs: economic development, environmental quality and homeland security. HHS registers its geospatial data, making it available from the single access point.

Line of Business - Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

Line of Business - Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

Line of Business - Grants Management: Supports end-to-end grants management activities promoting improved customer service, decision-making, financial management processes, efficient reporting procedures, and post-award closeout actions. An HHS agency, the Administration for Children and Families (ACF), is a Grants Management Line of Business (GMLOB) consortia lead, which has allowed ACF to take on customers external to HHS. These external customers have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence and has applied to be a GMLOB consortia lead. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardizing grants processes, thus reducing overall HHS costs for grants management.

Line of Business - Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Line of Business - Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Line of Business - IT Infrastructure: This initiative provides the potential to leverage spending on commodity IT infrastructure to gain savings; to promote and use common, interoperable architectures that enable data sharing and data standardization; secure data interchanges; and, to grow a Federal workforce with interchangeable skills and tool sets.

Disaster Assistance Improvement Plan (DAIP): DAIP, managed by the Department of Homeland Security, assists agencies such as HHS with active disaster assistance programs, to reduce the burden on other Federal agencies which routinely provide logistical help and other critical management or organizational support during disasters. During its first year of operation, the DAIP program office will quantify and report on the benefits and cost savings/cost reductions for each member agency.

Grants.Gov

The following is presented pursuant to Sections 737(b) and (d) of the Consolidated Appropriations Act of 2008 (P.L. 110-161).

The Assistant Secretary for Resources and Technology (ASRT) manages the Grants.gov program. Grants.gov is the Federal government's "one-stop-shop" for grants information, providing information on over 1,000 grant programs and $450 billion awarded by the 26 grant-making agencies and other Federal grant-making organizations. The initiative enables Federal agencies to publish grant funding opportunities and application packages online, while allowing the grant community of over one million organizations (State, local, and tribal governments, education and research organizations, non-profit organizations, public housing agencies, and individuals) to search for opportunities and download, complete, and electronically submit applications.

Through the use of Grants.gov, agencies are able to provide the public with increased access to government grants programs and are able to reduce operating costs associated with online posting and application of grants. Additionally, agencies are able to improve their operational effectiveness through the use of Grants.gov, by increasing data accuracy and reducing processing cycle times.

The initiative provides benefits to the following agencies:

- Department of Agriculture
- Department of Commerce
- Department of Defense
- Department of Education
- Department of Energy
- Department of Health and Human Services
- Department of Homeland Security
- Department of Housing and Urban Development
- Department of the Interior
- Department of Justice
- Department of Labor
- Department of State
- U.S. Agency for International Development
- Department of Transportation
- Department of the Treasury

- Department of Veterans Affairs
- Environmental Protection Agency
- National Aeronautical and Space Administration
- National Archives and Records Administration
- National Science Foundation
- Small Business Administration
- Social Security Administration
- Corporation for National Community Service
- Institute of Museum and Library Services
- National Endowment for the Arts
- National Endowment for the Humanities

From its inception, Grants.gov has transformed the Federal grants environment by streamlining and standardizing public-facing grant processes, thus facilitating an easier application submission process for our applicants. The Grants.gov Program Management Office (PMO) works with agencies on system adoption, utilization, and customer satisfaction.

RISK MANAGEMENT OVERVIEW: Risks are categorized and prioritized to facilitate and focus risk management activities. Risk categories are aligned with OMB risk management guidance, ensuring comprehensive consideration of possible risks and simplifying program reporting. Risk prioritization is based on the probability of occurrence and potential impact, and focuses project resources where they are most needed.

All risks are tracked in the Grants.gov Risk Management Database, from identification through resolution. This online database is accessible to all Grants.gov team members and is updated regularly, in keeping with a continuous risk management process. Although physically separate, the Risk Management Database is considered an integral part of the Grants.gov Risk Management Plan.

Risks are categorized to facilitate analysis and reporting. The Grants.gov risk categories are aligned with Office of Management and Budget (OMB) guidance on risk assessment and mitigation. The risk category describes potentially affected areas of the program, and helps put individual risks into context when assessing their severity. The categories are also used to drive risk identification: the lack of identified risks in a given category may indicate overlooked risks. The following risks have been identified to OMB:

Risk 1: Grants.gov may not receive sufficient funding to complete project milestones. The Grants.gov PMO operations are funded entirely by agency contributions, including salaries and expenses for full-time staff, and support contracts for system integration, hardware platforms, upgrades, software licenses, Independent Verification and Validation, outreach and liaison, contact center, performance metrics monitoring, and office support. If the PMO does not receive sufficient funding, or if the agency contributions are not provided in a timely manner, the PMO would have to limit or stop providing the services it offers to its stakeholders.

Risk mitigation response: Grants.gov risk mitigation is a multifaceted approach that includes internal actions as well as external entities. Internally, the PMO incrementally funds contract requirements when adequate funds are not available, and when funds becomes available it will fully fund requirements. The PMO closely monitors contract expenditures and PMO activities such as training and travel expenditures to ensure the available budget will cover the actual expense. Externally at the beginning of the fiscal year the PMO develops and sends documentation to each funding agency to initiate funding transfers and then reports the status of agency contribution to the Grants Executive Board (GEB) and OMB. Another mitigation activity is that the GEB is currently working on a long term funding strategy for Grants.gov. In FY 2010 Grants.gov will transition to a Fee-for-Service based fee structure that was approved by the GEB in FY 2008. This structure will distribute agency costs amongst agencies on usage basis, however it does not alleviate the current funding process of executing 26 funding agreements each fiscal year to transfer operating funds to HHS for Grants.gov. The GEB will explore ways to transfer the funding with out having to execute 26 separate agreements.

Risk 2: Grants.gov receives and distributes grants applications that contain proprietary information that must be safeguarded.

Risk mitigation response: Grants.gov mitigates this risk through the use of policy /procedure and by physical means. Grants.gov has specific policy on the creation of system super user accounts and provides these users recommended authentication procedures. Grants.gov uses encrypted channels and limits the time that application data is retained on the Grants.gov system.

Risk 3: A fundamental concept of electronic commerce is the standardization of a common set of terms to be used by trading partners during business communications. Grants.gov requires common data processes in order to function. The inability to define common data and processes could delay system adoption or impede program goals.

Risk mitigation response: The Grants.gov system was developed in accordance with the electronic standards for core grants data, Transaction Set 194, which were developed by the Inter-Agency Electronic Grants Committee (IAEGC). The Grants.gov PMO worked with the PL 106/107 workgroup and IAEGC to build consensus, and continues to work to minimize the required changes to agency and applicant processes, to minimize agency-specific forms, and to publish existing forms and encourage agencies to use them.

Risk 4: The Grants.gov system's centralized architecture increases the impact of system failure and performance issues.

Risk mitigation response: The PMO has incorporated off-line forms that can be submitted through alternate paths (e.g., e-mail, mail, or fax) and that distribute the computational load. The PMO also ran pilot electronic applications in parallel with paper submissions during it initial operational phases. The Grants.gov system uses a high-

availability configuration for central system and has implemented effective monitoring & restoration procedures. The PMO routinely measures system performance and forecasts application loads and recommends that agencies spread opportunity closing dates to spread system loads. In times of heavy system loads the PMO gives a higher priority to application receipt processing and defers back-end processing to after peak capacity periods. In FY 2009 the PMO continues to deploy a series of system changes and enhancements to reduce application processing load and will continue to enhance the system to increase efficiency.

Risk 5: Unanticipated increase in system usage volume may exceed system operating limits. The American Recovery and Reinvestment Act (ARRA) has introduced unprecedented and unplanned doubling of usage volume beginning in January 2009 that has resulted in diminished system performance.

Risk Mitigation Response: HHS has devoted significant additional management resources to augment the current PMO efforts at various levels. Executive engagement with the System integrator and HHS Senior Management to convey the importance of the project as well as assure appropriate resources and timely performance; Grants.gov PMO Management – Increased and pro-active engagement of the System Integrator in conjunction with increased IV&V testing and inspection activities; modification of the System Integrator contract to ensure technical transparency, communication, timely progress, performance metrics and deliverables; and HHS as Managing Partner has dedicated additional technical and management resources to proactively address system issues, and drive contract/system performance. The PMO is also implementing enhancements, known as the "Boost," to the Grants.gov system to include additional and upgraded hardware platforms and operating system to provide a more robust operating platform capable of processing increased system volume. The additional funds required for the Boost enhancements are captured in the 2009 Supplemental column in the chart below. The source of the 2009 Supplemental funds is an additional FY2009 contribution from each of the 26 Federal agencies that support Grants.gov. HHS facilitates the timely collection of funds by initially providing a template funding agreement that was emailed to all agencies with directions on how to complete the agreement and the due date for submissions. HHS tracks the receipt of agency contributions by means of an agreement tracking spreadsheet that is updated daily and sent to agencies weekly. The PMO follows up with any agency that has not submitted its contribution, by contacting the agency twice a week via email. The HHS executive staff follows the email request with a weekly phone call to each agency.

FUNDING: The total development cost of the Grants.gov initiative by fiscal year -- including costs to date, estimated costs to complete development to full operational capability, and estimated annual operations and maintenance costs -- are included in the table below. Also included are the sources and distribution of funding by agency, showing contributions to date and estimated future contributions through FY 2009 to include the FY2009 supplemental funds provided to enhance the Grants.gov system The FY2010 Grants.gov budget was approved based on a redesign of the Grants.gov architecture, which would represent a significant development effort for the system. The

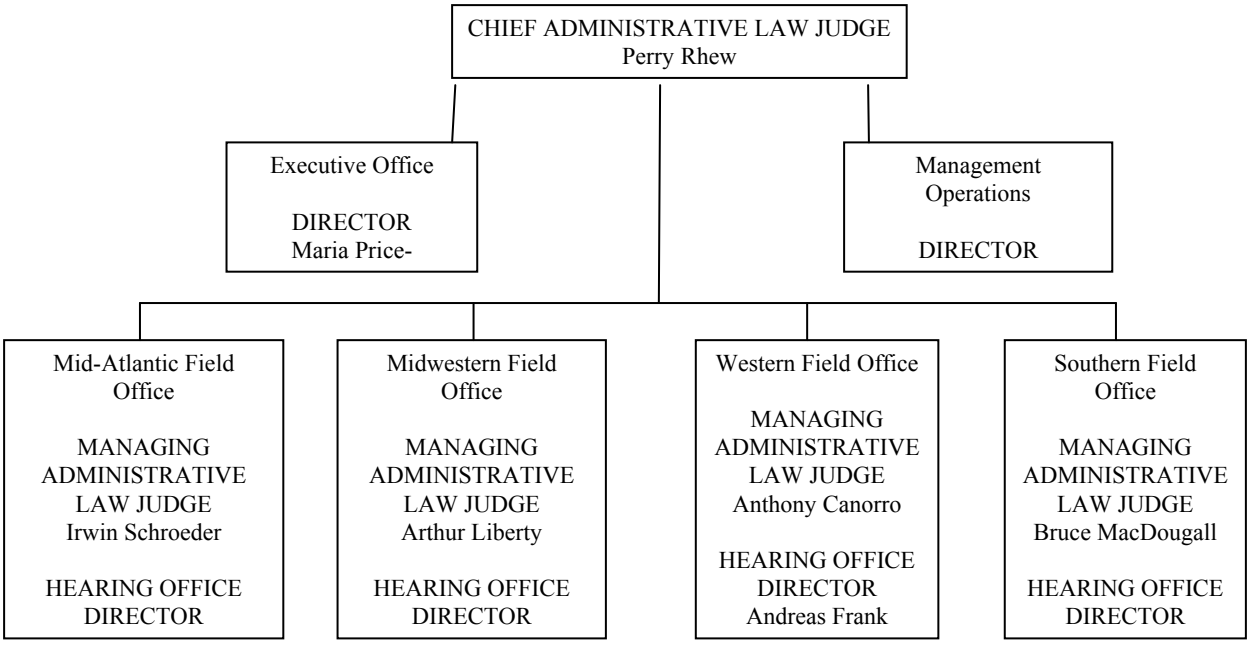
benefits of a redesigned architecture include addressing the continually increasing system user volume to allow for more users to access and use the system simultaneously; reduce application processing times and more effectively process grant applications during peak volume periods. The redesigned architecture will also provide better support to the transfer of application data and attachments from applicants through the Grants.gov system to the Grantor agency; and provide additional system functionality such as on-line forms, as well as complex and collaborative mechanisms. The budgeted cost for this work is $8,600,000 for FY2010.

	2007	TDCTD*	2008 (ECTCD*)	2009 (O&MC*)	2009 Supplemental	GRAND TOTAL
HHS	1,900,000	**6,139,000**	1,957,000	1,889,755	872,931	**12,758,686**
DOT	1,073,700	**5,312,700**	1,105,885	1,067,885	493,131	**9,053,301**
ED	1,073,700	**5,312,700**	1,105,885	1,067,885	493,131	**9,053,301**
HUD	1,073,700	**5,312,700**	1,105,885	1,067,885	493,131	**9,053,301**
NSF	520,600	**3,246,000**	536,187	517,763	239,331	**5,059,881**
DOJ	520,600	**3,246,000**	536,187	517,763	239,331	**5,059,881**
DOL	520,600	**3,849,600**	536,187	517,763	239,331	**5,663,481**
USDA	1,073,700	**3,482,700**	1,105,885	1,067,885	493,131	**7,223,301**
DOC	520,600	**2,326,000**	536,187	517,763	239,331	**4,139,881**
DOD	520,600	**1,873,300**	536,187	517,763	239,331	**3,687,181**
DHS	520,600	**2,326,000**	536,187	517,763	239,331	**4,139,881**
AID	520,600	**1,426,000**	536,187	517,763	239,331	**3,239,881**
EPA	520,600	**1,426,000**	536,187	517,763	239,331	**3,239,881**
DOE	520,600	**1,426,000**	536,187	517,763	239,331	**3,239,881**
NASA	520,600	**1,426,000**	536,187	517,763	239,331	**3,239,881**
DOI	520,600	**1,426,000**	536,187	517,763	239,331	**3,239,881**
CNCS	130,000	**582,600**	133,900	129,299	59,931	**1,035,730**
VA	130,000	**582,600**	133,900	129,299	59,931	**1,035,730**
IMLS	130,000	**582,600**	133,900	129,299	59,931	**1,035,730**
State	130,000	**582,600**	133,900	129,299	59,931	**1,035,730**
SBA	130,000	**582,600**	133,900	129,299	59,931	**1,035,730**
NEH	130,000	**695,800**	133,900	129,299	59,931	**1,148,930**
NEA	130,000	**695,800**	133,900	129,299	59,931	**1,148,930**
SSA	75,000	**527,600**	77,250	74,596	34,131	**788,577**
Treasury	75,000	**527,600**	77,250	74,596	34,131	**788,577**
NARA	75,000	**527,600**	77,250	74,596	34,131	**788,577**
TOTAL	13,056,400	**55,444,100**	13,447,647	12,985,569	6,000,006	**100,933,722**

Office of Medicare Hearings and Appeals

OFFICE OF MEDICARE HEARINGS AND APPEALS

ORGANIZATIONAL CHART



EXECUTIVE SUMMARY

Agency Mission

The Office of Medicare Hearings and Appeals (OMHA), an agency of the U.S. Department of Health and Human Service (HHS), administers hearings and appeals nationwide for the Medicare program, and ensures that the American people have equal access and opportunity to make such appeals and can exercise their rights for health care quality and access. On behalf of the Secretary of HHS, the Administrative Law Judges (ALJs) within OMHA conduct impartial hearings and issue decisions on claims determination appeals involving Medicare Parts A, B, C and D, as well as Medicare entitlement and eligibility appeals.

Vision

OMHA will continue to be a model Federal adjudicative agency for serving the American public by:

- developing and maintaining a highly-qualified, professional staff to adjudicate Medicare appeals;
- utilizing state-of-the-art technology;
- maintaining a quality assurance program that ensures the integrity of decisions and data, while maintaining decisional independence; and
- serving appellants and other customers in such a way as to reflect a seamless Medicare appeals process.

Mission

OMHA provides an independent forum for the fair and efficient adjudication of Medicare appeals for beneficiaries and other parties. This mission is carried out by a cadre of knowledgeable ALJs, exercising judicial and decisional independence under the Administrative Procedures Act, with the support of a professional legal and administrative staff. In fulfilling this mission, OMHA strives for the equitable treatment of all who appear before it, and recognizes its responsibility to be an efficient and effective agency within HHS.

Overview of Budget Request

The FY 2010 President's Budget request for OMHA is $71,147,000 – an increase of $6,543,000 above the FY 2009 enacted level. This budget supports HHS Strategic Goal 1, "Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care," by supporting the Medicare program -- providing the basic mechanisms through which individuals and organizations who are dissatisfied with Medicare determinations affecting their right to, or their participation in, the Medicare program may administratively appeal these determinations.

APPROPRIATIONS LANGUAGE

For expenses necessary for administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions of title XI of such Act), **[**$64,604,000**]** *$71,147,000*, to be transferred in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

(Department of Health and Human Services Appropriations Act, 2009.)

AMOUNTS AVAILABLE FOR OBLIGATION

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 Request
Trust funds:			
Annual appropriation	$65,000,000	$64,604,000	$71,147,000
Rescission pursuant to P. L.110-161	-1,136,000	0	0
Subtotal, adjusted budget authority	63,864,000	64,604,000	71,147,000
Unobligated balance lapsing.....	- 75,000		
Total obligations	$63,789,000	$64,604,000	$71,147,000

SUMMARY OF CHANGES

2009	General funds appropriation	$0
	HI/ SMI adjusted trust funds transfer	64,604,000
	Total adjusted budget authority	64,604,000
2010	Request – General funds	0
	Request – HI/ SMI trust funds transfer	71,147,000
	Total estimated budget authority	71,147,000
	Net change	+$6,543,000

	2009 Omnibus		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Increases:				
A. Built-in:				
1. Annualization of January 2009 pay raise (3.9)	(366)	31,072,000	(+12)	+1,211,808
2. Cost of January 2010 pay raise (2.0%)	(366)	31,072,000	(+12)	+466,080
3. Rental Payments to GSA		6,528,000		+163,200
Subtotal, Built-in Increases				**+1,841,088**
B. Program:				
1. Other personnel compensation	(366)	31,072,000	(+12)	+418,509
2. Cost of 3 new ALJ Teams	(366)	39,807,000	(+12)	+1,260,591
3. Travel		148,000		+37,000
4. Transportation of things		173,000		+43,250
5. Communications, misc charges		1,225,000		+91,875
6. Printing and reproduction		21,000		+5,250
7. Other contractual services		16,389,000		+2,765,681
8. Supplies and materials		267,000		+70,556
9. Equipment		46,000		+9,200
Subtotal, Program Increases				**+4,701,912**
Total increases/ Net Change				**+$6,543,000**

BUDGET AUTHORITY BY ACTIVITY
(Dollars in thousands)

	FY 2008 Appropriation		FY 2009 Omnibus		FY 2010 Request	
	FTE	Amount	FTE	Amount	FTE	Amount
Total budget authority.....	366	$63,864	366	$64,604	378	$71,147

BUDGET AUTHORITY BY OBJECT

	FY 2009 Omnibus	FY 2010 Request	Increase or Decrease
Full-time Equivalent Employment	366	378	+12
Average SES salary	$144,242	$153,618	+$9,376
Average GS grade	12.6	12.7	+.1
Average GS salary	$84,570	$88,080	+$3,510
Personnel compensation:			
Full-time permanent	$31,072,000	$33,764,414	+$2,692,414
Other than full-time permanent	0	0	0
Other personnel compensation	250,000	668,509	+418,509
Subtotal, personnel compensation	31,322,000	34,432,923	+3,110,923
Civilian personnel benefits	8,485,000	8,731,065	+246,065
Benefits to former personnel	0	0	0
Subtotal, Pay costs	39,807,000	43,163,988	+3,356,988
Travel	148,000	185,000	+37,000
Transportation of things	173,000	216,250	+43,250
Rental payments to GSA	6,528,000	6,691,200	+163,200
Rental payments to others	0	0	0
Communications, misc charges	1,225,000	1,316,875	+91,875
Printing and reproduction	21,000	26,250	+5,250
Other contractual services:			
Advisory and assistance services	8,784,684	9,136,071	+351,387
Other services	1,802,665	3,517,732	+1,715,067
Purchases of goods and services from Government accounts	5,108,651	5,958,378	+849,727
Operation and maintenance of facilities	635,000	470,000	-165,000
Research and development contracts	0	0	0
Medical care	0	0	0
Operation and maintenance of equipment	58,000	72,500	+14,500
Subsistence and support of persons	0	0	0
Subtotal, Other contractual services	16,389,000	19,154,681	+2,765,681
Supplies and materials	267,000	337,556	+70,556
Equipment	46,000	55,200	+9,200
Grants, subsidies and contributions	0	0	0
Subtotal, Non-pay costs	24,797,000	27,983,012	+3,186,012
Total, Budget Authority	**$64,604,000**	**$71,147,000**	**+$6,543,000**

SALARIES AND EXPENSES
(Budget Authority)

	FY 2009 Omnibus	FY 2010 Request	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$31,072,000	$33,764,414	+$2,692,414
Other than full-time permanent (11.3)	0	0	0
Other personnel compensation (11.5/11.8)	250,000	668,509	+418,509
Subtotal, personnel compensation (11.9)	31,322,000	34,432,923	+3,110,923
Civilian personnel benefits (12.1)	8,485,000	8,731,065	+246,065
Benefits to former personnel (13.0)	0	0	0
Subtotal, Pay costs	39,807,000	43,163,988	+3,356,988
Travel (21.0)	148,000	185,000	+37,000
Transportation of things (22.0)	173,000	216,250	+43,250
Rental payments to others (23.2)	0	0	0
Communications, misc charges (23.3)	1,225,000	1,316,875	+91,875
Printing and reproduction (24.0)	21,000	26,250	+5,250
Other contractual services:			
Advisory and assistance services (25.1)	8,784,684	9,136,071	+351,387
Other services (25.2)	1,802,665	3,517,732	+1,715,067
Purchases of goods and services from Government accounts (25.3)	5,108,651	5,958,378	+849,727
Operation and maintenance of facilities (25.4)	635,000	470,000	-165,000
Research and development contracts (25.5)	0	0	0
Medical care (25.6)	0	0	0
Operation and maintenance of equipment (25.7)	58,000	72,500	+14,500
Subsistence and support of persons (25.8)	0	0	0
Subtotal, other contractual services	16,389,000	19,154,681	+2,765,681
Supplies and materials (26.0)	267,000	337,556	+70,556
Subtotal, Non-pay costs	18,223,000	21,236,612	+3,013,612
Total Salaries and Expenses	**$58,030,000**	**$64,400,600**	**+$6,370,600**

AUTHORIZING LEGISLATION

	2009 Amount Authorized	2009 Enacted	2010 Amount Authorized	2010 Budget Request
Medicare Prescription Drug, Improvement, and Modernization Act of 2003.....	Indefinite	$64,604,000	Indefinite	$71,147,000

APPROPRIATIONS HISTORY TABLE
(Non-Comparable)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
Trust Funds	$80,000,000	$60,000,000	$75,000,000	$60,000,000
Rescission	–	–	–	-600,000
FY 2007				
Trust Funds	74,250,000	70,000,000	75,000,000	59,727,000
FY 2008				
Trust Funds	74,250,000	70,000,000	70,000,000	65,000,000
Rescission	–	–	–	-1,136,000
FY 2009				
Trust Funds	64,604,000	64,604,000	64,604,000	64,604,000
FY 2010				
Trust Funds	71,147,000			

OFFICE OF MEDICARE HEARINGS AND APPEALS

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2009 Recovery Act	FY 2010 Request	FY 2010 +/- FY 2009
Budget Authorit	$63,864,000	$64,604,000	$0	$71,147,000	+$6,543,000
FTE	366	366	0	378	+12

Authorizing Legislation……...Titles XVIII and XI of the Social Security Act
Allocation Method……...……...Direct Federal

Program Description and Accomplishments

The Office of Medicare Hearings and Appeals (OMHA) was established by Section 931 of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), enacted on December 8, 2003. MMA transferred the responsibility for hearing Medicare appeals at the Administrative Law Judge (ALJ) level – the third level of Medicare claims appeals – from the Social Security Administration (SSA) to the Office of the Secretary at the Department of Health and Human Services (HHS). The Medicare Benefits Improvement and Protection Act of 2000 (BIPA) also mandated that ALJ appeals be heard within 90 days after receipt of a request from a Medicare appellant. OMHA began processing cases on July 1, 2005.

Approximately 45 million Americans have Medicare coverage, of which 35 million are enrolled in the traditional Medicare (Medicare fee-for-service) program. In FY 2008, the claims processing contractors for traditional Medicare (Medicare administrative contractors, fiscal intermediaries, and carriers) processed approximately 1.2 billion claims for payment, of which about 190 million (16%) were claims from health care institutions (Part A claims) and about 1 billion (84%) were claims from health care practitioners and suppliers (Part B claims). Of the 1.2 billion total claims processed, Medicare made payment on more than 990 million claims (84%) and did not make payment on more than 190 million claims (16%).

Claims submitted for Medicare items and services are denied for a variety of reasons. The most common reasons for denying a claim are:

- The services provided were determined to not have been medically necessary for the beneficiary;
- Medicare did not cover the services; or
- The beneficiary was not eligible for the services.

OMHA administers its program in four field offices, including the Southern Field Office in Miami, Florida; the Midwestern Field Office in Cleveland, Ohio; the Western Field Office in Irvine, California; and the Atlantic Field Office in Arlington, Virginia. OMHA extensively

utilizes video-teleconferencing (VTC) and telephone hearings, in order to provide appellants with hearings which are timely, close to their homes, and have a broad array of access points. VTC technology, which is now commonly used throughout the country in courtrooms and for telemedicine, plays a critical role in OMHA's ability to both meet the BIPA timeframes and provide expanded access for appellants to ALJ hearings.

Since opening its doors in July 2005, OMHA's caseload has continued to increase as follows:

OMHA Claims Received

FY 2006	FY 2007	FY 2008
106,474	137,347	183,326

In January 2006, OMHA began hearing appeals arising from the new Medicare Part D Prescription Drug Plan. In January 2007, OMHA began hearing Medicare Part B Income-Related Medicare Adjustment Amount (IRMAA) appeals.

In August 2007, OMHA began receiving new cases as a result of a pilot Recovery Audit Contractor (RAC) program by the Centers for Medicare & Medicaid Services (CMS). This program includes RACs for both Medicare Secondary Payer (MSP) claims and non-MSP claims. The demonstration project was designed to determine whether the use of RACs would be a cost-effective means of ensuring that correct payments are made to providers and suppliers, thereby protecting the Medicare Trust Funds. CMS selected California, New York and Florida as the three pilot States. Under Title III, Section 302, of the Tax Relief and Health Care Act of 2006, the RAC program has become permanent and is being expanded to all 50 States by no later than January 1, 2010. In FY 2008, OMHA received a total of 13,392 RAC claims from the pilot States; that number is expected to increase during FY 2009. As a result of the permanent program expansion, OMHA expects that it will receive more than 40,000 additional RAC specific claims in FY 2010.

Moreover, OMHA's overall workload (for both RAC and non-RAC claims) continues to increase. In FY 2006, OMHA received 106,474 claims; in FY 2007, claims increased to 137,347 (+29%), and in FY 2008, to 183,326 (+33%). Given workload increases of this magnitude, OMHA is challenged to meet its statutory deadlines with current Federal and contractor staffing levels. The requested increase of $6,543,000 over FY 2009 is needed to fund additional Federal staff, pay raises for current Federal staff, and associated programmatic expenses to support a portion of the increased caseload.

Since opening its doors, OMHA has undertaken a number of successful initiatives focused on improving the quality and timeliness of its services. These include:

- A five-year strategic plan that codifies OMHA's objectives and establishes the foundation for organizational performance;
- A Best Practices initiative that shares and facilitates efficient operational approaches across offices;

- A unified workload measurement system (UWMS) that established a methodology for balancing caseload across the agency;
- A national data standardization initiative to promote data quality; and
- An enhanced, citizen-centric internet presence based on usability testing to clearly communicate the Medicare appeals process to citizens.

OMHA demonstrated significant progress and achievement through these initiatives and setting seven organizational performance goals. (See Outputs and Outcomes Table below for additional detail.) In FY 2008, OMHA met or exceeded all seven agency performance goals as follows:

- *Increase the number of BIPA cases closed within 90 days* -- One of OMHA's long-term goals is to consistently adjudicate BIPA cases within the 90-day statutory timeframe mandated by BIPA. Prior to this function being transferred from SSA to OMHA, GAO reported that SSA averaged 295 days to resolve an appeal. OMHA's five-year goal is to process 90% of BIPA cases within 90 days. In FY 2008, OMHA processed 95% of BIPA cases within the statutory timeframe, its best result in its three years of operation. OMHA was able to exceed its performance target in FY 2008 primarily because of the nationwide implementation of Best Practices identified in OMHA field offices, and other process improvements that supported reduced case processing timeframes.

- *Increase the number of non-BIPA cases closed within 90 days* -- Although there is no statutory requirement to decide non-BIPA cases within 90 days, OMHA identified the timely closure of non-BIPA cases as an important long-term goal. OMHA makes a concerted effort to adjudicate non-BIPA cases expeditiously, and has adopted many of the same process improvements for non-BIPA cases. This measure assures OMHA meets or exceeds all mandated case processing timelines throughout the Medicare appeals process. OMHA expects the number of non-BIPA cases to decrease in the out years. In FY 2008, OMHA processed 72% of its non-BIPA cases within 90 days, thereby exceeding its performance target of 51% -- again due primarily to the nationwide implementation of Best Practices identified in OMHA field offices, and other process improvements that supported reduced case processing timeframes.

- *For cases that go to hearing, increase the percentage of decisions rendered in 30 days* -- OMHA's primary mission is to adjudicate cases within required timelines. Rendering decisions within 30 days of when a hearing is held is a leading indicator of the likelihood of meeting a 90-day total timeframe. This percentage represents the cases where a decision is rendered within 30 days of completing an ALJ hearing. In FY 2008, OMHA issued 84% of its decisions for cases that went to hearing within 30 days, thus exceeding the performance target of 82%. In part, this success is attributable to operational experience.

- *Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council* -- The legal accuracy of OMHA decisions remains of paramount importance to the agency. OMHA is committed to providing accurate decisions that are

not reversed or remanded on appeals to the Medicare Appeals Council (MAC), which provides the fourth level of Medicare appeals. This goal focuses on maintaining the overall quality and accuracy of OMHA decisions. The performance target for FY 2008 was 1%, which OMHA exceeded by having only 0.8% of its decisions reversed or remanded on appeals to the MAC.

- *Average survey results from appellants reporting good customer service on a scale of 1–5 at the ALJ Medicare Appeals level* -- OMHA is evaluating its efficiency and effectiveness through an independent evaluation that captures the scope of the Level III appeal experience by randomly surveying selected appellants and appellant representatives. The OMB cleared survey measures the overall appellant experience, the quality of OMHA materials, hearing scheduling and format, and interactions with OMHA staff. The measure aims to assure that appellants and related parties are satisfied with their Medicare appeals experience with OMHA. On a scale of 1–5, the FY08 performance target was 3.2; OMHA achieved a result of 4.36 in the appellant survey.

- *Decrease the cost per claim adjudicated* -- OMHA seeks to gain efficiencies and cost savings through its reduced case processing timeframes despite rising costs for staffing, rent, contracts and other services needed to support the appeals process. In FY 2008, OMHA exceeded the performance target of a 10% reduction (to $445 per claim) when it decreased its average cost per claim by 26% (to $364 per claim). This increased efficiency is due to several factors, including the completion of "start-up" costs for the first two years of OMHA's operation, and increased efficiencies gained from OMHA's operational and adjudicatory experience.

- *Increase the number of claims processed per ALJ team* -- ALJs strive to meet statutory timeframes and increasing workloads while also maintaining the quality and accuracy of OMHA decisions. OMHA's caseload increased by 36% in FY 2008 over FY 2007, while the number of ALJ teams (comprised of an ALJ, attorney, paralegal and hearing clerk) remained fairly constant, with 66 ALJ teams nationwide at the end of FY 2008. The FY 2008 performance target was to increase the number of claims by 3%, to 1,868 claims per ALJ team. OMHA's actual performance in FY 2008 was to increase the number by 49%, to 2,710 claims per ALJ team.

These accomplishments were noted in OMB's FY 2008 performance assessment. This assessment cited program purpose and design, strategic planning and program management as strong attributes of OMHA's program. Additionally, an external HHS Office of Inspector General audit in January 2009 of OMHA's first three years of operation conveyed improvements in decision timeliness and data quality.

Funding History

FY	Amount	FTE
2006	$59,359,000	274
2007	$59,727,000	356

2008	$63,864,000	366
2009	$64,604,000	366

Budget Request

By all measures, OMHA's caseload has continued to increase significantly since it began adjudicating the third level of Medicare appeals. In addition to increases in its planned case load, OMHA began receiving new appeals resulting from CMS' Recovery Audit Contractor (RAC) Program Demonstration in FY 2007. The RAC Program has been made permanent and will be expanded to all 50 states by January 2010.

The FY 2010 budget request for OMHA of $71,147,000 is an increase of $6,543,000 over the FY 2009 enacted level. Based on RAC program assumptions, OMHA's average monthly RAC caseload is expected to quadruple by the end of FY 2010, exponentially impacting workload and challenging OMHA's statutory timeframe for issuing decisions. With OMHA's non-RAC caseload increasing annually and new cases from the RAC program expansion reaching OMHA in FY 2010, the additional funding is needed by OMHA to address a portion of the FY10 caseload increase through modest staffing increases including:

- Twelve additional FTE to adjudicate all Medicare appeals, including Medicare Parts A, B, C, D, Medicare entitlement and eligibility appeals, IRMAA cases, and RAC cases.

- Continued legal and administrative support provided by contractors working across the four offices nationwide, to adjudicate appeals and ensure strict adherence to all financial and administrative management internal controls.

Additionally, the requested funding will support key operational and infrastructure investments:

- Maintaining information technology systems, including the Medicare Appeals System (MAS), intranet expansion and planning for ALJ enhancements to MAS.

- Maintenance of 59 on-site adjudication hearing rooms and the associated VTC equipment and telecommunications infrastructure, along with access to external hearing room facilities via commercial vendors.

OUTPUTS AND OUTCOMES TABLE

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY2009
1.1: Increase the number of BIPA cases closed within 90 days *(Output)*	FY 2008: 95% (Target Exceeded)	87%	88%	+1%
1.2: Increase the number of non-BIPA cases closed within 90 days *(Output)*	FY 2008: 72% (Target Exceeded)	53%	55%	+2%
1.3: For cases that go to hearing, increase the percentage of decisions rendered in 30 days *(Output)*	FY 2008: 84% (Target Exceeded)	83%	84%	+1%
1.4: Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council *(Output)*	FY 2008: 0.8% (Target Exceeded)	1%	1%	Maintain
1.5: Average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level *(Output)*	FY 2008: 4.36 (Target Exceeded)	3.2	3.2	Maintain
1.6: Decrease the cost per claim adjudicated *(Efficiency)*	FY 2008: -26% (Target Exceeded)	-5%	-3%	-2%
1.7: Increase number of claims processed per ALJ team *(Efficiency)*	FY 2008: +49% (Target Exceeded)	+2%	+1%	-1%
Program Level Funding ($ in millions)	**$63.9M**	**$64.6M**	**$71.1M**	**+$6.5M**

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 Estimate
Medicare Hearings and Appeals.....	366	366	378

Average GS Grade

2008. .....GS-12/5

2009.....GS-12/6

2010……GS-12/7

DETAIL OF POSITIONS

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 Estimate
AL-1	1	1	1
AL-2	4	4	4
AL-3	60	60	63
Subtotal, ALJs	65	65	68
SES	2	2	2
GS-15	8	8	8
GS-14	28	28	28
GS-13	5	5	5
GS-12	120	120	122
GS-11	63	63	61
GS-10	0	0	0
GS-09	16	16	22
GS-08	48	48	48
GS-07	12	12	12
GS-06	3	3	6
GS-05	0	0	0
GS-04	0	0	0
GS-03	0	0	0
GS-02	0	0	0
GS-01	0	0	0
Subtotal	303	303	312
Ungraded Positions	0	0	0
Total Positions	370	370	382
Total FTE usage, end of year	366	366	378
Average SES salary	$140,724	$144,242	$153,618
Average GS grade	GS-12/5	GS-12/6	GS-12/7
Average GS salary	$80,263	$84,570	$88,080

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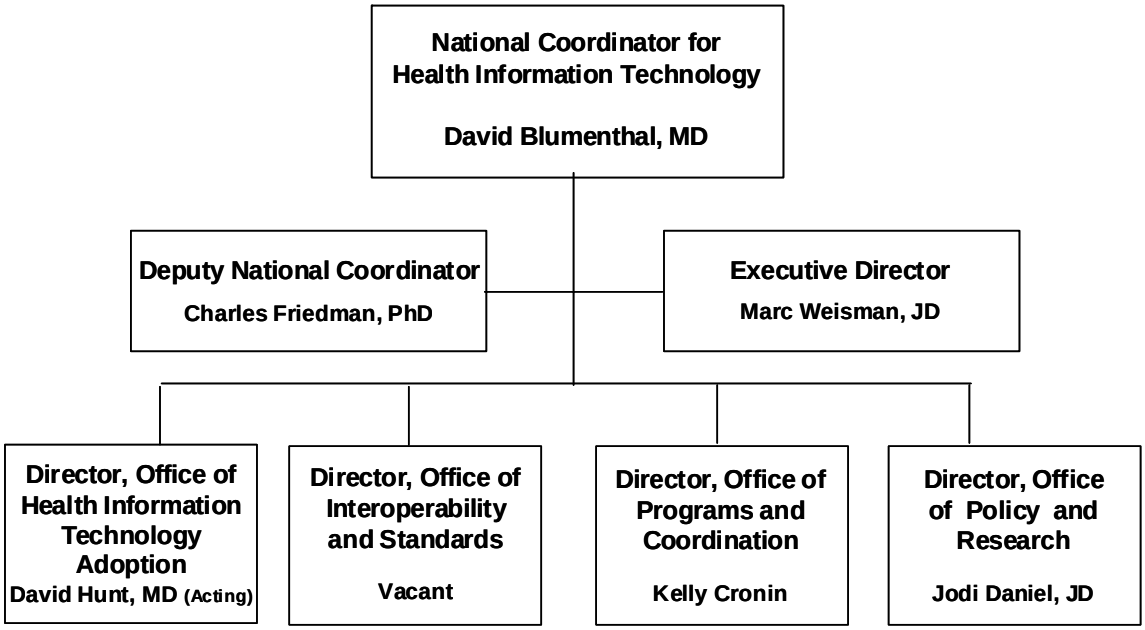
Office of the National Coordinator for Health Information Technology

Office of the National Coordinator for Health Information Technology



OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

Executive Summary

Introduction and Mission

The Office of the National Coordinator for Health Information Technology (ONC), in the Office of the Secretary for the U.S. Department of Health and Human Services (HHS), is the principal Federal organization charged with coordinating national efforts related to the implementation and use of electronic health information exchange. By encouraging providers to adopt health information technology (health IT), both the quality of care and the efficiency with which it is delivered can be improved. Health IT use and adoption is the effective integration of health information products and services that support safer, better health and care. A key ONC role is coordinating the public and private-sector efforts to improve the quality of health and care through information technology.

Vision

A Nation in which the health and well-being of individuals and communities are enabled by health information technology.

Mission

ONC leads, coordinates, and stimulates public and private sector activities that promote the development, adoption, and use of health information technologies to achieve a healthier Nation.

ONC provides leadership, program resources and services needed to guide nationwide implementation of interoperable health IT. ONC organizes its activities in four program areas:

- **Standards** – Standards in health IT-related systems, State-level business policies, and across Federal agencies are important components for achieving nationwide adoption of interoperable health IT. Implementation of common standards allows software applications to work together. Certifying health IT products that incorporate these standards gives assurance that products will be able to work together. Consistent business policies and practices for health information exchange organizations will enable interoperability and sustainability. Coordinating Federal efforts optimizes resources and increases information exchange among Federal and private health care systems.
- **Privacy and Security** – Careful attention to privacy and security policies to guide evolving technologies will help to build the high degree of public confidence and trust needed to achieve adoption and use of health IT. In addition to developing a privacy and security framework, continuing work identifies disparate State policies and business practices that impede electronic health information exchange across jurisdictional lines.
- **Architecture and Adoption** – The Nationwide Health Information Network (NHIN) is building on a set of technical and data exchange standards and specifications, and data use and reciprocal support agreements. The NHIN also provides the foundation for population health information exchange, which is important to all aspects of public health.

Substantiating the value of electronic and personal health record systems and identifying enablers and barriers to their use and implementation will advance adoption of health IT. Regularly assessing the adoption rate through surveys and studies will monitor progress toward ONC's goals.

- **Operations** – Support for administrative, financial and reporting requirements for ONC including planning, procurement, and performance measurement activities.

American Reinvestment and Recovery Act

The American Reinvestment and Recovery Act (Recovery Act) was signed into law by President Obama on February 17, 2009. It is an unprecedented effort to jumpstart our economy, create or save millions of jobs, and put a down payment on addressing long-neglected challenges so our country can thrive in the 21st century. The Act is an extraordinary response to a crisis unlike any other since the Great Depression, and includes measures to modernize our Nation's infrastructure, enhance energy independence, expand educational opportunities, preserve and improve affordable health care, provide tax relief, and protect those in greatest need.

The Office of the National Coordinator for Health Information Technology has received $2 billion in total of Recovery Act funding. As part of this total, the National Institute of Standards and Technology (NIST), Regional Extension Centers and Department efforts to address privacy and security will receive funding in FY 2009. Funding for additional programs in FY 2009 will be determined with the arrival of the new National Coordinator for Health Information Technology.

The Recovery Act instructed the Secretary to transfer $20 million to NIST. These funds will support coordinated efforts between NIST and ONC to advance health care information enterprise integration. Work will focus in areas such as conducting technical standards analysis and establishing a conformance testing infrastructure for electronic health record products. The coordination of this work will increase the adoption rate and use of health IT by making available tested and recognized standards and an infrastructure that will allow vendors to test their products for interoperability prior to going to market.

ONC is developing a program that will support local and regional efforts toward health information exchange. A draft plan to establish Health IT Regional Extension Centers will be published on May 18, 2009. These centers will provide health information technology assistance and services and increase the level of adoption by providing a resource for new users of health IT that will help them with implementing and maintaining their systems.

In addition, a robust program addressing the Privacy and Security concerns related to adoption and use of health IT was initiated in FY 2009. This program will coordinate activities with the HHS Office of Civil Rights, the Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration. These organizations will work together to promulgate regulations and guidance, enhance enforcement of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, carry out mandated audits and train States Attorney Generals in enforcing the modified regulations.

More information on these and other Recovery Act programs can be found at www.hhs.gov/recovery .

FY 2010 Budget Overview

The FY 2010 President's Budget for ONC is $61,342,000 including $19,011,000 in Public Health Evaluation Funds to maintain current service levels. It is an increase of $111,000 above an FY 2009 Omnibus level. This budget supports the implementation of the ONC-Coordinated Federal Health IT Strategic Plan and planned revision, and the HHS Strategic Plan, Goal 1.3: improve health care quality, safety, cost and value.

Program Increases:

Operations (+$6,122,000).
This increase will provide for infrastructure support and additional term and permanent staff to fulfill the requirements of the Recovery Act.

Architecture and Adoption (+$1,439,000).
The Recovery Act provides funding for projects such as the Nationwide Health Information Network (NHIN). The FY 2010 request ($23,250,000) will support development of additional performance measures, work needed to identify the best way to structure consumer-directed access to electronic medical data in a health information exchange, the Health Information Technology Policy Committee and policy-related work that will inform and encourage adoption of health IT.

Program Decreases:

Standards (-$5,500,000)
The Recovery Act provides funding for projects such as certification and standards harmonization. The FY 2010 requested level of funding ($8,500,000) will support these efforts, provide support for the Health Information Technology Standards Committee, and establish and implement the required NHIN Governance activities.

Privacy and Security (-$1,950,000).
The Recovery Act provides funding for projects to address barriers to exchanging health information electronically across states, territories and regions while maintaining and improving important privacy and security protections nationwide. The FY 2010 request ($10,500,000) will support the new Office of the Chief Privacy Officer, as required by the Recovery Act, as well as priorities that will be established through that position.

Discretionary All-Purpose Table

Office of the National Coordinator for Health Information Technology

(Dollars in Thousands)

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2009 Recovery Act*	FY 2010 President's Budget Request
Budget Authority.....	$ 41,661	$ 43,552	$ 2,000,000	$ 42,331
PHS Evaluation Funds.....	18,900	17,679	-	19,011
Total, Program Level.....	$ 60,561	$ 61,231	$ 2,000,000	$ 61,342
FTE.....	30	31	-	65
HCFAC Account	*[$490]*	*0*		*0*

Funding for the Health Care Fraud and Abuse Control (HCFAC) program in FY 2008 was appropriated separately and is a non-add to ONC.

*Note: FY 2009 Recovery Act funding is X-year funding.

Budget Exhibits

Appropriation Language

For expenses necessary for the Office of the National Coordinator for Health Information Technology, including grants, contracts and cooperative agreements for the development and advancement of interoperable health information technology **[**$43,552,000**]***$42,331,000*: Provided, That in addition to amounts provided herein, **[**$17,679,000**]***$19,011,000* shall be available from amounts available under section 241 of the Public Health Service Act. (Department of Health and Human Services Appropriations Act, 2009.)

Office of the National Coordinator for Health Information Technology

Amounts Available for Obligation

	FY 2008 Actual	FY 2009 Omnibus	FY 2010 PB
General Fund Discretionary Appropriation:			
Annual Appropriation.....	$42,402,000	$43,552,000	$42,331,000
Rescission (PL 110-161).....	(741,000)		
Subtotal, Adjusted Appropriation.....	$41,661,000	$43,552,000	$42,331,000
Total Obligations.....	$41,661,000	$43,552,000	$42,331,000

Office of the National Coordinator for Health Information Technology

Summary of Changes

2009	
Total estimated budget authority.....	$ 43,552,000
(Obligations).....	-$ 61,231,000
2010	
Total estimated budget authority.....	$ 42,331,000
(Obligations).....	-$ 61,342,000
Net Change total obligations	+$ 111,000
Net Change budget authority.....	-$ 1,221,000

	FY 2010 Estimate FTE	FY 2010 Estimate Budget Authority	Change From Base FTE	Change From Base Budget Authority
Increases:				
A. Built-in:	65		+ 34	
1. Cost of January 2010 Civilian Pay Raise of 3.2 percent		$ 7,111,000		+$ 2,787,000
2. Cost of January 2010 Commission Officer Pay Raise of 3.0 percent		350,000		+ 238,000
Subtotal, Built-in Increases.....		**$ 7,461,000**		**+$ 3,025,000**
A. Program:				
1. Architecture and Adoption.....		$ 13,239,000		+$ 928,000
[Evaluation Funds]		[10,011,000]		[+ 511,000]
2. Operations.....		11,631,000		+ 3,097,000
Subtotal, Program Increases.....		**$24,870,000**		**+$ 4,025,000**
[Evaluation Funds]		[10,011,000]		[+ 511,000]
Total Increases.....		**$ 32,331,000**		**+$ 7,050,000**

Decreases:		
A. Program:		
1. Standards.....	$ 4,500,000	-$ 4,000,000
[Evaluation Funds]	[4,000,000]	[-1,500,000]
2. Privacy and Security.....	5,500,000	- 4,271,000
[Evaluation Funds]	[5,000,000]	[+ 2,321,000]
Total Decreases.....	**$10,000,000**	**-$ 8,271,000**
[Evaluation Funds]	[9,000,000]	[+ 821,000]
Net Change.....	**$42,331,000**	**-$ 1,221,000**
[Evaluation Funds]	[$19,011,000]	[+$1,332,000]

Office of the National Coordinator for Health Information Technology

Budget Authority by Activity

(Dollars in thousands)

	FY 2008 Actual	FY 2009 Omnibus	FY 2010 PB
Health Information Technology Standards BA.....	$ 12,279	$ 8,500	$ 4,500
[Evaluation Funds].....	[1,500]	[5,500]	[4,000]
Total Standards Program.....	[$13,779]	[$14,000]	[$8,500]
Privacy and Security BA.....	$ 3,897	$ 9,771	$ 5,500
[Evaluation Funds].....	[14,250]	[2,679]	[5,000]
Total Privacy and Security Program....	[$18,147]	[$12,450]	[$10,500]
Architecture and Adoption BA.....	$ 16,035	$ 12,311	$ 13,239
[Evaluation Funds].....	[3,150]	[9,500]	[10,011]
Total Architecture and Adoption Program	[$19,185]	[$21,811]	[$23,250]
Operations BA.....	$ 9,450	$ 12,970	$ 19,092
Total, Budget Authority	$ 41,661	$ 43,552	$ 42,331
Evaluation Funds	$ 18,900	$ 17,679	$ 19,011
Total Program Level	$ 60,561	$ 61,231	$ 61,342
FTE	30	31	65

Office of the National Coordinator for Health Information Technology

Authorizing Legislation

	FY 2009 Amount Authorized	FY 2009 Omnibus	FY 2010 Amount Authorized	FY 2010 President's Budget
Health Information Technology		$ 43,552,000		$ 42,331,000
PHS Evaluation Funds (non-add)		[$ 17,679,000]		[$ 19,011,000]

Office of the National Coordinator for Health Information Technology

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
Budget Authority	$ 75,000,000	$ 58,100,000	$ 32,800,000	$ 42,800,000
PHS Evaluation Funds	2,750,000	16,900,000	12,350,000	18,900,000
Rescission (PL 109-148)				(428,000)
Transfer to CMS				(29,107)
Total	77,750,000	75,000,000	45,150,000	61,242,893
FY 2007				
Budget Authority	89,872,000	86,118,000	51,313,000	42,402,000
PHS Evaluation Funds	28,000,000	11,930,000	11,930,000	18,900,000
Total	117,872,000	98,048,000	63,243,000	61,302,000
FY 2008				
Budget Authority	89,872,000	13,302,000	43,000,000	42,402,000
PHS Evaluation Funds	28,000,000	48,000,000	28,000,000	18,900,000
Rescission (PL 110-161)				(741,000)
Total	117,872,000	61,302,000	71,000,000	60,561,000
FY 2009				
Budget Authority	18,151,000	43,000,000	60,561,000	43,552,000
PHS Evaluation Funds	48,000,000	18,900,000	--	17,679,000
Recovery Act (PL 110-161)				2,000,000,000

Total.....	66,151,000	61,900,000	60,561,000	2,061,231,000
.				

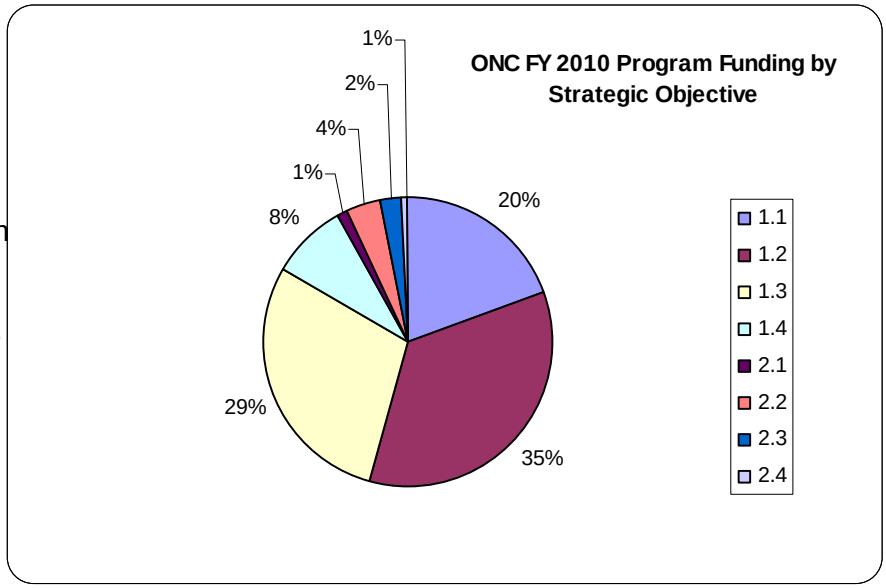
FY 2010

Budget Authority.....	42,331,000
PHS Evaluation Funds.....	19,011,000
Total.....	61,342,000
.	

Narrative By Activity

The ONC-Coordinated Federal Health Information Technology Strategic Plan: 2008 – 2012 was published in June 2008. ONC, in consultation with other Federal agencies, will update the plan during 2009, to include specific objectives, milestones and metrics outlined in Section 13101 in the Health Information Technology for Economic and Clinical Health (HITECH) Act. Once this is complete, ONC will ensure that program funding is aligned with the new strategic objectives.

The chart on the right and the table on the following page illustrate distribution of the total FY 2010 ONC President's Budget as applied across the ONC-Coordinated Federal Health Information Technology Strategic Plan goals and objectives. The allocations include attribution of operating costs that support ONC's three main programs: Standards, Privacy and Security, and Architecture and Adoption.



ONC Program Funding by Strategic Goal and Objective

FY 2010 PRESIDENT'S BUDGET		Percent of Total ONC Budget	ONC PROGRAM *(dollars in thousands)*		
GOAL	**OBJECTIVE**		**Standards**	**Privacy and Security**	**Architecture and Adoption**
HHS Goal 1: Health Care	***HHS 1.3 - Improve health care quality, safety, cost, and value.***	**$61,342**	**$ 12,341**	**$15,245**	**$ 33,756**
Goal 1: Patient-focused Health Care Enable the transformation to higher quality, more efficient, patient-focused health care through electronic health information access and use by care providers and by patients and their designees	**1.1 - Privacy and Security:** Facilitate electronic, exchange, access and use of electronic health information for patients while protecting the privacy and security of their information	20%	$ 2,323	$ 9,319	$ 357
	1.2 - Interoperability: Enable exchange of health information to support patients' health and care needs	35%	$ 3,774	$ 1,219	$ 16,209
	1.3 - Adoption: Promote nationwide deployment of EHRs and PHRs and other consumer health IT tools	29%	$ 1,719	$ 2,673	$ 13,550
	1.4 - Collaborative Governance: Establish mechanisms for multi-stakeholder priority-setting and decision-making	8%	$ 3,463	$ 1,407	$ 333
Goal 2: Population Health Enable the appropriate, authorized, and timely access and use of electronic health information to benefit public health, biomedical research, quality improvement, and emergency preparedness.	**2.1 - Privacy and Security:** Advance principles, procedures, and protections for information access in population health	1%	$ 258	$ 492	
	2.2 - Interoperability: Enable exchange of health information to support population-oriented uses	4%	$ 419	$ 135	$ 1,801
	2.3 - Adoption: Promote nationwide adoption of technologies to improve population and individual health	2%			$ 1,506
	2.4 - Collaborative Governance: Establish coordinated organizational processes supporting information use for population health	1%	$ 385		

Standards

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 + / - FY 2009
Budget Authority….....	$ 12,279,000	$ 8,500,000	$ 4,500,000	$ -4,000,000
PHS Evaluation Funds….	1,500,000	5,500,000	4,000,000	$ -1,500,000
Total Program Level…….	$ 13,779,000	$ 14,000,000	$ 8,500,000	$ -5,500,000

Note: FY 2010 Budget request does not include Recovery Act funding.

Authorizing Legislation: None
Allocation Method: Contract, Cooperative Agreement

Program Description and Accomplishments

The Standards program addresses the need to identify and harmonize specific standards necessary for information exchange in all aspects of health care and supports the goal of increasing adoption of health IT and specifically the Federal Health IT Strategic Plan goals: 1.1, 1.2, 1.3, 1.4, 2.1, 2.2, and 2.4. Established processes gather priorities from all stakeholders and incorporate them into activities that enable different health IT systems to exchange data. These activities include: harmonization of existing data and technical standards; certification of systems technologies and products that have incorporated these standards; and development of consistent health information exchange organizational policies to enable data sharing and sustainability of these organizations. These processes are key to the advancement of interoperability among systems engaged in health information exchange and the advancement of the widespread adoption of interoperable health information technologies.

In addition, the Federal entities engaged in health care delivery or exchange of health information are incorporating established standards within their IT systems. This effort will ensure that needed health information can easily be exchanged between, for example, Department of Defense and the Department of Veterans Affairs; or the Social Security Administration and a private-sector physician's office both resulting in a quicker claim resolution time.

Requested FY 2010 funds for the Standards Program will support the Health IT Standards Committee (newly established FACA Committee in FY 2009), and development of a governance mechanism for the nationwide health information network – both required by the Recovery Act – as well as support for other Recovery Act-related projects.

The Healthcare Information Technology Standards Panel (HITSP) – established as a multi-stakeholder, consensus-based body in 2006 – has representatives from all aspects of health care who collaboratively select and harmonize standards for health IT. As of June 2008, there were more than 410 member organizations involved and more than 19,000 volunteer hours supported these results. During FY 2008, the HITSP process harmonized 152 standards: 32 for Security,

Privacy and Infrastructure; 106 for Care Management and Health Records; and 14 for Administrative and Financial.

The Certification Commission for Healthcare Information Technology (CCHIT) has worked to develop specific criteria for health IT systems and established a process to evaluate products and systems to determine that they meet the criteria for security, interoperability and functionality. This process may be modified to reflect the language of the Recovery Act. Certification gives confidence to providers and consumers that the electronic health information products and systems being used are secure, can maintain data confidentiality as directed by patients and consumers, can work with other systems to share information, and can perform a set of well-defined functions. Through August 2008, CCHIT certified 53 provider-based ambulatory care electronic health records (EHRs) and 14 inpatient EHRs using this established public-private process. During FY 2009, the CCHIT is developing a certification process for health information networks, EHRs in specialty settings, and specific components of longitudinal personal health records. CCHIT closely coordinates its work with HITSP and the NHIN to integrate standards and specifications necessary for secure, reliable, patient-controlled exchange of health information.

Another important ONC-led activity is the development of organizational policies and practices to enable data sharing and sustainability of health information exchange organizations such as State-level public-private initiatives. Established State-level health information exchange organizations demonstrate that they can effectively engage State governments to reach State goals for quality and cost-effective health care while forging new collaborations for data sharing across regions and among organizations that have traditionally used data for competitive purposes. ONC contracted with the American Health Information Management Association (AHIMA/FORE) to study of State-level health information exchanges. This study, completed in 2008, evaluated the potential for advancing consistent polices to enable multi-jurisdictional exchange. The study also found that State-level health information exchanges serve as an important link for implementing State policy objectives using electronic exchange of health information. For example, health IT could ensure equitable health information access for underserved populations. Resulting recommendations included the need for State governments to formally recognize the State-level entities and authorize them to fully accomplish their unique roles. These reported findings highlight the importance of State-level health information exchanges to the national momentum for improved quality, value, and transparency in healthcare.

HHS is transitioning the collaborative functions for standards carried out through the Secretary's American Health Information Community (AHIC) from 2006 - 2008 – to the Health Information Technology (HIT) Standards Committee. This Federal Advisory Committee Act body was chartered in FY 2009 in response to the HITECH Act, which was passed under the Recovery Act and is a public-private enterprise focused on achieving health information interoperability. The HIT Standards Committee will recommend to the National Coordinator standards, implementation specifications, and certification criteria for the electronic exchange and use of health information for purposes of adoption. ONC staff will continue to actively coordinate across the relevant Federal departments and agencies to ensure that the Federal representation on the HIT Standards Committee is fully engaged and informed to speak on behalf of broad Federal

interests.

As a major stakeholder in the health care industry, there are many Federal efforts utilizing the results of ONC-sponsored work as the government moves to implementing recognized standards and certified products within Federal health care systems. Executive Order 13410, issued on August 22, 2006, requires all Federal agencies ensure that internal programs and external contracts utilize, where possible, recognized interoperability standards. This requirement applies to the implementation, acquisition, and upgrade of health IT systems. The Federal Health Architecture – an ongoing initiative that involves all Federal entities with a health care practice – provides Federal expertise and experience as a coordinated voice, reviewing standards recommendations produced through the HITSP process, and then works with and across agencies toward implementation of these standards. These activities include coordination of Federal participation in health care-related Standard Development Organization activities, communication, and collaboration on National Health IT Standards. The Federal Government also requires all Federal health care delivery systems that support direct patient care to implement recognized standards in new and upgraded health-related technology systems for exchanging information with external systems.

ONC provides subject matter expertise at both the Department and Government-wide levels to help facilitate overall success by monitoring progress towards achieving established goals. This information is derived in part from a quarterly health information survey. Agencies report on the implementation of recognized standards for new and upgraded health IT systems engaged in external health information exchange and aligned with a recognized interoperability specification.

To assess the effectiveness of this effort, ONC developed ambitious targets with which to measure Federal progress toward the goal of increasing the implementation of recognized standards in Federal systems. ONC will gauge progress by utilizing the results of the Health IT survey that reports the number of standards being implemented in Federal systems. ONC will also track the increased implementation of recognized standards in commercial systems as certified by CCHIT.

Funding History

FY 2005	NA	
FY 2006	$	9,480,000
FY 2007	$	10,963,000
FY 2008	$	13,779,000
FY 2009	$	14,000,000

Budget Request

The FY 2010 budget for Standards is $8,500,000. It is a decrease of $5,500,000 under the FY 2009 Omnibus level; however, this base funding will be augmented by funding from the

Recovery Act. The development and implementation of standards in health IT are critical to enabling an interoperable, secure capability for health information exchange. This includes:

- Funding for staff support to the ongoing standards harmonization and certification work that will continue under Recovery Act funding.

- This amount also funds the HIT Standards Committee, a public-private FACA that will provide advise to the National Coordinator with a focus on achieving health information interoperability. Because implementation of health IT is an incredibly complex undertaking, the FACA will solicit and consider input from both the public and private sectors.

- Finally, funding that supports ongoing governance activities will continue. As a requirement in the Recovery Act, the nationwide health information network governance mechanism will continue to be developed and implemented. Additionally, resources will support ongoing State-level health information exchange organizational access, use and control policies, identified as increasingly important to address sustainability of health information exchange.

The FY 2010 Standards budget will fund critical efforts building on the extensive progress already made in the areas of standards harmonization and certification of EHR products, will continue to provide an essential advisory function through the public/private partnership of the HIT Standards Committee, and provide the Federal implementation and coordination needed to further interoperability of health information systems.

ONC underwent a performance review in 2006. At that time, results could not be demonstrated as the office had been established only eight months earlier in August 2005. As a result of the performance review, ONC:

- developed milestones and targets for the annual measures to gauge progress toward the ultimate goal of increased adoption of electronic health records, including an efficiency measure that was added in FY 2008, a measure to monitor progress related to implementation of recognized standards, and one that will measure the increase in electronic exchange of health information through the NHIN;
- led development of the ONC-Coordinated Federal Health IT Strategic Plan: 2008 – 2012, and is working to operationalize and coordinate work to implement the plan;
- is developing additional performance measures that will have outcome-oriented results and show clear links to the program's resources and overall mission;
- developed an operational plan that will incorporate steps needed to achieve the goals outlined in the Strategic Plan; and
- incorporated the Strategic Plan into the ONC performance budget.

Outcomes Table

Long-Term Objective 1: Increase adoption of Electronic Health Records (EHRs)

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.3.5: Increase the implementation of recognized standards in federal and commercial systems.	N/A	Baseline	10% over 2009	+10%
Program Level Funding ($ in millions)	N/A	$ 61	$ 61	$ -
Recovery Act Level Funding ($ in millions)	N/A	$ 2,000	N/A	N/A

Privacy and Security

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 + / - FY 2009
Budget Authority……	$3,897,000	$9,771,000	$5,500,000	-$4,271,000
PHS Evaluation Funds….	$14,250,000	$2,679,000	$5,000,000	+$2,321,000
Total Program Level…….	$18,147,000	$12,450,000	$10,500,000	-$1,950,000

Note: FY 2010 Budget request does not include Recovery Act funding.

Authorizing Legislation: None
Allocation Method: Contract

Program Description and Accomplishments

The Privacy and Security Program provides leadership to Federal, State and local governments and the private sector to ensure that health information is exchanged in a manner that is appropriately confidential, private and secure. These activities support the goal of increasing adoption of health IT and specifically the Federal Health IT Strategic Plan goals: 1.1, 1.2, 1.3, 1.4, 2.1, and 2.2.

Accelerating health IT adoption requires addressing the privacy and security concerns related to electronic health information exchange. Under ONC leadership, significant progress continues through a collaborative process with other Federal agencies supported by the Privacy and Security Program specifically in the areas of HIPAA and regulation development funded under the Recovery Act. Additionally, both the Health Information Security and Privacy Collaboration (HISPC) and the State Alliance for e-Health (State Alliance), which provide the Federal Government the ability to communicate and coordinate with multiple State governments and organizations. These collaborative initiatives address issues that cannot be resolved at the Federal level alone and have direct benefit to U.S. citizens.

During 2009, multi-state collaboration among the 41 HISPC participants resulted in common, replicable solutions to state level privacy and security challenges related to electronic health information exchange. HISPC participants developed educational materials for consumers and providers as well as tools, templates, common policies, and agreements to help advance how their colleagues in other states approach privacy and security. Each HISPC participant adapted, disseminated, and tested the consumer and provider education materials developed during 2008 and improved and updated their prior body of work. An action and implementation manual (AIM) was published to provide states and other stakeholders with a comprehensive but easy to use guide to all of the replicable tools developed by HISPC participants. HISPC participants are endorsed by their State or territorial governor and maintain a steering committee and contact with a range of local stakeholders to ensure that developed solutions accurately reflect local preferences.

The State Alliance for e-Health (State Alliance), initiated in FY 2006, is managed by the National Governors Association Center for Best Practices. The State Alliance is a consensus-based, executive-level body of State elected and appointed officials, formed to address the unique role that States can play in facilitating electronic health information exchange. The State Alliance explored solutions to programmatic and legal issues and released its first report to the States in fall 2008. This report included recommendations and strategies about:

1. providing leadership and support to e-health efforts,
2. addressing health information privacy and security,
3. promoting the use and adoption of standards-based, interoperable technology,
4. streamlining the licensure process to enable cross-state e-health,
5. engaging consumers to use health IT and health information exchange in managing their health and health care, and
6. developing workforce and agency capacity to support electronic health information exchange efforts.

The report is intended to spur continued innovation in States to make the vision of an interconnected, efficient, quality-based health care system a reality for all Americans. It calls on States to act in a collaborative fashion, to make the needed reform happen. The report will be provided to every Governor's office for information and implementation of relevant solutions.

In addition, since 2006, ONC has led the Interagency Health Information Technology Policy Council, which involves representation from across the Federal Government. Through this group, more than 20 Federal departments and agencies regularly interact and exchange information about Federal health IT activities and examine collaborative approaches to implementing health IT policy priorities. Interest in participating in this group continues to grow with the newest members representing the Office of Minority Health, the Department of State and the Bureau of Prisons.

As an identified priority for the office, ONC continues to provide leadership in areas related to privacy and security in electronic health information exchange. Through the activities described above, much progress has been made. In addition ONC awarded a contract in 2008 through available Health Care Fraud and Abuse Control (HCFAC) funding, to develop a knowledge base and a roadmap for health IT and health information exchange actions to help prevent, detect, and remedy medical identity theft in the U.S. In FY 2010, plans are to continue to develop more detailed best practices, tools, training, and outreach mechanisms that could be built into existing health IT initiatives.

Funding History

FY 2005	NA
FY 2006	$13,921,000
FY 2007	$10,568,000
FY 2008	$18,147,000
FY 2009	$12,450,000

Budget Overview and Supported Activities

The FY 2010 budget for Privacy and Security is $10,500,000; a decrease of $1,950,000 under the FY 2009 Omnibus level, however, this base funding will be augmented by funding from the Recovery Act. This level of support includes support for the Recovery Act-required Chief Privacy Officer who will advise the National Coordinator on privacy, security, and data stewardship of electronic health information and coordinate with other Federal agencies (and similar privacy officers in such agencies), with State and regional efforts, and with foreign countries with regard to the privacy, security, and data stewardship of electronic individually identifiable health information. These funds are also critical to continue the contracted support of the implementation of regional, State and multi-State solutions to identified barriers to exchange of electronic health information and, where appropriate, align State and health information exchange efforts with the work of the NHIN.

Architecture and Adoption

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 + / - FY 2009
Budget Authority...……..	$16,035,000	$12,311,000	$13,239,000	+$928,000
PHS Evaluation Funds…	$3,150,000	$9,500,000	$10,011,000	+$511,000
Total Program Level……	$19,185,000	$21,811,000	$23,250,000	+$1,439,000

Note: FY 2010 Budget request does not include Recovery Act funding.

Authorizing Legislation: None
Allocation Method: Contract, Cooperative Agreement

Program Description and Accomplishments

Architecture and Adoption provide coordination and leadership for activities that are moving toward a nationwide solution that supports the creation, use, and exchange of reliable and secure electronic health information. The program aims to better coordinate care among providers; engage individuals in their own health maintenance and management; and meet the needs of research, public health, biomedical research, quality improvement, and emergency preparedness including other related community and population health efforts. These activities support the goal of increasing adoption of health IT and specifically the Federal Health IT Strategic Plan goals: 1.1, 1.2, 1.3, 1.4, 2.2, and 2.3. ONC is focusing on a number of non-technical barriers to and enablers of adoption while developing and demonstrating an information technology architecture that will allow interoperable exchange of electronic health information.

Architecture

One of the goals of ONC is that health care providers can interconnect using health IT to better coordinate care through secure and reliable exchange of health information. Building on the work of the Standards Program and Privacy and Security Program, ONC has led activities to establish a minimum set of information exchange standards that can be adopted by any entity engaged in exchanging electronic health information. This minimal set of standards and services is the architectural basis of the Nationwide Health Information Network (NHIN). Entities that use this architecture of standards and services will be able to exchange health information with other entities that also use them.

In September 2008, multiple entities successfully demonstrated the NHIN architecture of standards and services for health information exchange. This demonstration validated that existing technologies can be leveraged to allow interoperability among organizations that had previously created distinct and separate ways of exchanging data within each organization or had not previously had capacity to exchange information with others.

The NHIN has evolved through the following steps:

- In FY 2006, four contracts were awarded to develop prototype IT 'blueprints' or architectures with functional requirements, as well as security and business models for health information exchange. Each of the contracts required the ability to exchange data among three types of health care markets. Through public discussion, basic requirements were developed that defined the functions needed in the NHIN including the necessity to ensure security and protect confidentiality of data, and consideration of the implications on policy and practicality of implementation.
- In FY 2007 and FY 2008, the NHIN Cooperative was formed through a combination of contracts and cooperative agreements with 15 health information exchange organizations to use, as a starting point, the prototype architecture developed in 2006. The Cooperative's purpose is to develop and implement the data and technical standards and specifications necessary to advance the NHIN. It also includes a Federal presence involving the Indian Health Service, Social Security Administration, Centers for Disease Control and Prevention, National Cancer Institute, Department of Defense, and Department of Veterans Affairs. The Cooperative includes public and private health information exchange organizations across the country that already have the capability to move health-related data among entities within a State, a region or a non-geographic participant group and, through implementation of data and technical specifications, will now be able to exchange data among the entities that make up the Cooperative.
- In September and December 2008, the Cooperative successfully demonstrated, in public meetings, interoperable and secure health information exchange based on common specifications: 1) delivery of data across the involved health information exchanges that include a summary patient record; 2) the ability to look up and retrieve data across the exchanges from EHRs and personal health records; 3) the ability for consumers to decide whether they want to participate in electronic exchange of their data and to whom they want to give access; and 4) supporting the delivery of data for population health uses, such as emergency response.
- Also during 2008, specific scenarios were added to the existing successful demonstrations, included one coordinated with and supported by contracts issued by the Centers for Disease Control and Prevention (CDC). These sites demonstrated information exchange in specific areas, such as reporting laboratory test result data to the clinician who ordered the test through secure data delivery, while limiting access to only the appropriate health care provider, and notifying the recipient of the information's availability. Other priority areas to demonstrate information exchange include: medication management, emergency responder EHRs, biosurveillance (with CDC funding), consumer registration and medication history, consumer access to clinical information, and quality information data exchange.

Adoption

ONC is also focusing on the non-technical issues related to adoption of interoperable EHRs. A number of activities have been undertaken to increase adoption. An annual survey to measure EHR adoption in inpatient care or hospital setting are in place and results will be reported in

2011. A demonstration pilot was developed and launched to measure and demonstrate the value of utilizing secure messaging between a clinician and patient. These pilots were implemented, and results will assess the effect of different forms of reimbursement for clinician's time and expertise on patient care and outcomes.

As instructed in the Recovery Act, ONC has established the Health IT Policy Committee, a FACA Committee, to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure, including implementation of the Federal Health IT Strategic Plan.

ONC also engages the private sector to encourage innovative practices related to health IT adoption. Examples include: working with malpractice insurers to offer credits toward malpractice premiums for use of certified EHRs; collaborating with local medical societies and others in their efforts to purchase and implement certified EHRs; engaging local commercial health insurers when developing secure messaging pilots; and working with the community of the disabled in developing a personal health record focused on the unique needs of this population.

Through three performance measures (1.3.1, 1.3.2 and 1.3.4 in the Outcomes Table), ONC monitors its progress on adoption of interoperable EHRs. Specific measures were established through a FY 2006 performance review process with baselines and goals set in 2007.

The preliminary results of the 2008 outpatient adoption survey indicate that 21 percent of physicians have adopted minimally functional EHRs. While this is lower than the anticipated rate of 24 percent in 2008, it does represent an increase over the prior year result of 14 percent. Data for this measure is derived from a survey conducted annually by CDC of a randomized sample of ambulatory care providers. CDC has conducted the National Ambulatory Medical Care (NAMC) Survey for over 20 years; however, prior to 2008, the sample size was too small to meet ONC's needs to interpret these findings to the Nation. In 2007, ONC conducted its own survey while working with CDC to expand its sample size for the NAMC Survey such that in 2008 and moving forward, the results from this survey could be used to calculate physician adoption of EHRs.

In 2009, ONC contracted with the American Hospital Association to conduct a survey for measuring health IT adoption in the hospital setting. Results of this survey expect to be published in 2009. The collection of this data will enable ONC to begin reporting a national rate of hospital adoption of EHRs.

An efficiency measure (1.3.7 in the Outcomes Table) provides information about the cost of adopting certified EHRs. This efficiency measure was established with targets in FY 2008. This measure indicates the per physician cost by dividing the costs of certification by the number of physicians who are adopting certified EHRs as reported through the annual adoption survey. The information could inform the adoption rate results as the cost of adoption has been identified as one of the barriers that need to be addressed.

The demonstration projects to validate and measure the value of secure messaging in two geographically distributed areas will yield at least one year's worth of data in 2009, resulting in methodologically sound information with respect to outcome assessment and value demonstration. Data generated will be analyzed with a report published in 2009. This report will inform areas in policy and aspects of the NHIN that would require modification to increase the potential for physician adoption of EHRs.

Federal entities are collaborating with ONC to further the goal of advancing and adopting interoperable EHRs and health information exchange. Some examples include:

- ONC is collaborating with CMS to define 'meaningful use' of an EHR. This work, funded by the Recovery Act, will inform the incentives program for health IT adoption that will be conducted by CMS.
- Leading the work of the Federal Health Architecture Program, ONC has management responsibility for this initiative that involves representation from across the Federal Government of all organizations that engage in health care activities. Through this group, a collaborative Federal voice informs the development of the NHIN from the government's perspective and provides a venue for implementing and deploying a Federal version of the architecture that will allow data exchange with all entities across the Nation.
- To further the adoption of health IT, the CMS budget includes funding for a demonstration project providing financial incentives for physician practices to adopt certified EHR systems to improve the quality and efficiency of services.
- The Internal Revenue Service, after working closely with ONC, provided guidance to non-profit hospitals and other institutions that their non-profit status would not be threatened when exercising Stark Amendment and Anti-Kickback relief.
- ONC is coordinating closely with the Agency for Healthcare Research and Quality (AHRQ) to leverage contracts that support the establishment of health information exchange organizations and to document the benefits of EHRs on health care quality and efficiency.

Funding History

FY 2005	NA
FY 2006	$29,500,000
FY 2007	$29,465,000
FY 2008	$19,185,000
FY 2009	$21,811,000

Budget Overview and Supported Activities

The FY 2010 budget for Architecture and Adoption is $23,250,000; an increase of $1,439,000 under the FY 2009 Omnibus level; in addition, this base funding will be augmented by funding from the Recovery Act This amount includes:

- Funding to provide staff support to ongoing activities related to the NHIN.
- Through a Memorandum of Understanding, the Centers for Disease Control and Prevention (CDC) will continue surveying physicians to measure the adoption rate of EHRs in physician offices. Continuation of contracted analyses of hospital adoption rates through established surveys.
- Funding to support the activities of the Health IT Policy Committee as a FACA.
- Funding in support of policy development, other than for privacy and security.

Outcomes Table

Long-Term Objective 1: Increase adoption of Electronic Health Records (EHRs)

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.3.2: Increase physician adoption of EHRs	FY 2008: 21% (Target Unmet, but Improved)	30%	30%	0%
1.3.3: Increase the percentage of small practices with EHRs	FY 2008: 13% (Target Exceeded)	11%	12%	+1%
1.3.4: Percent of physician offices adopting ambulatory EHRs in the past 12 months that meet certification criteria	FY 2007: 27% Baseline	30%	35%	+5%
1.3.6A: Increase over the prior year in the number of Nationwide Health Information Exchanges (NHIEs) using Nationwide Health Information Network (NHIN) components to exchange health information.	N/A	Baseline	50% increase over 2009	+50%
1.3.6B: The increase in the number of records exchanged among Nationwide Health Information Exchanges (NHIEs) using the Nationwide Health Information Network Components (NHIN) to exchange information.	N/A	Baseline	10% increase over baseline	+10%
1.3.7: Cost per physician for adopting certified EHRs	FY 2008: $285 (Target Unmet, but Improved)	$270	$230	-$40

Program Level Funding ($ in millions)	N/A	$ 61	$ 61	$ -
Recovery Act Level Funding ($ in millions)	N/A	$ 2,000	N/A	N/A

These measures will likely be modified with new baselines established for adoption once the key terms in the Recovery Act are defined.

Operations

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 + / - FY 2009
Budget Authority……	$9,450,000	$12,970,000	$19,092,000	+$6,122,000
PHS Evaluation Funds…..	0	0	0	0
Total Program Level……..	$9,450,000	$12,970,000	$19,092,000	+$6,122,000
FTE…… ……..	30	31	65	34

Note: FY 2010 Budget request does not include Recovery Act funding.

Authorizing Legislation: None
Allocation Method: Contract

Program Description and Accomplishments

ONC operates as a Staff Division within the Office of the Secretary and provides continuing leadership for the development and nationwide implementation of interoperable health IT to improve the quality and efficiency of health care. This includes increased responsibilities as a result of the Recovery Act for program evaluation and reporting. In addition, it will provide the funding necessary to cover the costs of facilities, including rental increases, communications, acquisition of assets, and a small number of Memoranda of Understanding, Inter-Agency Agreements and contracts supporting ONC administrative, financial, logistical and planning activities.

Funding History

FY 2005	NA
FY 2006	$8,799,000
FY 2007	$10,306,000
FY 2008	$9,450,000
FY 2009	$12,970,000

Budget Overview and Supported Activities

The FY 2010 budget for Operations is $19,092,000 to fund increased service levels. It is an increase of $6,122,000 above the FY 2009 Omnibus level. The increase in funding for Operations reflects increased rent and infrastructure costs associated with ONC's responsibilities and staffing needs to efficiently and effectively support the Recovery Act requirements and manage the Recovery Act's $2 billion investment in health IT. The Recovery Act allows for up to $5 million for administrative support for Recovery Act activities. The FY 2010 Budget level of funding will allow ONC to support and manage its programs toward achievement of the

national health IT agenda, while maintaining basic office operations at a minimal level, and will allow ONC to prudently oversee and coordinate ongoing programs and Recovery Act activities.

Public Health Service Act Evaluation Funds

ONC's program level budget includes $19,011,000 of Public Health Service (PHS) Act Evaluation Funds. It is an increase of $1,332,000 above the FY 2009 Omnibus level. These funds will support the demonstration and evaluation activities described in the budget narrative discussions. These programs include Standards, Privacy and Security, and Architecture and Adoption.

Supplementary Tables

Office of the National Coordinator for Health Information Technology

Budget Authority by Object

	2009 Estimate	2010 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1).....	4,324,000	7,111,000	2,787,000
Other than full-time permanent (11.3).....	-	-	-
Other personnel compensation (11.5).....	-	-	-
Military personnel (11.7).....	112,000	350,000	238,000
Special personnel services payments (11.8).....	-	-	-
Subtotal personnel compensation.....	**4,436,000**	**7,461,000**	**3,025,000**
Civilian benefits (12.1).....	1,031,000	1,707,000	676,000
Military benefits (12.2).....	31,000	120,000	89,000
Benefits to former personnel (13.0).....	-	-	-
Total Pay Costs.....	**5,498,000**	**9,288,000**	**3,790,000**
Travel and transportation of persons (21.0).....	150,000	450,000	300,000
Transportation of things (22.0).....	-	-	-
Rental payments to GSA (23.1).....	2,400,000	4,800,000	2,400,000
Communication, utilities, and misc. charges (23.3)...	-	-	-
Printing and reproduction (24.0).....	80,000	200,000	120,000
Other Contractual Services:			
Advisory and assistance services (25.1).....	4,375,000	7,824,000	3,449,000
Other services (25.2).....	38,214,000	31,271,000	(6,943,000)

Purchase of goods and services from government accounts (25.3).....	10,409,000	7,394,000	(3,015,000)
Operation and maintenance of facilities (25.4).....	50,000	50,000	-
Research and Development Contracts (25.5).....	-	-	-
Medical care (25.6).....	-	-	-
Operation and maintenance of equipment (25.7)...	-	-	-
Subsistence and support of persons (25.8).....	-	-	-
Subtotal Other Contractual Services.....	**53,048,000**	**46,539,000**	**(6,509,000)**
Supplies and materials (26.0).....	15,000	15,000	-
Equipment (31.0).....	40,000	50,000	10,000
Land and Structures (32.0)	-	-	-
Investments and Loans (33.0).....	-	-	-
Grants, subsidies, and contributions (41.0).....	-	-	-
Interest and dividends (43.0).....	-	-	-
Refunds (44.0).....	-	-	-
Total Non-Pay Costs.....	**55,733,000**	**52,054,000**	**(3,679,000)**
Total Budget Authority by Object Class.....	**61,231,000**	**61,342,000**	**111,000**

Office of the National Coordinator for Health Information Technology

Salaries and Expenses

	2009 Estimate	2010 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1).....	4,324,000	7,111,000	2,787,000
Other than full-time permanent (11.3).....	-	-	-
Other personnel compensation (11.5).....	-	-	-
Military personnel (11.7).....	112,000	350,000	238,000
Special personnel services payments (11.8).....			
Subtotal personnel compensation.....	**4,436,000**	**7,461,000**	**3,025,000**
Civilian benefits (12.1).....	1,031,000	1,707,000	676,000
Military benefits (12.2).....	31,000	120,000	89,000
Benefits to former personnel (13.0).....			
Total Pay Costs.....	**5,498,000**	**9,288,000**	**3,790,000**
Travel and transportation of persons (21.0).....	150,000	450,000	300,000
Transportation of things (22.0).....	-	-	-
Rental payments to Others GSA (23.2).....	2,400,000	4,800,000	2,400,000
Communication, utilities, and misc. charges (23.3).....	-	-	-
Printing and reproduction (24.0).....	80,000	200,000	120,000
Other Contractual Services:			
Advisory and assistance services (25.1).....	4,375,000	7,824,000	3,449,000
Other services (25.2).....	38,214,000	31,271,000	(6,943,000)
Purchase of goods and services from			

government accounts (25.3).....	10,409,000	7,394,000	(3,015,000)
Operation and maintenance of facilities (25.4).....	50,000	50,000	-
Research and Development Contracts (25.5).....	-	-	-
Medical care (25.6).....	-	-	-
Operation and maintenance of equipment (25.7).....	-	-	-
Subsistence and support of persons (25.8).....	-	-	-
Subtotal Other Contractual Services.....	**53,048,000**	**46,539,000**	**(6,509,000)**
Supplies and materials (26.0).....	15,000	15,000	-
Total Non-Pay Costs.....	**55,693,000**	**52,004,000**	**(3,689,000)**
Total Salary and Expense.....	**61,191,000**	**61,292,000**	**101,000**
Direct FTE.....	31	65	34

Office of the National Coordinator for Health Information Technology

Detail of Full Time Equivalents (FTE)

	2008 Actual Civilian	2008 Actual Military	2008 Actual Total	2009 Est. Civilian	2009 Est. Military	2009 Est. Total	2010 Est. Civilian	2010 Est. Military	2010 Est. Total
Health Information Technology.									
ONC FTE Total.....	29	1	30	30	1	31	63	2	65

Increase of 35 FTE in 2010 due to addition of permanent and term staff to support Recovery Act activities.

Average GS Grade

FY 2005.....	N/A
FY 2006.....	12.9
FY 2007.....	12.8
FY 2008.....	13.2
FY 2009.....	13.8

Office of the National Coordinator for Health Information Technology

Detail of Positions

	2008 Actual	2009 Estimate	2010 Estimate
	$	$	$
SES.....	876,340	1,090,000	1,432,000
Total - SES Salary	876,340	1,090,000	1,432,000
GS-15.....	1,319,771	1,683,000	2,006,200
GS-14.....	420,312	1,051,000	1,332,000
GS-13.....	528,764	386,000	1,470,780
GS-12.....	68,315	81,000	800,020
GS-11.....			
GS-10.....			
GS-9.....	204,516	145,000	420,000
GS-8.....			
GS-7.....			
GS-6.....			
GS-5.....			
GS-4.....			
GS-3.....			
GS-2.....			
GS-1.....			
Total - GS Salary	2,541,678	3,346,000	6,029,000

Average ES level			
Average SES salary.....	$ 175,268	$ 207,703	$ 179,000
Average GS grade.....	13.2	13.8	11.5
Average GS salary.....	$ 84,723	$ 115,379	$ 105,772
Average CO salary	$ 108,132	$ 112,000	$ 175,000

Programs Proposed for Elimination

No ONC programs are proposed for elimination.

Significant Items in Appropriations Committee Reports

FY 2009 CONGRESSIONAL JUSTIFICATION HOUSE REPORT (H. Rpt 110-XXX, 221) (June 26, 2008)

Item (page 221)
Last year, the Committee also requested that ONC develop a privacy and security framework in order to establish trust among consumers and users of electronic personal health information. The Committee understands that such a framework will be produced sometime in calendar year 2008. The Committee continues to emphasize the, importance of this framework, particularly given recent disturbing breaches of patient privacy in NIH and Department of Veterans Affairs clinical trial records.

Action taken or to be taken
ONC understands the importance of ensuring privacy and security of electronic health information in health IT and continues to maintain these efforts as a priority. The privacy and security framework was drafted and published in 2008. This framework will be reviewed and the existing principles and tool kits modified as appropriate. With Recovery Act funding, ONC will focus its activities in 2009 on further developing guidance for implementing the revised principles, enhancing the tools kit and developing privacy and security policy consistent with the framework. All of these activities will involve obtaining both public and private stakeholder input.

Recovery Act and H.R. 1105 (March 2009)

Item (page 117)
HIT Policy Coordination — The National Coordinator shall coordinate health information technology policy and programs of the Department with those of other relevant executive branch agencies with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability and in a manner towards a coordinated national goal.

Action taken or to be taken
ONC has a number of ongoing programs that coordinate health IT activities across the government. In the area of Federal health IT policy, the Health Information Technology Policy Council includes representatives from across the government who share and discuss ongoing developments and how to better coordinate health IT policy. This group meets regularly and involves 24 agency representatives. In addition, the Federal Health Architecture program brings together technical federal staff who are involved with implementing interoperable health IT across the government. This group has representatives from more than 20 federal entities and meets regularly to discuss standards, implementation guidelines, concerns and developments in health IT. FHA's priorities are driven by Federal agency value propositions related to identifying business needs for secure, interoperable health information exchanges, architecting solutions, planning health IT investments, developing and implementing solutions, and measuring progress.

Item (pages 117-118)
Strategic Plan — The National Coordinator shall, in consultation with other appropriate Federal agencies (including the National Institute of Standards and Technology), update the Federal Health IT Strategic Plan (developed as of June 3, 2008) to include specific objectives, milestones, and metrics. The strategic plan shall be updated through collaboration of public and private entities. The strategic plan update shall include measurable outcome goals. The National Coordinator shall republish the strategic plan, including all updates. The National Coordinator shall maintain and frequently update an Internet website on which there is posted information on the work, schedules, reports, recommendations, and other information to ensure transparency in promotion of a nationwide health information technology infrastructure.

Action taken or to be taken
With Recovery Act funding, the National Coordinator will revise the current Federal Health IT Strategic Plan in 2009 through a collaborative and inclusive process with the intention of updating the goals, objectives, and milestones. Performance measures will be established to help guide the health IT program with ambitious targets that will monitor progress. This information will be widely broadcast utilizing a variety of communications vehicles such as an internet Web site, e-mail; and print with the goal of transparency and public education.

Item (page 118)
"The National Coordinator, in consultation with the Director of the National Institute of Standards and Technology, shall keep or recognize a program or programs for the voluntary certification of health information technology as being in compliance with applicable certification criteria adopted under this subtitle. Such program shall include, as appropriate, testing of the technology in accordance with section 13201(b) of the Health Information Technology for Economic and Clinical Health Act."

Action taken or to be taken
ONC is meeting with NIST staff to outline and coordinate the work efforts that will facilitate certification of health IT products. A memorandum of understanding will be completed by June 2009 between ONC and NIST and will detail the work to be done and the milestones to reach those goals.

Item (page 118)
Implementation Report - The National Coordinator shall prepare a report that identifies lessons learned from major public and private health care systems in their implementation of health information technology, including information on whether the technologies and practices developed by such systems may be applicable to and usable in whole or in part by other health care providers.

Action taken or to be taken

With Recovery Act funding, ONC plans to conduct a study that will inform a report identifying the lessons learned in major health care systems as they implement health IT. This report will be published in 2010.

Item (page 119)
Evaluation of Benefits and Costs of the Electronic Use and Exchange of Health Information - The National Coordinator shall evaluate and publish evidence on the benefits and costs of the electronic use and exchange of health information and assess to whom these benefits and costs accrue.

Action taken or to be taken
With Recovery Act funding, ONC plans to conduct a study that will evaluate and publish evidence on the benefits and costs of electronic use and exchange of health information including an assessment of to whom these benefits and costs accrue. Current plans are to publish this report in 2010.

Item (page 119)
Electronic Health Record - The National Coordinator shall estimate and publish resources required annually to reach the goal of utilization of an electronic health record for each person in the United States by 2014, including: (i) the required level of Federal funding; (ii) expectations for regional, State, and private investment; (iii) the expected contributions by volunteers to activities for the utilization of such records; and (iv) the resources needed to establish a health information technology workforce sufficient to support this effort (including education programs in medical informatics and health information management).

Action taken or to be taken
The National Coordinator plans to perform comprehensive assessments of the impact, value, and challenges associated with health IT adoption across a variety of communities by looking at the impact on public health, providers, and patient care. ONC will coordinate this work with other involved federal agencies to ensure that all aspects of health care delivery and health IT adoption are considered. Plans are to fund this work with Recovery Act funding and provide the first assessment in FY 2010.

Item (page 119)
The National Coordinator may provide financial assistance to consumer advocacy groups and not-for-profit entities that work in the public interest for purposes of defraying the cost to such groups and entities to participate under, whether in whole or in part, the National Technology Transfer Act of 1995 (15 U.S.C. 272 note).‘

Action taken or to be taken
The National Coordinator appreciates the ability to provide financial assistance to consumer advocacy groups and not-for-profit entities that work in the public interest and will utilize this

resource under the Recovery Act to ensure that these organizations can participate in activities related to adoption of recognized health IT standards.

Item (page 119)
Governance for Nationwide Health Information Network .— The National Coordinator shall establish a governance mechanism for the nationwide health information network.

Action taken or to be taken
ONC funding will support the development and implementation of a governance mechanism for the nationwide health information network. This work will begin in FY 2009. A well-defined and broadly-shared vision will be developed, as well as effective governance and operating mechanisms to set direction, coordinate activities, manage risks, and ensure widespread participation and continuous improvement.

Item (page 122)
The National Coordinator shall take a leading position in the establishment and operations of the HIT Policy Committee.

Action taken or to be taken
Plans are well under way in FY 2009 to establish the Health IT Policy Committee as a FACA under ONC. The National Coordinator is leading the development of the charter and coordinating the membership activities of the committee. The first meeting is planned for May 2009.

Item (page 123)
HIT Policy Committee - The National Coordinator shall ensure that the relevant and available recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of policies and standards.

Action taken or to be taken
The National Coordinator appreciates the input and recommendations that the National Committee on Vital and Health Statistics (NCVHS) provides, further informing health IT-related activities. NCVHS will be consulted as policies and standards are developed and ONC will participate in NCVHS hearings and activities.

Item (page 132/133)
Funding to Strengthen the HIT Infrastructure - The Secretary shall, using amounts appropriated under section 3018, invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information for each individual in the United States consistent with the goals outlined in the strategic plan developed by the National Coordinator (and as available) under section 3001. The Secretary shall invest funds through the different agencies with expertise in such goals, such as ONCHIT, HRSA, AHRQ, CMS, CDC, and IHS as follows: (1)

Health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner, including connecting health information exchanges, and which may include updating and implementing the infrastructure necessary within different agencies of the DHHS to support the electronic use and exchange of health information. (2) Development and adoption of appropriate certified electronic health records for categories of health care providers not eligible for support under title XVIII or XIX of the Social Security Act for the adoption of such records. (3) Training on and dissemination of information on best practices to integrate health information technology, including electronic health records, into a provider's delivery of care, consistent with best practices learned from the HIT Research Center developed under section 3012(b), including community health centers receiving assistance under section 330, covered entities under section 340B, and providers participating in one or more of the programs under titles XVIII, XIX, and XXI of the Social Security Act (relating to Medicare, Medicaid, and the SCHIP). (4) Infrastructure and tools for the promotion of telemedicine, including coordination among Federal agencies in the promotion of telemedicine. (5) Promotion of the interoperability of clinical data repositories or registries. (6) Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information. (7) Improvement and expansion of the use of health information technology by public health departments.

Action taken or to be taken

ONC will work with the Secretary to advise on the best use of funds that will be invested in health IT. Coordinating with relevant HHS agencies, the National Coordinator will ensure that all aspects of health IT infrastructure investments will promote the further adoption and use of electronic health information exchange and align with the revised strategic plan.

Item (page 133)

Health Information Technology Extension Program - To assist health care providers to adopt, implement, and effectively use certified EHR technology that allows for the electronic exchange and use of health information, the Secretary, acting through the Office of the National Coordinator, shall establish a health information technology extension program to provide health information technology assistance services to be carried out through the Department of Health and Human Services. The National Coordinator shall consult with other Federal agencies with demonstrated experience and expertise in information technology services, such as the National Institute of Standards and Technology, in developing and implementing this program.

Action taken or to be taken

Establishing a resource for knowledge transfer, training, support and assistance in the adoption and implementation of health IT is a priority for the National Coordinator. By May 18, 2009, ONC plans to publish a draft description of the program for establishing Health IT Regional Extension Centers. The National Coordinator is working with other Federal agencies to finalize the process for grant award.

Item (page 133/134)
Health Information Technology Research Center - (1) The Secretary shall create a HIT Research Center (in this section referred to as the 'Center') to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively utilize health information technology that allows for the electronic exchange and use of information in compliance with standards, implementation specifications, and certification criteria adopted under section 3004. The Secretary shall provide assistance for the creation and support of regional centers (in this subsection referred to as 'regional centers') to provide technical assistance and disseminate best practices and other information learned from the Center to support and accelerate efforts to adopt, implement, and effectively utilize HIT that allows for the electronic exchange and use of information in compliance with standards, implementation specifications, and certification criteria adopted under section 3004. Activities conducted under this subsection shall be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 3001.

Action taken or to be taken
The National Coordinator is working with the Secretary to establish a health IT research center that will work in conjunction with the extension centers to support and accelerate efforts to adopt, implement, and effectively utilize health information technology and support information exchange. The research center (and extension centers) will be created to foster innovative approaches to providing information, training and technical support; facilitate changes in organizations and professional behaviors to support integration of technology into the workflow; to foster a growing cadre of individuals and organizations that extend and sustain transformation of health care delivery. These activities will be consistent with the revised strategic plan.

Recovery Act and H.R. 1105 (March 2009)

Item (page 65/66)
Annual Operating Plans – That funds available under this heading shall become available for obligation only upon submission of an annual operating plan by the Secretary to the Committees on Appropriations of the House of Representatives and the Senate. That the fiscal year 2009 operating plan shall be provided not later than 90 days after enactment of this Act and that subsequent annual operating plans shall be provided not later than November 1 of each year. That these operating plans shall describe how expenditures are aligned with the specific objectives, milestones, and metrics of the Federal Health Information Technology Strategic Plan, including any subsequent updates to the Plan; the allocation of resources within the Department of Health and Human Services and other Federal agencies; and the identification of programs and activities that are supported.

Action taken or to be taken
The National Coordinator has prepared the operating plan for the Secretary's consideration and will submit this plan with the required components no later than May 17, 2009. Because the National Coordinator began in this position in late April 2009, a subsequent addition to the original submission will be provided in July 2009 outlining further FY 2009 plans.

Item (page 66)
Obligation and Expenditure –That the Secretary shall provide to the Committees on Appropriations of the House of Representatives and the Senate a report on the actual obligations, expenditures, and unobligated balances for each major set of activities not later than November 1, 2009, and every 6 months thereafter as long as funding provided under this heading is available for obligation or expenditure.

Action taken or to be taken
The National Coordinator will provide an annual report on the actual obligations, expenditures and unobligated balances for each major set of activities no later than November 1, 2009 and every six months thereafter outlining the use of Recovery Act funds.

Federal Health Architecture Program

The Federal Health Architecture (FHA) is a partnership among Federal agencies, the Office of the National Coordinator for Health IT (ONC), and the Office of Management Budget (OMB). The Department of Health and Human Services (HHS) is the Managing Partner; together with the Department of Defense (DoD) and the Department of Veterans Affairs (VA) serving as Lead Partners. The Lead Partners provide program funding. In addition, approximately 20 agencies, all with health-related responsibilities, contribute time and expertise to participate in specific FHA activities. These agencies collaborate to advance health information interoperability between Federal agencies and tribal, state, and local governments and the private sector.

FHA was initiated in July 2003 and is governed by principles that focus on achieving the vision of interoperable health information in support of the agency business priorities, Federal mandates and the national Health Information Technology (HIT) agenda to enable better care, increase efficiency and improve population health. FHA's priorities are driven by federal agency value propositions related to identifying needs for secure, interoperable health information exchanges, architecting solutions, planning HIT investments, developing and implementing solutions, and measuring progress. These activities support the requirements of the HITECH Act to develop an HIT architecture. FHA demonstrates the value of each task or activity and ensures that every undertaking is stakeholder-driven. This ensures alignment of FHA objectives, deliverables and timeframes to agency priorities and mandates.

In FY 2009, FHA carried out the operational activities to realize its 2007 strategy and goals of five initiatives and further refined initiative goals to support federal agency priorities.

1) CONNECT is a software solution that organizations can use to securely link their existing health IT systems into the Nationwide Health Information Network (NHIN). More than 20 federal agencies collaborated to build CONNECT through the FHA. The CONNECT solution enables secure and interoperable electronic health information exchanges with other NHIN-participating organizations, including federal agencies, state, tribal and local-level health organizations, and healthcare participants in the private sector. The NHIN will ultimately be a network of public and private-sector organizations securely sharing information with each other under clearly defined specifications, agreements and policies. CONNECT was jointly developed with the Lead Partners and used during nationwide health information exchange (NHIN) demonstration projects in September and December, 2008 by Department of Defense (DoD), Department of Veterans Affairs (VA), Social Security Administration (SSA), Center for Disease Control and Prevention (CDC), Indian Health Service (IHS) and National Cancer Institute (NCI). The health information exchange solution (CONNECT) was advanced into limited production by SSA and Med-Virginia (a private sector health information exchange organization) in late February, 2009, and released as publicly available, open-source software early April, 2009.

2) Federal Adoption of Standards for Health IT (FAST) evolved into the Federal Health Information Technology Standards Organization Participation (FHITSOP) to provide a

working environment from which the one voice to represent the federal perspective to Standards Development Organizations (SDO) could be developed.

3) Federal Health IT Planning and Reporting (FHIPR) created an investment guide and reporting capabilities together with support in work groups that assured successful investments and outcome measurements for the OMB scorecard activities for participating agencies. The guide and reporting capabilities reached the goal of providing support and guidance for health information exchange-specific investments to agencies for the purposes of planning investments and reporting outcomes.

4) Federal Health Interoperability Sharing Environment (FHISE) is a knowledge base and tool set that provides information to help guide program managers and enterprise architects in identifying, creating, and/or implementing products that have been created and made available by others while carrying out the national health IT agenda. This knowledgebase and end user tools is in its prototype phase and is scheduled for release and wide distribution the end of May, 2009.

5) Federal Security Strategy (FSS) has produced a document that helps federal agencies, state, local, and tribal governments as well as private entities, identify the Federal Information Security Management (FISMA) and Health Insurance Portability and Accountability Act (HIPAA) implementation considerations for nationwide health information sharing. Additional project planning is underway to support federal agencies in working together to achieve a policy that supports their security missions as they relate to health information exchanges.

These initiatives provide for information dissemination and support and guidance across federal agencies. Each of the initiatives is designed to support the President's health information technology initiative.

Schedule risk is managed throughout the entire lifecycle of each initiative for the program. FHA has a risk mitigation plan that is available upon request. In addition, FHA has developed an operational plan that outlines the following years' deliverables as well as a strategic plan for adjusting the direction of the program as a whole when needed. The identified tasks have been prioritized by the FHA Leadership Council. As part of the operational planning efforts, project charters, project plans, and project cost estimates are developed for tracking purposes. Changes in scope undergo an impact analysis including cost and appropriateness by the Leadership Council prior to moving forward.

FHA is incrementally funded, which allows for discussions to occur with existing funding partners, as well as opportunity to seek out additional partners to secure future funding if required and approved. FHA is not building a health information exchange system but rather helping to architect solutions. The operations and maintenance costs for the program are less than might be expected for such a large undertaking and these costs will be absorbed by the participating agencies. FHA partners reevaluate the lifecycle costs yearly during strategy planning to identify the next year's work plan.

Federal Health Architecture Program Funding

	2008 Actual	2009 Estimate	2010 Estimate
Health & Human Services	$ 3,522,000	$ 3,662,000	$ 3,808,000
Veterans Affairs	1,861,000	1,936,000	2,013,000
Defense	1,861,000	1,936,000	2,013,000
Total Funding Contributed	$ 7,244,000	$ 7,534,000	$ 7,834,000

PREVENTION AND WELLNESS FUND

	FY 2008 Appropriations	FY 2009 Omnibus	FY 2009 Recovery Act	FY 2010 President's Budget	FY 2010 +/- FY 2009
BA	$0	$0	$700	$0	$0
FTE	0	0	21	21	0

Authorizing Legislation…American Recovery and Reinvestment Act of 2009, PL 111-5 (2009).

Program Description and Accomplishments

The American Recovery and Reinvestment Act (Recovery Act), in the Prevention and Wellness Fund, appropriated $700 million to the Department of Health and Human Services (HHS), Office of the Secretary. Of this amount, the Recovery Act directed $50 million to provide to States to execute activities to implement healthcare-associated infections reduction strategies. The Recovery Act directed the remaining $650 million for evidence-based clinical and community-based prevention and wellness strategies that address chronic disease rates.

Healthcare-Associated Infections (HAI): $50 million

To execute the Recovery Act's healthcare-associated infections activity, HHS transferred $40 million to the Centers for Disease Control and Prevention (CDC) and $10 million to Centers for Medicare & Medicaid Services (CMS). CDC's and CMS's activities are aligned to the HHS Action Plan to Prevent HAIs and supported by the HHS Steering Committee for the Prevention of Healthcare-Associated Infections.

- CDC is using the $40 million to support State health department efforts to prevent HAIs by leveraging the National Health Care Safety Network to support the dissemination of HHS evidence-based practices within hospitals.
- CMS is using the $10 million to work with States to expand the State Survey Agency inspection capability of Ambulatory Surgery Centers nationwide.

Evidence-Based Clinical and Community-Based Prevention and Wellness Strategies: $650 million

HHS's implementation of this activity for evidence-based clinical and community-based prevention and wellness strategies is to deliver specific, measurable health outcomes addressing chronic disease rates. HHS agencies are collaborating with communities and States, territories, and Tribes to advance public health across the lifespan and to eliminate health disparities. The goal of this activity is to reduce risk factors and prevent or delay chronic disease, promote wellness, and better manage chronic conditions. HHS is working with communities and States to provide support and tools to strengthen and develop effective strategies and community interventions tailored to their needs.

Funding History

FY 2009 $700 million

Budget Request

There is no FY 2010 funding request for this activity.

Service and Supply Fund

HHS SERVICE AND SUPPLY FUND

	FY 2008 Actual	FY 2009 Board Approved	FY 2010 Board Approved	FY 2010 +/- FY 2009
Budget Authority	$758,897,000	$838,792,000	*$837,971,000	-$821,000
FTE	1218	1376	1376	-

Authorizing Legislation: 42 U.S.C. 231
2010 Authorization……..……Indefinite
Allocation Method ……Contract, Other
* Additional details on the 2010 SSF Board approved budget are found in the narrative.

Statement of the Budget

The FY 2010 budget for the Service and Supply Fund (SSF) is $837,971,000, a decrease of $821,000 from the FY 2009 SSF Board-approved level of $838,792,000 (both fiscal year budgets approved October 20, 2008). The overall decrease in the budget from FY 2009 to FY 2010 is primarily a reflection of revenue for FY 2010 SSF rates for Homeland Security Presidential Directive 12 (HSPD-12) operations that are still pending approval by the SSF Board. Until these rates are officially approved by the Board, they cannot be included in the budget. The FY 2010 budget presented above reflects the approved budget and does not include a request for approximately $7,499,000 for HSPD-12.

The FY 2010 Budget reflects a new SSF Activity and Cost Center, both approved by the SSF Board on October 20, 2008. At this meeting, the Board approved the addition of a “Web Policy Tester/Web Crawler” cost center to the Web Communications Division, starting in FY 2009. The Board also approved the addition of the Homeland Security Presidential Directive 12 (HSPD-12) as a new SSF program activity and cost center within the Office of Security and Strategic Information (OSSI). Additional information about these two new additions to the Fund is detailed in the “Program Description” section of this document. Rates for HSPD-12 are approved for FY 2009, but, as stated above, FY 2010 rates are still pending approval.

The Program Support Center’s (PSC) budget request for FY 2010 is $800,220,000, which is an increase of $5,313,000 above the FY 2009 budget request of $794,907,000. This budget includes modest increases to allow PSC to pay for upgrades to the UFMS accounting system, contract costs for HR activities and to pay for increased payroll processing charges. Most PSC activities will provide their services at the same rates and budget levels as in FY 2009.

Overall, the approved revenue for longstanding Non-PSC SSF activities has remained level, with

two exceptions. The Board approved a small increase ($216,000) for the Departmental Contracts Information System (DCIS) program activity for FY 2010 due to the need to award a contract that will allow the program activity to comply with Public Laws 93-400 and 109-282, also known as the "Transparency Act." In 2010, HHS will competitively contract for the OMB/OFPP required independent, statistically valid (IV & V) certification of data. Also, a modest increase to the budget for the Web Communications Division (approximately $300,000) was approved due to the addition of a new Web Crawler cost center within that activity. Additional details on this new cost center can be found in that activity narrative, below.

In FY 2007, both Enterprise Email and Information Technology (ITO) were Non-PSC SSF activities. In FY 2008, Information Technology (ITO) moved to the PSC side of the Fund, while Enterprise Email remained a part of the Non-PSC set of activities. In FY 2009, Enterprise Email will again be managed and operated as a component of Information Technology (ITO) within the PSC, and budget information for this activity is being reported separately as part of the PSC's FY 2010 SSF activity budget. For FY 2010, there is not a separate discussion of Enterprise Email as it is no longer a stand alone activity within the Fund.

Additionally, some PSC services were restructured during FY 2009 and related budget activity within the PSC has been realigned. Some rates now reside under different activities, but the underlying rate structure has not changed. One result is that the Enterprise Support Service was renamed the Information Systems Management Service (ISMS) during this realignment, and Business Technology Optimization (BTO) was subsumed under ISMS. The descriptions of PSC activities in the activity narrative section below provide more information on these changes at the PSC.

Program Description – Service and Supply Fund Overview and Activity Narratives

This section describes the activities funded through the Department's Service and Supply Fund (SSF), which is a revolving fund authorized under 42 U.S.C. 231. The SSF provides consolidated financing and accounting for business-type operations which involve the provision of common services to customers. The SSF is governed by a Board of Directors, consisting of representatives from each of the Department's ten (10) Operating Divisions (OPDIVs) and the Office of the Secretary. A representative from the Office of Inspector General (OIG) serves as a non-voting member of the SSF Board.

The SSF does not have its own appropriation but is funded entirely through charges to its customers (HHS's OPDIVs and STAFFDIVs, plus other Federal Departments and agencies) for their usage of goods and services. Each activity financed through the SSF is billed to the Fund's customers, based on either fee-for-service billing based upon actual usage of service or an allocated methodology. Each of these activities is described below.

Program Support Center Activities

Administrative Operations Service (AOS)

The Administrative Operations Service (AOS) provides a wide range of administrative and technical services to customers within HHS and to other Federal Agencies, as well as corporate support to the PSC. The mission of AOS is to provide high-quality administrative support services at competitive prices by capitalizing on its expertise and leveraging economies of scale. Major service areas in AOS include: *Property Management*, including facilities management, space leasing, disposition of surplus Federal property, personnel and physical security, and logistics services, including receiving, asset management, storage and disposal; *Technical Support*, including visual communications, printing and publications, reprographics, conference facilities, and mail and messenger services and *Other Administrative & Corporate Support*, including regional administrative support, services by Cooperative Administrative Support Units, ethics, competitive sourcing, and business operations.

The FY 2010 budget for Administrative Operations Service is $216,600,000 due to an increase of $300,000 for payroll processing charges from Defense Finance and Accounting Service (DFAS).

Financial Management Service (FMS)
The Financial Management Service (FMS) serves as a major part of the foundation of the Department's finance and accounting operations through the provision of a wide array of accounting and financial services; debt management and collection services; grant payment, cash management, and accounting support services; and indirect cost rate negotiation and approval services for HHS and other Federal grant and program activities. FMS also provides fiscal advice, technical and policy guidance, and assistance in implementing new initiatives aimed at assuring compliance with regulatory requirements. In addition, FMS is the Department's Center of Excellence for E-Gov Travel. The mission of FMS is to provide high-quality financial management services at competitive prices. This is accomplished through the provision of centralized products and services that focus on timely and accurate service delivery.

The FY 2010 budget for Financial Management Service is $70,200,000, which is an increase of $3,500,000 above the FY 2009 budget request of $66,700,000 to assess the need for and to plan for a future Unified Financial Management System (UFMS) upgrade of its underlying commercial software.

Federal Occupational Health Service (FOHS)
The Federal Occupational Health Service (FOHS) provides comprehensive, high-quality, customer-focused occupational health services in strategic partnership with Federal Agencies nation-wide. The mission of FOHS is to improve the health, safety and productivity of the Federal workforce. FOHS programs provide strategic prevention and early intervention services to employees and Federal Agency employers, such as:

- Health screenings for cholesterol, diabetes, blood pressure, and cancer identify diseases in early stages where they can be treated or cured and prevent more costly complications and treatment.
- Smoking cessation programs aimed at reducing tobacco use, preventing lung cancer,

heart disease and stroke and reducing other health care costs and absenteeism.
- Influenza Immunization programs to reduce the incidence of infections among employees which in turn reduces absenteeism, decreases health care costs and improves productivity.

FOHS currently provides services to 45 Federal Departments and Agencies and serves over 1.5 million Federal employees.

The FY 2010 budget for Federal Occupational Health Service is $138, 300,000, which is the same level as in FY 2009.

Information Systems Management Service (ISMS)/ Enterprise Support Service
The Information Systems Management Service (ISMS), formerly named the Enterprise Support Service, has the mission of providing high-quality information technology services, including project management, application development, operations and maintenance, infrastructure support services, records management, and requests for access to information from the public. The newly named office assumes the responsibilities of Enterprise Support Services and Business Technology Optimization, as well as Information Technology from Administrative Operations Service and HCAS and UFMS O&M from Financial Management Service. This consolidated information systems management into a single office for better accountability and efficiency.

The ISMS: (1) provides leadership and overall management for information technology resources for which PSC has responsibility; (2) directs the development, implementation, and enforcement of the Office of the Secretary and the PSC's information technology architecture, policies, standards and acquisitions in all areas of information technology; (3) oversees PSC's information systems security program, and serves as PSC's Information Technology Security Officer (PSC/ITSO); (4) manages and directs the PSC's IT business functions including business planning, development, budgeting and fiscal planning, establishing service level agreements, assessing customer satisfaction, assuring compliance with the Government Performance Results Act (GPRA) and overseeing capital planning and investment control (CPIC) for IT initiatives, researching emerging technologies and managing business systems initiatives; (5) provides operations and maintenance support services; (6) provides application software development support; (7) provides and updates PSC content for the HHS Intranet and Internet; plans and implements Section 508 compliance and remediation for Web content and other media for the PSC (in coordination with the HHS Web Communications Division, Office of the Assistant Secretary for Public Affairs); and (8) provides the Freedom of Information Act (FOIA) and record-keeping services.

The FY 2010 budget for Information and Systems Management Service (ISMS) is $177, 000,000, which is the same level as in FY 2009.

Strategic Acquisition Service (SAS)
The Strategic Acquisition Service (SAS) is responsible for providing leadership, guidance, and

supervision to the procurement operations of the PSC and for improving procurement operations within HHS. It provides strategic sourcing services; acquisition management services; and pharmaceutical, medical, and dental supplies to HHS and other Federal agencies. SAS streamlines procurement operations in HHS through activities such as the reduction of duplicate contracts, the use of consolidated contracts, and implementation of new procurement practices designed to provide higher quality procurement services at reduced cost.

The FY 2010 budget for Strategic Acquisition Service is $132,000,000, which is the same level as in FY 2009.

Human Resources Centers and HHS University

Human Resources Centers: Within the HHS, there are five Human Resources Centers (HR Centers). PSC oversees the financial aspects of three HR Centers that are located in Baltimore, Rockville, and Atlanta. A fourth HR Center is serviced by the National Institutes of Health (NIH) and is located in Bethesda. A fifth HR Center is serviced by the Indian Health Service (IHS) and is located in Rockville. The cost and FTE associated with the NIH and IHS sites are included in the respective OPDIV's budget requests. All sites report to the Department's Office of Human Resources for program and policy direction. These centers are responsible for providing high quality human resource services to HHS components and other customer agencies.

The HR Centers provide human resources strategic programs, customer service, and workforce relations support for HHS customer organizations. They serve as the principal advisor to the customer organizations' leadership on matters related to human resources management, including strategic human capital planning, recruitment and placement, position classification and management, compensation and pay administration, executive resources, workforce planning, labor and employee relations, employee services, and employee benefits, entitlements and advisory services. HR Centers interpret regulations, directives, and other guidance related to human resources programs. In addition, they provide policy direction, coordination and operational control for human resources programs.

HHS University: The HHS University (HHSU) supports the Department's mission and goals by providing high-quality, cost-effective continued learning and development opportunities. HHSU employs innovative approaches and emerging learning technologies, including on-line training courses. HHSU manages the Department's Learning Management System (LMS). Available to all HHS employees, LMS provides one-stop access to training, and allows tracking and reporting of training activities at any level within the Department. LMS also makes tools available to assist the Department with effective human capital management, through activities such as talent management, succession planning, and knowledge and content management.

The FY 2010 budget for Human Resources Centers and HHS University is $66,100,000, which is an increase of $1,500,000 above the FY 2009 budget request of $64,597,000 due to increased contract costs associated with a human resources database upgrade. Approximately $11,000,000 of that FY 2010 total is specifically for HHS University.

Non-PSC SSF Activities

The Non-PSC Activities of the SSF provide services that differ from those at the PSC by their predominant focus on facilitating compliance with public law, regulations, or other federal management guidelines, as well as targeted workforce management. These Non-PSC SSF Activities are described below.

Acquisition Integration and Modernization (AIM): AIM creates a seamless integration of HHS-wide acquisition process standardization, internal controls and oversight, and performance measurement inputs to serve employees, customers and vendors. AIM leverages HHS spending opportunities, captures knowledge within the acquisition workforce, and seizes opportunities to adopt best practices. The AIM activity was added to the SSF effective October 1, 2004.

During FY 2007 and FY 2008, contractor support was used to achieve the following milestones: (a) developing process standardizations in the areas of purchase cards, acquisition plans, interagency contracting, and earned value management; (b) establishing emergency contracting procedures, developing an emergency contracting website, identifying emergency contracting training opportunities; and (c) issuing the BuyLines newsletter which fosters communication within the acquisition community and promotes sharing lessons-learned and best practices across the Department.

From FY 2007 to FY 2008 we developed additional performance measures to emphasize the use of performance-based acquisitions, increase the use of competition and support workforce training and development. This focus on critical performance factors resulted in an increase from 40% rated exceptional in FY 2007 to 68% in FY 2008. Further refinements to promote timely data reporting and contract closeouts and to increase the performance-based acquisition goal were incorporated for FY 2009.

In FY 2010 we will continue to pursue opportunities to standardize and modernize acquisition processes and support the American Recovery and Reinvestment Act efforts. An ongoing objective is to focus on performance measurement, including additional purchase card oversight and management reviews to measure how well HHS manages its procurement function. We will continue to review performance criteria to ensure goals/performance standards are still relevant; we intend to explore different methods to benchmark or measure strategic sourcing.

The FY 2010 budget for AIM is $1,126,000 which is the same as the budget for FY 2009.

Audit Resolution: Audit Resolution, as mandated by P.L. 96-304 and P.L. 98-502, resolves grantee audit findings within a statutorily mandated six-month period. Based on findings identified by auditors in a grantee's A-133 audit, Audit Resolution reviews and resolves audit findings containing monetary and/or systemic findings of grantee organizations affecting the programs of more than one HHS Operating Division or Federal agency. Audit Resolution makes recommendations and ensures that corrective action is taken on deficiencies in grantee

accounting systems, internal controls, or other management systems. Under the authority of OMB Circular A-50, paragraph 7.c., Audit Resolution, as an audit follow-up official, has responsibility for ensuring that timely responses are made to all audit reports, disagreements are resolved, and corrective actions are implemented.

Audit Resolution is responsible for providing departmental leadership to the OPDIVs, such as Department-wide guidance and Department-wide coordination of the function. Audit Resolution is also responsible, HHS-wide, for identifying and following up with all grantees that have not submitted their annual A-133 audit in a timely manner. Grantees that have not submitted their audit reports after HHS' initial follow-up are reported to the relevant Operating Division or other Federal agency for additional follow-up. Audit Resolution also provides departmental leadership in working with the Office of Management and Budget and the Operating Divisions to annually update the Compliance Supplement. In addition, Audit Resolution provides functional leadership for completing and reconciling with OIG the Annual Management Report on Final Action to Congress.

Audit Resolution also works closely with the Operating Divisions to measure, identify, and implement corrective actions to prevent improper payments from a programmatic perspective; coordinates required program risk assessments; and engages in recovery auditing activities.

The FY 2010 budget for Audit Resolution is $1,350,000 which is the same as the budget for FY 2009.

Claims: The Federal Tort Claims Act (FTCA) requires claimants to file administrative claims with the responsible agency before filing suit against the United States in Federal court. The HHS Office of the General Counsel (OGC) receives and adjudicates all administrative tort claims (e.g., medical malpractice, vehicle accidents, acts or omissions that cause damages) on behalf of the Department. Each agency is given six months to settle or deny administrative claims. If no action is taken within six months, the claimant may then file suit in Federal court. As such, administrative claim processing is mission critical work that is required by Federal statute.

The overall process works as follows. The General Law Division of OGC is responsible for processing these claims. This processing includes the logging in of matters, the creation of files, researching the issues, coordinating with claimants and preparing recommendations for the HHS settlement authority. The settlement authority on these claims also resides within OGC. OGC settles claims where appropriate, and denies claims where not. For claims that are not settled which result in litigation, OGC works with the Department of Justice to defend the agency. At the administrative adjudication level, the work is funded by those department clients that use the service via the HHS Service and Supply Fund (e.g., most medical malpractice claims are from HRSA-funded Community Health Centers and from Indian Health Service clinics). Claims that result in litigation go through an additional process and are worked by other OGC personnel (e.g., a secretary, paralegals, and attorneys). Thus all tort claims are processed from beginning to end by OGC personnel.

In FY 2005, OGC received 407 new claims. In FY 2006, 475 claims were received, about two-thirds of which reflected claims from nearly 900 community health centers deemed eligible for FTCA coverage with more than 3,000 delivery sites throughout the nation. The number of claims filed continued to increase in FY 2007, when 537 were filed, demanding approximately $1.5 billion in damages. Thus, the number of claims had increased by 30% between FY 2005 and FY 2007. In FY 2008, the OGC Claims Office received a total of 493 tort claims, 299 of which were related to deemed community health centers. As of April 15, 2009, OGC has received 264 tort claims, including 139 community health center claims.

The FY 2010 Budget for Claims is $1,050,000 which is the same as the budget for FY 2009.

Commissioned Corps Force Management (CCFM): CCFM provides both personnel support to active-duty and retired PHS Commissioned Officers, and force management activities for the Corps as a whole. Force management of the Corps is administered by two offices within the Office of Public Health and Science (OPHS) – the Office of Commissioned Corps Force Management (OCCFM) that reports to the Assistant Secretary for Health (ASH) and the Office of Commissioned Corps Operations (OCCO) within the Office of the Surgeon General (OSG). OCCFM establishes timelines, performance standards, and measurements of the evaluation of the operations and management of the Corps. The office works closely with the OSG to facilitate operations and the implementation of policies and programs and it provides advice on matters related to the day-to-day management of the Corps, and also provides for the delivery of training and career development. OCCO manages the personnel administration systems for the assignment, appointment, promotion, assimilation, and awards for Corps members.

CCFM recent accomplishments include: Interactive Web site developed to respond to frequent and diverse requests for detail assignments placing Corps Officers into another Federal Agency; Electronic Commissioned Corps Issuance System - Issued 6 Personnel Policy Memorandums and 12 Instructions and Directives; Vital Commissioned Corps personnel and payroll information was moved from the WANG legacy system to Lyceum and other Oracle based applications; completed and deployed Officer Profiles Collection System to collect and validate information to be transferred to the Coast Guard Direct Access system in preparation for the officer competency section of Direct Access which comes on-line in the spring of 2009.

The FY 2010 budget for CCFM is $22,884,000 which is the same as the budget for FY 2009.

Departmental Contracts Information System (DCIS): DCIS provides a central repository for HHS procurement data, and is HHS' primary method for fulfilling procurement reporting requirements to the Federal Procurement Data System Next Generation/OMB (FPDS-NG), which is mandated by Public Law 93-400. DCIS collects stores and compiles contract information to produce various reports to the Office of Management and Budget (OMB), GAO and Congress under P.L. 93-400. DCIS provides information on HHS contracts for Freedom of Information Act (FOIA), requests from OMB, Congress, State governments, and HHS management.

In FY 2008 through FY 2009, contractor support was and will be obtained to provide IT support services to DCIS. In FY 2009, the DCIS contractor will deploy an ad hoc reporting system as well as a new search engine, which will facilitate quick answers to ad hoc queries. Prior to FY 2008, HHS data on open contracts and orders awaiting closeout was collected manually or resided within each Operating Division. As a result, there was no uniform, automated method to record and assess contract closeout activity, including backlog, on a department-wide basis. Utilizing DCIS to capture order and contract closeout transactions provided the Department a robust, automated method to maintain and report this important activity.

The FY 2010 Budget for DCIS is $1,052,000 which is $216,000 more than the budget for FY 2009. This increase is due to the need to award a contract for the OMB/OFPP required independent, statistically valid (IV & V) certification of data (Memorandum to Chief Acquisition Officers dated March 9, 2007).

Homeland Security Presidential Directive-12 (HSPD-12): The HSPD-12 program implements the Presidential Directive to provide greatly-enhanced security for physical access to HHS facilities and logical access to systems and applications. Identity cards will be issued to all permanent Federal, contractor, and affiliate staff, after a rigorous background adjudication process. The identity cards are printed in accordance with NIST standards and contain electronic credentials on the embedded smart chip. A total of 65,000 HHS staff has been sponsored in the card issuance system. For each of the 30,000 identify cards that have been issued to date the sponsor is responsible for substantiating the need for a PIV credential to be issued to the applicant. The PIV sponsor requests the issuance of a PIV credential and remains aware of the applicant's status and continuing need for holding this credential. All of the cards need to be issued by June 20, 2010 and enrollments need to be completed by October 27, 2009. The total cards that need to be issued will vary depending on the number of employees and contractors. The interface between the physical and logical systems has been implemented for the Office of the Secretary physical access control system. Identity cards from all HHS OPDIV's and external agencies are recognized by the Office of the Secretary physical access control system. Use of the identity card to access logical systems has been implemented and is in production to support two HHS-wide human capital systems. HHS has a single department-wide Human Capital Management System, Enterprise Human Resources Program (EHRP), which serves as the system of record and authoritative source for the HHS civilian workforce. HHS utilizes the Coast Guard system for management of the Commissioned Corps. EWITS is the Enterprise Workflow Information Tracking System which provides workflow management supporting EHRP. Both EHRP and EWITS have been integrated into the Department's access management system which requires the use of the HSPD-12 PIV card for authentication at level 4 and may be used for authentication at level 3 and below. The access management system is in production today.

There are a number of additional functional applications that fall under the broader heading of human resources to include:

- Integrated Time and Attendance System (ITAS),
- workman's compensation,
- electronic Official Personnel Folder (eOPF),
- MyPay (payroll) and similar systems.

The system owners are both within and external to HHS for line of business systems. Planning for integration of these systems into the Department's single sign on solution and use of the HSPD-12 PIV card is underway. These will be implemented incrementally with a number integrated into the Department's authentication service in calendar year 2009 with others extending into calendar year 2012. Use of the identity card for remote access is in limited production at a number of OPDIVs as is the ability to authenticate to the network from the desktop.

The SSF funding for HSPD-12 is used to support and pay for contracts. Please note that the Service and Supply Fund (SSF) Board has not yet approved the FY 2010 budget for HSPD-12. Therefore, the FY 2010 budget is $6,650,000 less than the budget for FY 2009.

High Performing Organizations and Commercial Services Management (HPO & CSM): HPO & CSM supports Commercial Services Management (CSM) Reporting, the inventory and reporting of Federal Activities Inventory Reform (FAIR) Act inventory, the active sponsorship of High Performing Organizations (HPO) creation and prospectively Insourcing through central service activities. The Federal Activities Inventory Reform Act of 1998 (Public Law 105-270), authorized and required annual inventories of agency positions. Section 647 (b) of Division F of the Consolidated Appropriations Act, FY 2004, P.L. 108-109 requires annual commercial services management reports. And, section 735 of Title VII of the Omnibus appropriations Act, 2009, P.L. III-8 addresses Insourcing. This legislation will have the effect of requiring central service activities to ensure that consideration is given to using, on a regular basis, Federal employees to perform new functions and functions that are performed by contractors and could be performed by Federal employees. It is anticipated, Insourcing will be brought to the SSF Board's attention prior to the conclusion of FY 09 as a FY '10 central service activity.

Recent highlights include: December 2007 received Presidential Quality Award for Program Management; and continuously aim to provide information that is current and accessible to OPDIV commercial services managers at least 100% of the time.

The FY 2010 budget for HPO & CSM is $171,000 which is the same as the FY 2009 budget.

Office of Small and Disadvantaged Business Utilization (OSDBU): OSDBU was established in 1979 under Public Law 95-507, the Small Business Act. OSDBU provides leadership, guidance and recommendations to insure that small businesses are given an equitable opportunity to participate in the provisions of goods and services by HHS. The activities and performance goals for Small Business can be grouped into three broad categories; training, vendor outreach and meet or exceed Small Business goals.

OSDBU will continue to increase the use of mechanisms and programs which "maximize opportunities for small businesses". It will work to disseminate best practices and policy that insures sufficient numbers of small businesses are considered during the procurement process including those needs as necessary to meet contract needs under the American Recovery and Investment Act.

The FY 2010 budget for OSDBU is $2,660,000 which is the same as the budget for FY 2009.

Tracking Accountability in Government Grants System (TAGGS): TAGGS is the HHS central repository of grant award data. The publicly searchable database houses HHS discretionary and mandatory grant funding awarded from 1995 to the present. As the largest grant-making agency in the Federal government, awarding approximately 60 percent of the Federal government's grant dollars and annually providing over $273 billion in grants to domestic and foreign grantees for U.S. health assistance and social service programs, the system allows users the ready ability to query the system for information on all HHS grant awards.

TAGGS supports HHS' grant transparency and accountability efforts under the Federal Funding Accountability and Transparency Act (FFATA) and the American Recovery and Reinvestment Act (ARRA). The system reports data to OMB's USASpending.gov and produces customized management reports for Recovery.gov reporting. Leveraging the Department's grant consolidation goals and objectives, the system primarily receives HHS Operating Division and Staff Division data via the Administration for Children and Families' GrantsSolutions.gov or the National Institutes of Health's IMPAC II systems, effectively decreasing costs and resources attributed to maintaining multiple interfaces with multiple grants management systems, and facilitating improved data quality, oversight, and integrity.

Performance Achievements:

- Successfully completed all FFATA reporting requirements each month for FY 2008 and FY 2009.
- Selected as only reporting system government-wide to assist OMB in developing a proof of concept towards meeting the sub-award requirements of FFATA.
- Partnered with OMB and GSA to successfully pilot FFATA sub-award proof of concept requirements with over 55 participants from across the country.
- Successfully met and exceeded SSF performance metrics for FY 2009, achieving over 80 percent of project abstracts in the database for FY 2009 grant awards.

The FY 2010 budget for TAGGS is $894,000 which is the same as the budget for FY 2009.

Web Communications and New Media Division (WCD): The WCD is a part of the Office of the Secretary, Office of the Assistant Secretary for Public Affairs. The Division is responsible for the coordination of HHS communication and outreach activities, including implementing Web 2.0 applications, related to health and human service information, education and public interaction.

On October 20, 2008, the SSF Board voted to allow the WCD to add a new cost center to its existing activity. The Web Policy Tester cost center (also commonly known as a Web crawler tool) will greatly enhance the ability of the Department to carry out its Section 508 Compliance efforts, while also improving maintenance efforts for the many thousands of Web pages across the various Operating Divisions at HHS. Specifically, the crawler surveys all Web sites and pages and identifies where there are 508 errors, broken links, orphan pages, privacy notices, and other Web maintenance functions. The crawler produces reports that identify exactly where problems are and corrective actions that need to be taken. This activity was previously funded through HHS Enterprise IT Fund and does not represent a new activity for HHS.

The Web Communications activity includes:

- Providing standards and guidance for all Departmental Web activity;
- Creating and coordinating the government-wide Web site for health care reform activities and programs;
- Managing the Web-based dissemination of all Departmental Recovery Act, activities and reporting;
- Managing several additional cross-federal Web sites, including PandemicFlu.gov;
- Managing all Office of the Secretary Web sites (HHS.gov);
- Managing the Department's five-year Section 508 Compliance and Remediation Plan, including implementing new tools for making the Department's Web sites accessible for persons with disabilities;
- Increasing the availability of Web information disseminated in Spanish (and other languages, as needed); and
- Managing, including increasing capacity, the Department-wide cost-saving portal community collaboration application.

The FY 2010 budget for Web Communications increased by $300,000 from the FY 2009 budget. This increase is for costs associated with the web policy tester.

FY 2010 Congressional Justification

Program Support Center
Overview of Key Performance Measures, Outcomes and Outputs

Key Outcomes and Outputs

PSC Key Performance Measures Table

Long Term Objective: Improve quality – Provide quality administrative support so that high performance can be maintained in HHS Program Services.

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.1.1: Increase the percentage of services achieving timelines targets. *(Outcome)*	FY 2008: 95% (95% Target Met)	95%	95%	Maintain
1.1.2: Increase the percentage of customers responding to PSC comment cards and indicating excellent/good ratings for satisfaction of services. *(Outcome)*	FY 2008: 91% (90% Target Exceeded)	90%	90%	Maintain
1.1.3: Increase the percentage of cost centers processing billings to coincide with service delivery *(Outcome)*	FY 2008: 95% (95% Target Met)	95%	95%	Maintain

Long Term Objective: Increase Cost Savings to HHS by Expanding Market Share or Increasing Size of Customer Base.

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.2.1: Increase percentage of new customers acquired annually. *(Outcome)*	FY 2008: 4% (2% Target Exceeded)	2%	2%	Maintain

Long Term Objective: Increase Cost Savings to HHS through Asset Management

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.3.1: Participate in Department-wide consolidations. *(Outcome)*	FY 2008: 2 consolidation (1 Target Exceeded)	1 consolidation	1 consolidation	Maintain
1.3.2: Maintain PSC overhead rate to be less than 1.6% of total costs. *(Outcome)*	FY 2008: 1.2% (1.6% Target Exceeded)	1.6%	1.6%	Maintain

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1.3.3: Maintain percentage of revenue consumed by intra-service costs. *(Outcome)*	FY 2008: 5% (4% Target Not Met)	4%	Discontinued	N/A
1.3.4: Increase the percentage of overall employee satisfaction PSC-wide. *(Outcome)*	FY 2008: 53% (75% Target Not Met)	75%	75%	Maintain
1.3.5: Increase the percentage of cost centers recovering within an established variance and achieving target Net Operating Result (NOR). *(Outcome)*	FY 2008: 61% (75% Target Not Met but Improved)	75%	75%	Maintain

Improve Quality:

PSC has a long term goal of improving quality of service delivery so that HHS OPDIVs may receive superior service while maintaining focus on their mission-related programs. There are three key outcomes or measures that indicate quality of service: Timeliness (Performance Measure 1.1), Customer Satisfaction (Performance Measure 1.2) and Timely Billings (Performance Measure 1.3).

Performance Measure 1.1 (Timeliness: Target met in FY 2008):

Timely service and responsiveness are critical elements that determine a customer's level of satisfaction with PSC. It is essential that PSC place a continued focus on maintaining and improving timeliness in order to maintain and improve the customers' perceptions of their service provider. PSC seeks to provide timely, accurate and efficient products and services to all customers through simplified, streamlined processes and procedures, and through employing best business practices.

PSC measures the timeliness of service delivery against the timeliness performance standards established for each product and service listed in our comprehensive Directory of Products and Services. Service delivery is considered timely when the requested service is delivered to the customer in a prompt manner and within the time frame published for the timeliness performance standard for that product or service. These standards exist in order to set expectations with the customer and to allow the customer to hold PSC accountable.

For FY 2008, PSC tracked 156 individual timeliness standards for 71 products and services. There were less products and services in FY 2008 compared to FY 2007 because of cost center consolidations by the CASUs and realignment of the products and services provided by the Enterprise Support Service (ESS). In FY 2008, the performance results were also timely 95% of the time, thus PSC achieved the target of 95%.

Looking towards FY 2009 and FY 2010, the target for Timeliness will remain constant at 95%. PSC will continue to analyze the targets established for each product and service to ensure that appropriate yet challenging targets are established. In addition, we will continue to evaluate ways to improve the effects of external forces on our business as well as to cost effectively plan to address these situations as they arise. With this approach, it is expected that PSC, as a whole, will be able to continue to achieve the timeliness standards at least 95% of the time in upcoming years.

Performance Measure 1.2 (Customer Satisfaction: Target exceeded in FY 2008):

The other factor in measuring quality is overall customer satisfaction. PSC has placed great emphasis on providing quality, value-added services to all customers through reengineered processes and procedures, transparency, management and employee attention to quality, and through employing best business practices. PSC will measure the perceived quality of its service

delivery as the percentage of customers expressing overall satisfaction with the quality of services provided. When PSC's customers are satisfied with products and services they are receiving, it allows them to keep focus on their core mission.

Additionally, it is important for PSC to track customer satisfaction because the higher the satisfaction ratings, the more likely customers are going to continue purchasing PSC products and services, as well as increase their purchases. More sales have an overall effect on price per service in that the total cost of the service is being spread over a larger customer base, thus reducing the price per unit. It is clear that customer satisfaction has a direct relationship not only to quality, but also to price for customers.

The customer satisfaction measure defines quality as those customers who are highly satisfied with overall service. PSC encourages customers to complete an on-line survey upon delivery of products and services and makes the survey available on PSC's website.
Survey responses are collected and analyzed on a monthly basis to arrive at the customer satisfaction rating. The monthly performance results are distributed to the cost center managers to resolve issues and to monitor the performance of their respective areas.

In FY 2008, the questions in the comment cards were updated and modified to be more relevant to customer requirements and easier to understand. Questions specific to the Information Technology Operations were also added so that management would be aware of items applicable only to ITO.

The following table displays the customer satisfaction results by Service Area in FY 2008.

FY 2008 Overall Satisfaction Ratings (# of Comments)	AOS	BTO	FMS	FOH	ESS	SAS	OD	PSC Overall
Very Satisfied	522	6	204	185	167	159	30	1,273
Satisfied	80	4	33	71	21	8	14	231
Dissatisfied	24	0	7	11	8	2	2	54
Very Dissatisfied	40	0	17	10	12	5	3	87
Total	666	10	261	277	208	174	49	1,645
Percentage of Customers Very Satisfied and Satisfied	90%	100%	91%	92%	90%	96%	90%	91%

The PSC initiative related to Dissatisfied Customers was implemented in FY 2008. For each dissatisfied comment related to a certain product or service documented in the monthly Customer Satisfaction report, the Cost Center Manager is required to complete a Comment Card Feedback Form to provide the issue that caused the unfavorable rating and the corrective action plan taken to resolve the issue. This initiative reinforced PSC's commitment to superior customer service.

The results for customer satisfaction in FY 2008, demonstrated that 1,645 customers completed the PSC On-line Customer Survey with a resulting customer satisfaction rating of 91% based on a four point scale, thus PSC achieved the target of 90%. In addition, all Service Areas and the Office of the Director (OD) within the PSC exceeded the 90% target for customer satisfaction rating.

Despite the success achieved in FY 2008, the FY 2009 and FY 2010 targets will remain constant at 90% due to the potential for customer satisfaction fluctuations arising from the recently implemented organizational realignment. Cost centers were moved from Financial Management Service (FMS), Administrative Operations Service (AOS) and Enterprise Support Service (ESS) to the newly-formed Information and Systems Management Service (ISMS).

Performance Measure 1.3 (Timely Billing: Target met in FY 2008):

In an effort to improve the quality of PSC service delivery, PSC established a new performance measure for FY 2008 that strives to achieve timely billings. As a fee-for-service organization, it is important for PSC to process its billings when services are rendered in order to collect revenue from its customers in a timely manner.

Timely billing in PSC Revenue, Invoicing, and Cost Estimation System (PRICES) is affected by the prompt receipt of billing data from the service providers, availability of the related UFMS reports and the efficient set-up by the cost center managers for the customers' billing information in PRICES. Billing is considered timely when the invoices for the products and services of a certain cost center are entered by the Cost Center Manager into PRICES on or before the monthly cut-off date or deadline. For example, the cut-off date for entering December invoices is January 3rd, the Cost Center Manager completes his/her billing on December 12th, and thereby meeting the December billing deadline and his/her billing is considered timely.

In FY 2008, PSC achieved the target of 95%. By having a performance result of 95%, PSC was successful in achieving its intended outcome of increasing the percentage of cost centers processing billings to coincide with service delivery. The targets remain constant for FY 2009, as well as FY 2010.

Improve Cost Savings to HHS by Expanding Market Share:

The PSC seeks to expand its portion of the Federal shared services market in order to establish itself as the leader in shared services, benefit from economies of scale, achieve operational

efficiencies, foster standardization, and free customers to focus on their core mission. As the shared services provider for HHS, it is essential that our prices be competitive and costs be controlled. To best serve our customers, we strive to identify ways that costs can be reduced and prices can be maintained and/or reduced.

Performance Measure 2.1 (Increase in Number of Customers: Target exceeded in FY 2008):

One method of controlling price increases is through obtaining new Federal customers, not just internal customers in the Department, but especially customers outside the Department. By doing this, the PSC can spread overhead costs to a greater number of work units and achieve economies of scale through volume buys, thus lowering the cost to customers.

During FY 2008, PSC strived to increase its customers by 2% over the FY 2007 customer base. The FY 2008 result for this measure was 4% with an increase of 54 new customers. Eighty seven percent of the FY 2008 new customers were new customers of the CASUs. The other new customers were earned by the Supply Support Center, Federal Occupational Health (FOH) Seattle and Division of Property Management. The bulk of the FY 2008 customers were DOD (27%), General Services Administration (GSA) (7%) and DOI (3%).

For FY 2009 and FY 2010, PSC has set a target of maintaining growth for the number of new customers at a rate of 2% over the prior year.

Improve Cost Savings to HHS through Asset Management:

Two critical factors that influence a customer's decision to purchase services from the PSC are quality of the service and price. PSC's first two goals (Improve Quality and Improve Cost Savings by Expanding Market Share), address methods for monitoring quality and customer satisfaction. They focus on monitoring volume of services purchased which directly correlates to the price PSC charges its customers.

The remaining goal (Improve Cost Savings through Asset Management) addresses factors that influence price. This goal focuses on overall cost of delivering the products and services. If PSC costs can be maintained or reduced and the volume of services purchased remains steady or increases, there will be a positive result for the customer (i.e. prices remain the same or decrease).

Performance Measure 3.1 (Department-wide Consolidations: Target exceeded in FY 2008):

This performance measure was established for FY 2007 and replaced a retired measure that previously tracked PSC's contributions to the Department's goal for a reduction in administrative staff. This measure is intended to track PSC's participation in Department-wide

consolidations which will address the overall Department goal of reducing administrative costs.

In FY 2008, PSC participated in two Department-wide consolidations through HHS Consolidated Acquisition Solution (HCAS) and HSPD-12 Shared Biometric Enrollment and PIV Card Issuance Initiative. PSC participated in the Department-wide consolidation of acquisition systems. There were two distinct ways in which this created administrative cost savings. First, by consolidating operations and maintenance activities for HCAS into one team, PSC was able to bring IHS onto HCAS without additional administrative staff. Additional HHS OPDIVs will be joining in this effort in FY 2009 without a requirement for additional administrative staff. In addition, cost savings have been achieved between HCAS Operations and UFMS operations with respect to sharing and leveraging tools, processes, and infrastructure. This obviated the need for an additional FTE and achieved approximately $1.5M savings in contractor resources, $1.1M in savings in software tool costs, and $0.5M in server infrastructure.

The target for FY 2009 and FY 2010 is for PSC to participate in at least one consolidation. If by working with other HHS components on consolidation initiatives, these other HHS components cease providing duplicate administrative services offered by the PSC as the Department's shared services provider; then, overall savings should be seen across the Department.

Performance Measure 3.2 (Overhead Costs: Target exceeded in FY 2008):

PSC recognizes that it must be prudent in controlling overhead costs (those not involved directly in the performance of our products and services). To achieve this outcome, PSC originally established a performance measure to reduce the resources consumed by overhead to the extent possible while still maintaining required internal support functions.

For FY 2008, PSC achieved a 1.2% performance result which exceeded the FY 2008 target of 1.6%.

For FY 2009 and FY 2010, the performance targets remain at the maintenance of an overhead rate of 1.6%.

Performance Measure 3.3 (Intra-service Costs: Discontinued for FY 2010; Target not met in FY 2008):

Intra-service costs are the costs of PSC services provided by one PSC cost center to another PSC cost center. This performance measure is being dropped for FY 2010 as PSC does not believe it will significantly contribute to PSC's long term goal to improve cost savings. PSC is searching for another performance measure that will enable PSC to reduce costs.

In FY 2008, the actual intra-service costs were $32,129,559 and the revenue was $690,134,553 resulting in 5% (4.7% if not rounded), of revenue consumed by PSC intra-service costs which did not achieve the 2008 target of 4%. There were more intra-service costs spent than projected for the corresponding revenue collected. The variance between the projected intra-costs and the

actual intra-service costs was due to the costing process wherein the costs were not properly identified and aligned.

PSC is focused on educating managers on prudent use of PSC products and services in an effort to control operational costs and improve buying behavior. The target for FY 2009 is to maintain 4.0% of revenue consumed by intra-service costs which was the same target in FY 2008.

As indicated above, in FY 2010, this performance measure will be discontinued.

Performance Measure 3.4 (Employee Satisfaction: Target not met in FY 2008):

Studies have shown that there is a direct link between employee satisfaction, productivity, and customer satisfaction. As a result, it is essential that PSC monitor employee satisfaction levels because dips in satisfaction may result in lower levels of productivity, which then has a correlation to a potential increase in costs. PSC recognizes the importance of employee satisfaction with respect to the overall success of the organization.

To measure employee satisfaction levels, PSC relies on the results of the Department's bi-annual human capital survey (even years) and the OPM HCIS (odd years). PSC previously participated in the HHS-wide Human Resource Management Index (HRMI) Survey. The results of the FY 2008 Human Capital Improvement Survey were released to PSC in April 2009 and demonstrated that PSC employees who responded to the survey had an overall job satisfaction rating of 53%. Therefore, the FY 2008 target of 75% was not met. To address the outcome of the FY 2008 HCIS, PSC evaluated the results and planned new strategies to address the shortcomings. The PSC has already implemented "Operation High GEAR", a series of 15 initiatives to address tactical and strategic goals to transform the PSC into a customer-focused shared services organization. Five of these initiatives are designed to improve PSC's Human Capital experience.

The annual communications survey conducted in FY 2008 revealed that the PSC eNews, which was implemented as an employee newsletter, was "Useful" or "Somewhat Useful" to 73% of the respondents. Feedback from the new hire orientation program revealed that knowledge of HHS, PSC and PSC Performance increased by 10%, 40% and 42% respectively. On the whole, the PSC Employee Communication Survey results showed many components of PSC communications are effective in providing useful and timely information to the PSC employee. The data also showed there are some areas that will require more attention. Those areas have been the focus of continuous improvement in the Communications Program which is an ongoing effort.

The PSC also implemented the Employee Awards and Recognition Program as a means to ensure that managers are aware of their role in rewarding high performance and motivating their employees as well as providing the tools that are available to support them. The PSC also provided work-life balance programs such as Alternative Work Schedules (AWS) and Child Care Subsidy which began on October 1, 2000. Lastly, PSC implemented its Succession

Planning Program to ensure it is proactively planning for the loss of employees in mission-critical positions. The Succession Planning Programs helps improve job satisfaction through mentoring and training that prepares personnel to be ready for the mission critical positions. In the end, these efforts will assist the PSC in achieving higher levels of satisfaction across the organization and help it achieve the targets for FY 2009.

Performance Measure 3.5 (Cost Recovery: Target not met in FY 2008):

The Cost Recovery performance measure is one of several performance measures with a long-term objective of increasing cost savings to HHS through asset management. As a working capital fund, PSC must fully recover its operating costs with customer revenue at the agency level. However, in order to ensure that this rolled up information is being managed as effectively as possible, PSC also tracks this information at each individual cost center (product/service) level. Cost recoveries are measured by the Net Operating Results (NORs) which are the variances between revenues and obligations.

The Cost Recovery performance measure enables PSC management to evaluate the performance, cost, and business results of each product line; identify problem areas; and take appropriate action. PSC monitors cost center performance with an expectation that all costs will be covered by revenue.

The performance results for FY 2008 demonstrated that 61% of cost centers fully recovered costs thus the target was not met. While the results achieved for FY 2008 were below the target of 100%, organizationally PSC recovered 100% of its operating costs.

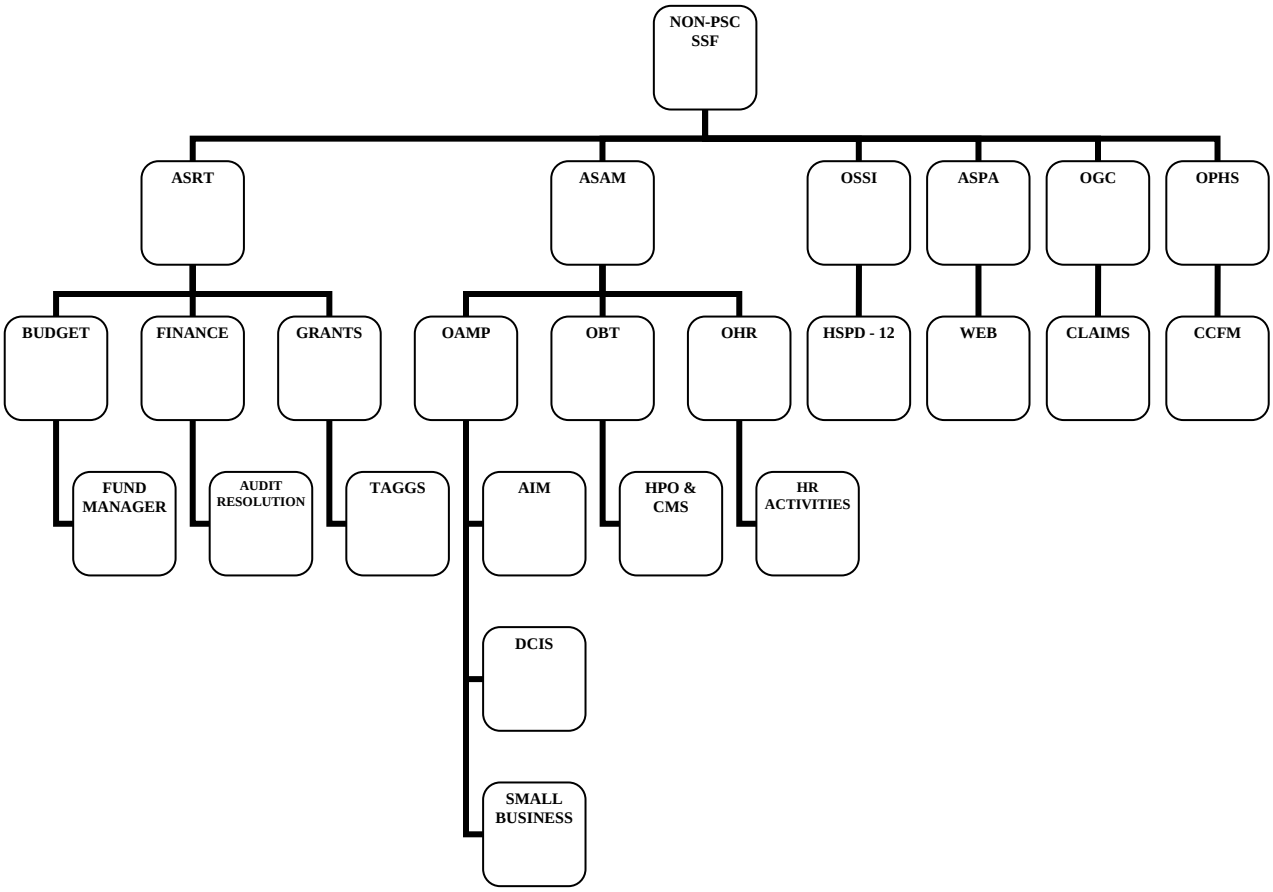
Even though the performance result for FY 2007 was 60% and the performance result for FY 2008 was 61%, the number of cost centers that did not achieve the performance targets for two consecutive fiscal years was reduced from 10 or 22% to 7 or 11% of the total number of cost centers.

While PSC continues to strive for full cost recovery at the organizational level and cost center level each year, it realizes that unforeseen circumstances and business fluctuations may alter its operations during the course of the year. Therefore, PSC established its FY 2010 target to have 75% of its cost centers recover costs within an established variance.

FY 2010 Congressional Justification

Supplementary Materials

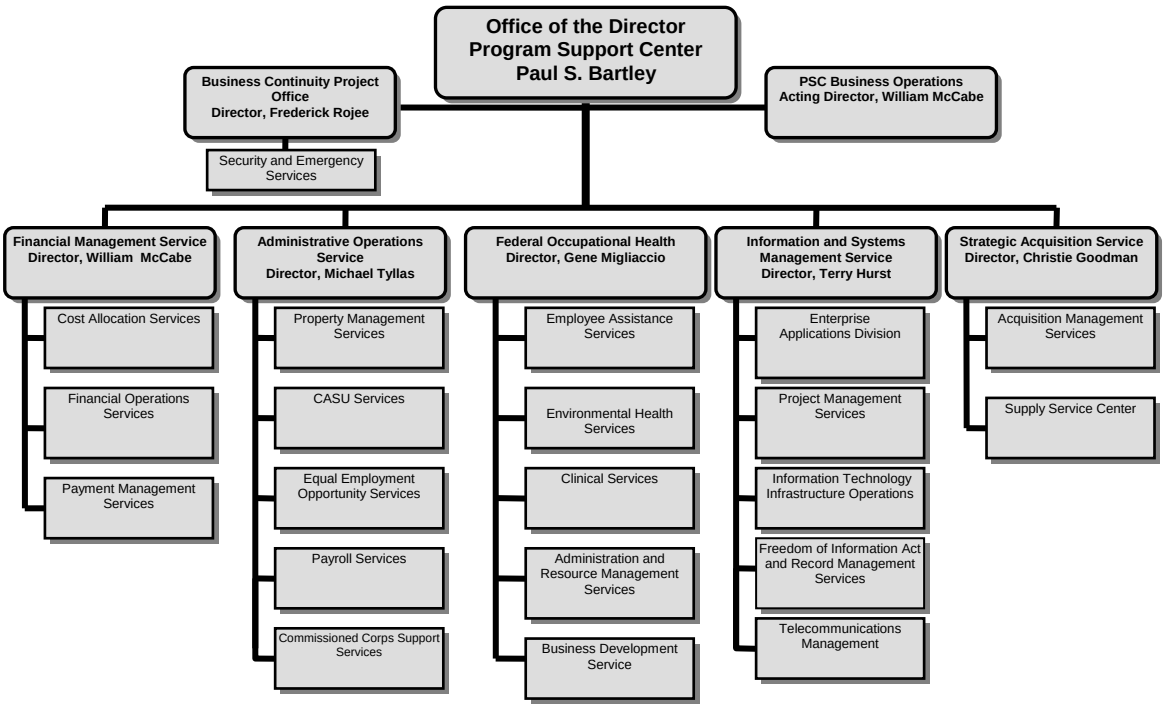
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NON-PSC SERVICE AND SUPPLY FUND ACTIVITIES



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROGRAM SUPPORT CENTER

Organizational Chart



Department of Health and Human Services
Service and Supply Fund
(Dollars in Thousands)

Service and Supply Fund Activities	FY 2008 Actual	FY 2008 Actual Comp.**	FY 2009 Board Approved	FY 2010 Board Approved	FY 2010 +/- FY 2009
PSC					
Administrative Operations Service	289,451	241,512	216,243	216,556	313
Financial Management Service	92,971	56,937	66,729	70,229	3,500
Federal Occupational Health Service	123,274	123,274	138,320	138,320	-
Enterprise Support Service*	38,574	-	-	-	-
Info. & Systems Mgmnt Service*	-	146,468	177,046	177,046	
Strategic Acquisitions	98,479	98,479	131,972	131,972	-
Business Technology Operations*	5,237	-	-	-	-
HR Centers & HHS Univ	57,393	57,393	64,597	66,097	1,500
PSC Subtotal	*705,379*	*724,063*	*794,907*	*800,220*	*5,313*
Non-PSC					
AIM	1,102	1,102	1,126	1,126	-
Audit Resolution	1,849	1,849	1,350	1,350	-
CCFM	20,740	20,740	22,884	22,884	-
DCIS	775	775	836	1,052	216
HPO & Commercial Services Mgmnt	162	162	171	171	-
OGC Claims	1,003	1,003	1,050	1,050	-
Small Business Consolidation (OSDBU)	2,582	2,582	2,660	2,660	-
TAGGS	847	847	894	894	-
Web Communications	5,773	5,773	6,264	6,564	300
Enterprise Email/HHS Mail*	18,685	-	-	-	-
HSPD-12*	-	-	6,650	-	(6,650)
Non-PSC Subtotal	*53,518*	*34,834*	*43,885*	*37,751*	*(6,134)*
Total SSF Revenue	758,897	758,897	838,792	837,971	(821)

* For additional information on the realignment of cost centers between SSF activities, please see the section entitled, “Summary of Changes to SSF Budget by Activity” for explanations regarding differences between the FY 2009 and FY 2010 budgets for the PSC and Non-PSC Activities.

** This column displays FY 2008 actual revenue on a comparable basis for realigned services.

Summary of Changes to SSF Budget by Activity

Most PSC and Non-PSC activities will provide their services at the same rates and budget levels as in FY 2009, but changes to other SSF activity budgets are explained below.

Information Systems Management Service
The estimated FY 2010 budget for the Information Systems Management Service is $177,046,000 to provide services that support the Information and Systems Management. The newly named office assumes the responsibilities of **Enterprise Support Service** and **Business Technology Optimization**, as well as some programs from Administrative Operations Service and Financial Management Service. No comparable budget increase for this Service is requested in FY 2010.

Financial Management Service
The estimated FY 2010 budget for the Financial Management Service is $70,229,000 to provide financial management services. The estimate has been impacted by the realignment of services discussed elsewhere, but underlying rates remain unchanged. The FY 2010 increase of $3,500,000 above the comparable FY 2009 budget request of $66,700,000 is due to a planned UFMS ORACLE upgrade.

Administrative Operations Service
The estimated FY 2010 budget for Administrative Operations Service is $216,556,000 to provide administrative operations services. The estimate has changed due to the realignment of services discussed elsewhere, but underlying rates remain largely unchanged. In FY 2010, there is a minor increase of $300,000 above the comparable FY 2009 budget request for this activity that is attributable to an increase in payroll processing charges from the Defense Finance and Accounting Service (DFAS).

Enterprise Email/HHS Mail
In FY 2007, both Enterprise Email and Information Technology (ITO) were Non-PSC SSF activities. In FY 2008, Information Technology (ITO) moved to the PSC side of the Fund, while Enterprise Email remained a part of the Non-PSC set of activities. In FY 2009, Enterprise Email will again be managed and operated as a component of Information Technology (ITO) within the PSC, and budget information for this activity is being reported separately as part of the PSC's FY 2010 SSF activity budget. The "FY 2008 Comparable" column of the budget table reflects the FY 2008 actual revenue for Enterprise Email on this comparable basis.

Human Resources Centers
The FY 2010 budget for Human Resources Centers is $66,097,000, which is an increase of $1,500,000 above the FY 2009 budget request of $64,597,000 due to increased contract costs associated with a human resources database upgrade.

Departmental Contracts Information System (DCIS)
The FY 2010 budget for the Departmental Contracts Information System (DCIS) program activity will increase slightly by $216,000 to $1,052,000 due to the need to award a contract for the OMB/OFPP required independent, statistically valid (IV & V) certification of data (Memorandum to Chief Acquisition Officers dated March 9, 2007).

Web Communications Division
A modest increase from $6,264,000 in FY 2009 to $6,564,000 in the FY 2010 budget for the Web Communications Division ($300,000 increase) was also approved as part of the addition of a new Web Crawler cost center within that activity.

OPDIV Share of SSF Budget

(Dollars in Thousands)

	FY 2009	FY 2010	+/- FY 2009
ACF	29,466	29,620	154
AoA	2,735	2,773	38
AHRQ	6,178	6,249	71
CDC	49,422	49,265	(157)
CMS	23,662	23,467	(195)
FDA	68,930	69,112	182
HRSA	28,887	29,231	344
IHS	47,299	47,042	(257)
NIH	61,344	60,239	(1,105)
OS	74,238	74,343	105
PSC	49,411	49,318	(93)
SAMHSA	9,896	9,984	88
Non HHS	387,327	387,326	(1)
Total Budget	838,792	837,971	(821)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SERVICE AND SUPPLY FUND
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2008 Actual	FY 2009 Estimate	FY 2010 Estimate
Reimbursable Obligations			
Personnel Compensation and Benefits:			
Personnel Compensation (11).....	**109,982**	**115,070**	**115,650**
Personnel Benefits (12).....…	30,565	37,119	37,548
Benefits to Former Employees (13.0)……....	180	206	241
Subtotal, Pay Costs	**140,727**	**152,394**	**153,438**
Travel (21.0).....…	2,589	3,613	3,494
Transportation of Things (22.0).....…	3,421	4,307	3,555
Rental Payments to GSA (23).....	55,891	65,059	64,622
Communications, Utilities, and Misc			
Printing and Reproduction (24.0).....…	350	564	636
Other Contractual Services (25)	525,960	580,550	579,998
Supplies and Materials (26.0).....	24,433	25,100	25,119
Equipment (31.0).....	6,047	7,118	7,108
Other (32)(42)(61).....	87	87	-
Subtotal, Non-Pay Costs…….....	**618,778**	**686,398**	**684,533**
Total, Reimbursable Obligations…….....	**759,505**	**838,792**	**837,971**

FY 2010 Budget Submission
Service and Supply Fund
Statement of Personnel Resources

	Total Full-Time Equivalents (Workyears)								
	FY 2008 Actual			**FY 2009 Target**			**FY 2010 Target**		
Reimbursable	Civ	Mil	Total	Civ	Mil	Total	Civ	Mil	Total
PSC Activities:									
Administrative Operations Service	180	6	186	207	6	213	209	4	213
Financial Management Service	226		226	231		231	231		231
Federal Occupational Health	38	33	71	71	12	83	71	12	83
ISMS/(Enterprise Support Service)	171		171	175		175	175		175
Strategic Acquisition Service	100		100	111		111	111		111
Human Resource Activities	322		322	407		407	407		407
Office of the Director	28		28	29		29	29		29
Total, Reim. PSC-SSF FTE	1,065	39	1,104	1,231	18	1,249	1,233	16	1,249
Non-PSC Activities:									
Acquisition Integ. & Mod. (AIM)	-	-	-	-	-	-	-	-	-
Audit Resolution	7		7	8		8	8		8
Comm Corps Force Mgmnt	27	40	67	31	40	71	29	42	71
Dept. Contracts Info. System	1		1	1		1	1		1
HPO & Commercial Services Mgmt	2		2	2		2	2		2
Claims	5		5	7		7	7		7
Small Business Office	10		10	12		12	12		12
TAGGS	2		2	2		2	2		2
Web Communications	18		18	20		20	20		20
Email	-		-	-		-	-		-
Homeland Security Pres Dir - 12	-		-	-		-	-		-
Fund Manager	2		2	4		4	4		4
Total, Reim. Non-PSC-SSF FTE	74	40	114	87	40	127	85	42	127
Total, Reimburesable FTE SSF	1,139	79	1,218	1,318	58	1,376	1,318	58	1,376

Retirement Pay and Medical Benefits for Commissioned Officers

Appropriation Language

The Program Support Center has responsibility for the administration of the retirement pay for commissioned officers. The appropriations language for that account follows.

Retirement Pay and Medical Benefits for Commissioned Officers

For retirement pay and medical benefits of Public Health Service Commissioned Officers as authorized by law, for payments under the Retired Serviceman's Family Protection Plan and Survivor Benefit Plan, and for medical care of dependents and retired personnel under the Dependent's Medical Care Act (10 U.S.C. ch. 55), such amounts as may be required during the current fiscal year.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Amounts Available for Obligation

Total, Mandatory Appropriation

	FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request
Mandatory Appropriation [1]	$401,406,616	$434,694,266	$474,557,377
Unobligated Balance, start of year			
Unobligated Balance, end of year			
Unobligated Balance, lapsing			
Total Obligations	$401,406,616	$434,694,266	$474,557,377

[1] Includes Retirement Payments, Survivor's benefits, and Medical care.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Accrued Medical Amount Available for Obligation

Amounts Available for Obligation

Total, Discretionary Appropriation

	FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request
Discretionary Appropriation	$36,646,560	$34,778,000	$35,589,736
Unobligated Balance, start of year			
Unobligated Balance, end of year			
Unobligated Balance, lapsing			
Total Obligations	$36,646,560	$34,778,000	$35,589,736

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Summary of Changes

2009 Appropriation……..	$469,472,266
2010 Request…….	$510,147,113
Net change……..	+40,674,847

	FY 2009 Current Estimate Base		Change from Base	
	FTE	BA	FTE	BA
Changes:				
1. Annualization of the FY 2010 COLA, 2.0% COLA in FY 2009, and for the projected net increase of retirees during FY 2009.	---	$339,351,824	---	+$17,103,218
2. Annualization of the FY 2010 COLA, 2.0% COLA in FY 2009, and projected net increase in average costs per survivor in FY 2009	---	19,474,068	---	+5,118,718
3. Will only cover medical benefits for Officers under age 65. Costs do include a projected increase of 16% in medical care costs for these Officers.	---	75,868,374	---	+17,641,175
4. Will cover Medicare Eligible Accrual Benefits for Officers under age 65.	---	34,778,000	---	+811,736
Net change			---	+$40,674,847

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Activity

	FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request
Retirement payments	$303,911,469	$339,351,824	$356,455,042
Survivors' benefits	21,399,296	19,474,068	24,592,786
Medical care	76,095,851	75,868,374	93,509,549
Total Retired Pay	401,406,616	434,694,266	474,557,377
Medicare Eligible Accruals	36,646,560 1/	34,778,000 2/	35,589,736 3/
Total	$438,053,176	$469,472,266	$510,147,113

1/FY08 – The DoD Office of the Actuary letter dated 6/27/06 set the PHS FY08 per capita amount for the DoD MERHCF at $5988 for full-time members.

2/FY09 – The DoD Office of the Actuary letter dated 7/19/07 set the PHS FY09 per capita amount for the DoD MERHCF at $5560 for full-time members.

3/FY10 – The DoD Office of the Actuary letter dated 7/24/08 set the PHS FY10 per capita amount for the DoD MERHCF at $5642 for full-time members.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Object

	FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request	Increase/ Decrease
Benefits for former Personnel	$401,406,616	$434,694,266	$474,557,377	+$39,863,112
Accrued Health Care Benefits	36,646,560	34,778,000	35,589,736	+811,736
Total budget authority by object	$438,053,176	$469,472,266	$510,147,113	+$40,674,847

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Authorizing Legislation

	FY 2009 Amount Authorized	FY 2009 Omnibus	FY 2010 Amount Authorized	FY 2010 President's Budget Request
1. Retirement payments Chapter 6A of Title 42, U.S.C.	Indefinite	$339,351,824	Indefinite	$356,455,042
2. Survivors' benefits Chapter 73 of Title 10, U.S.C.	Indefinite	19,474,068	Indefinite	24,592,786
3. Medical care Chapter 55 Of Title 10 U.S.C., P.L. 89-614; P.L.106-398; P.L. 107-107.	Indefinite	75,868,374	Indefinite	93,509,549
4. Medicare Eligible Accruals, Chapter 55 Of Title 10 U.S.C., P.L. 108-375	Indefinite	34,778,000	Indefinite	35,589,736

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Appropriations History Table

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2000	214,905,000	214,905,000	214,905,000	201,842,168
2001	219,772,000	219,772,000	219,772,000	245,956,147
2002	242,577,000	242,577,000	242,577,000	273,478,736
2003	251,039,000	251,039,000	251,039,000	291,471,400
2004	308,763,000	308,763,000	308,763,000	321,083,552
2005	324,636,000	324,636,000	324,636,000	343,885,944
2006	363,029,000	363,029,000	363,029,000	376,517,351
2007	377,982,000	377,982,000	377,982,000	406,967,837
2008	439,907,000	439,907,000	439,907,000	438,053,176
2009	469,472,266	469,472,266	469,472,266	469,472,266
2010	510,147,113			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Justification

A. Account Summary

	FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request	Increase or Decrease
Retirement payments	$303,911,469	$339,351,824	$356,455,042	+$17,103,218
Survivors' benefits	21,399,296	19,474,068	24,592,786	+5,118,718
Medical care	76,095,851	75,868,374	93,509,549	+17,641,176
Medicare Eligible Accruals	36,646,560	34,778,000	35,589,736	+811,736
Total budget authority	$438,053,176	$469,472,266	$510,147,113	+$40,674,847

B. General Statement

This appropriation provides for retirement payments to Public Health Service (PHS) officers who are retired for age, disability, or a specified length of service as well as for payments to survivors of deceased retired officers who had elected to receive reduced retirement payments.

This account also funds the provision of medical care to active duty and retired members of the PHS Commissioned Corps, and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps.

The FY 2010 request is a net increase of $40,647,847 over the FY 2009 level. This amount reflects increased medical benefits costs, an annualization of amounts paid to retirees and survivors in FY 2008, and a net increase in the number of retirees and survivors during FY 2008. The budget request includes a cost-of-living adjustment (COLA) of 2.0 percent.

C. Retirement Payments

Authorizing legislation - Chapter 6A of Title 42 U.S.C.

FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request	Increase or Decrease
$303,911,469	$339,351,824	$356,455,042	+$17,103,218

2010 Authorization..... Indefinite

Purpose and Method of Operation

The purpose of this activity is to provide mandatory payments to Commissioned Officers of the Public Health Service who have been retired for age, disability or specified length of service.

Funding levels for the past five fiscal years were as follows:

2005…….……	247,031,515
2006…….……	268,611,441
2007…….……	292,249,000
2008…….……	303,911,469
2009…….……	339,351,824

Rationale for the FY 2010 Budget Request

The FY 2010 request of $356,455,042 is an increase of $17,103,218 over the FY 2009 level and will support payments to an estimated 5283 annuitants. The increase will fund the annualization costs of the FY 2009 COLA, an FY 2010 COLA of 2.0 percent, and the projected net increase of 124 retirees during FY 2010.

The FY 2010 estimates are based on payments to the following number of retirees:

Period Ending	Total	Net Increase/(Decrease)
September 30, 2008, (act.)	4985	146
September 30, 2009, (est.)	5159	174
September 30, 2010, (est.)	5283	124

D. Survivors' Benefits

Authorizing legislation - Chapter 73 of Title 10 U.S.C.

FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request	Increase or Decrease
$21,399,296	$19,474,068	$24,592,786	+$5,118,718

2010 Authorization..... Indefinite

Purpose and Method of Operation

This activity provides for the payment of annuities to survivors of retired officers who had elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan and Survivor's Benefit Plan. This program is financed by the Federal Government although deductions are made in the retirement payments to the officers who elect the option of survivors' benefits.

Funding levels for the past five years were as follows:

2005…….	14,206,440
2006…….	16,674,656
2007…….	18,004,871
2008…….	21,399,296
2009…….	19,474,068

Rationale for the FY 2010 Budget Request

The FY 2010 request of $24,592,786 is an increase of $5,118,718 from the FY 2009 level and will provide payments for an estimated 907 annuitants. This amount includes funds for the annualization costs of the FY 2009 COLA and the FY 2010 COLA of 2.0 percent.

The FY 2010 estimates are based on payments to the following numbers of annuitants:

Period Ending	Total	Net Increase/(Decrease)
September 30, 2008, (act.)	917	27
September 30, 2009, (est.)	907	-10
September 30, 2010, (est.)	907	0

E. Medical Care

Authorizing legislation - Chapter 55 of Title 10 U.S.C.; P.L. 106-398; and P.L. 107-107.

FY 2008 Actual	FY 2009 Omnibus	FY 2010 President's Budget Request	Increase or Decrease
$76,095,851	$75,868,374	$93,509,549	$17,641,176

2010 Authorization..... Indefinite

Purpose and Method of Operation

This program provides for the cost of medical care rendered in non-Federal and in uniformed service facilities to active duty and retired PHS commissioned officers and dependents of eligible personnel.

This activity fulfills the mandatory medical care obligations of the Public Health Service to Commissioned Officers and their dependents. Medical care to eligible beneficiaries is authorized under the Dependents' Medical Care Act, as amended by P.L. 89-614, which allows for an expanded and uniform program of medical care to active duty and retired members of the uniformed services, and dependents of active duty, retired and deceased members. Health care provided in a uniformed service facility is billed directly to the Public Health Service by that organization. When medical care is provided to dependents or retirees in a private facility, the Civilian Health and Medical Program of the Uniformed Services (TRICARE) acts as the Government's agent to arrange payment and, in turn, bills the Public Health Service for the services rendered. In addition, contract medical care is arranged for active duty officers who are not stationed in an area accessible to uniformed facilities.

Funding levels for the past five years were as follows:

	Total Funding Level
2005	44,992,558
2006	56,754,254
2007	65,998,265
2008	76,095,851
2009	75,868,374

Rationale for FY 2010 Budget Request

The request of $93,509,549 will provide medical care for under age 65 beneficiaries. The FY 2010 request reflects increases in the cost of drugs and inpatient and outpatient care for all beneficiaries in Federal and non-Federal facilities.

The FY 2010 estimates are based on payments to the following numbers of active duty officers:

Period Ending	Total	Net Increase/(Decrease)
September 30, 2008, (act.)	6,099	-21
September 30, 2009, (est.)	6,228	129
September 30, 2010, (est.)	6,308	80

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROPOSED GENERAL PROVISIONS FOR FISCAL YEAR 2010

The President's Budget recommends that a number of general provisions be included in the FY 2010 Departments of Labor, Health and Human Services and Education Appropriations Act. These provisions follow appendix schedules for the Department of Health and Human Services (Title II General Provisions) and the Departments of Labor, Health and Human Services and Education (Title V General Provisions). Following is a summary of the proposed provisions:

Title II

Sec. 201. This provision authorizes not to exceed $50,000 in appropriated funds may be used for official reception and representation expenses that are specifically approved by the Secretary.

Sec. 202. This provision enables the Secretary to assign not more than 60 Public Health Service employees to assist in child survival activities and to work in AIDS programs through and with funds provided by the Agency for International Development, the United Nation's International Children's Emergency Fund or the World Health Organization.

Sec. 203. This provision states that no funds appropriated in this Act for the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.

Sec. 204. This provision allows the Secretary to use not more than 2.4 percent of any appropriations authorized under the Public Health Service Act for evaluation (directly, or by grants or contracts) of the implementation and effectiveness of the Public Health Service Act programs.

Sec. 205. This section provides that not to exceed 1 percent of discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) appropriated for the current fiscal year for the Department of Health and Human Services in this Act may be transferred between appropriations, with a limitation that no such appropriation may be increased by more than 3 percent, and that an appropriation may be increased by up to an additional 2 percent after notification of the Appropriations Committees in both the House and Senate. The Appropriations Committees of both the House and Senate are to be notified at least 15 days in advance of any transfer.

Sec. 206. This provision states that the Director of the National Institutes of Health, jointly with the Director of the Office of AIDS Research, may transfer up to 3 percent among institutes and centers from the total amounts identified by these two Directors as funding for research pertaining to the human immunodeficiency virus, provided that the House and Senate Appropriations Committees are promptly notified of the transfer.

Sec. 207. This section provides that the amount for research related to the human immunodeficiency virus at the National Institutes of Health, as jointly determined by the Director of the National Institutes of Health and the Director of the Office of AIDS Research, shall be available to the "Office of AIDS Research" account and that the Director of the Office

of Aids Research shall transfer from the account amounts necessary to carry out section 2353(d)(3) of the Public Health Service Act.

Sec. 208. This provision states that none of the funds appropriated in this Act may be made available to any entity under title X of the Public Health Service Act unless the award applicant certifies to the Secretary of Health and Human Services that it encourages family participation in decisions of minors to seek family planning services and provides counseling to minors on how to resist coercion into engaging in sexual activities.

Sec. 209. This section allows that no provider of services under title X of the Public Health Service Act shall be exempt from State laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape or incest.

Sec. 210. This provision provides that none of the funds appropriated by this Act, including trust funds, may be used to carry out the Medicare Advantage program if the Secretary of Health and Human Services denies an otherwise eligible entity participation in the program because the entity informs the Secretary that it will not provide, pay for, provide coverage of, or provide referrals for abortions; provided that the Secretary shall make appropriate prospective adjustments to the capitation payment to such an entity (based on an actuarially sound estimate of the expected costs of providing the service to such entity's enrollees), and provided further that nothing in this section shall be construed to change the Medicare program's coverage for such services and a Medicare Advantage organization described in this section shall be responsible for informing enrollees where to obtain information about all Medicare covered services.

Sec. 211. This provision provides that none of the funds appropriated by this Act can be used to withhold substance abuse funding from a State, if the State certifies to the Secretary of Health and Human Services by May 1, 2010, that it will commit additional State funds to ensure compliance with State laws prohibiting the sale of tobacco products to individuals under 18 years of age. The State is to submit a report to the Secretary on all fiscal year 2009 State expenditures and all fiscal year 2009 obligations for tobacco prevention and compliance activities, by program activity, by July 31, 2010.

Sec. 212. This provision provides authority to support HHS in carrying out international HIV/AIDS and other infectious, chronic and environmental disease and other health activities abroad during fiscal year 2010.

Sec. 213. This provision provides authority for the Office of the Director of the National Institutes of Health (NIH) to enter into transactions (other than contracts, cooperative agreements, or grants) in order to implement the NIH Common Fund, in lieu of the peer review and advisory council review procedures that would otherwise be required. The Director of NIH may utilize such peer review procedures as determined appropriate to obtain assessments of scientific and technical merit.

Sec. 214. This section allows funds made available in this Act to be used to continue operating the Council on Graduate Medical Education established by section 301 of Public Law102-408.

Sec. 215. This provision provide authority not to exceed $35,000,000 the amount of funds appropriated by this Act to the Institutes and Centers of the National Institutes of Health that may be used for alteration, repair, or improvement of facilities, as necessary for the proper and efficient conduct of the activities authorized herein, at not to exceed $2,500,000 per project.

Sec. 216. This provision provides that 1 percent of the funds made available for the National Institutes of Health National Research Service Awards (NRSA) will be available to the Administrator of the Health Resources and Services Administration for NRSA awards for research in primary medical care; 1 percent of the amount made available for NRSA is to be available to the Director of the Agency for Healthcare Research and Quality to make NRSA awards for health service research.

Title V

Sec. 501. This provision authorizes the Secretaries of Labor, Health and Human Services, and Education to transfer unexpended balances of prior appropriations to accounts corresponding to those included in this Act as long as the balances are used for the same purpose and the same period of time they were originally appropriated.

Sec. 502. This section states that no appropriation contained in this Act shall remain available for obligation for a period beyond the current fiscal year, unless it is expressly stated in this Act.

Sec. 503. This provision provides that:

(a) Except for normal and recognized executive-legislative relationships, no part of any appropriation in this Act shall be used for publicity or propaganda, preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio or TV broadcast or film presentation designed to support or defeat legislation pending before the Congress or any State legislature, except as a presentation to the Congress or any State legislature itself.

(b) No part of any appropriation in this Act be used to pay the salary or expenses of any grant or contract recipient (or their agent) related to activities designed to influence legislation or appropriations pending before the Congress or any State legislature.

Sec. 504. This provision provides the amounts available to the Secretaries of Labor and Education, the Director of the Federal Mediation and Conciliation Service, and the Chair of the National Mediation Board, from their respective Salaries and Expenses accounts, for official reception and representation expenses.

Sec. 505. This provision provides that no funds appropriated under this Act may be used to carry out a program of distributing sterile needles for the hypodermic injection of any illegal drug.

Sec. 506. This provision provides that all Federal grantees (including State and local governments and recipients of Federal research grants) issuing press releases, requests for proposals and other documents describing projects or proposals supplied with Federal money clearly state the following: (1) the percentage of total costs of the program or project financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) the percentage and dollar amount of the total cost to be financed by non-governmental sources.

Sec. 507. This provision provides that none of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, may be expended for abortion or for health benefits coverage that includes coverage of abortion. The term ‘health benefits coverage’ means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

Sec. 508. The limitations established in the preceding section shall not apply to an abortion:

(a) If the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless the abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

(d) None of the funds may be available to any Federal program, agency or State and local government, if said institution subjects the individual or health care entity to discrimination on the basis that the health care entity does not provide coverage of, or referrals for abortions. Further, the section defines the term "health care entity."

Sec. 509. This section provides that none of the funds made available in this Act to be used for creation of a human embryo, embryos for research, or research in which a human embryo or embryos is destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under the Public Health Service Act. For the purposes of this section, human embryo or embryos include any organism derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

Sec. 510. This provision provides that none of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or controlled substance except when there is significant medical evidence of therapeutic advantage to the use of such drug or other substance, or Federally-sponsored clinical trials are being conducted to determine therapeutic advantage.

Sec. 511. This provision provides that none of the funds made available in this Act may be used to promulgate or adopt any final standard under section 1173(b) of the Social Security Act providing for, or providing for the assignment of, a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard.

Sec. 512. This provision provides that none of the funds made available in this Act may be used to enter into or renew a contract with a contractor with the U.S. Government who is subject to section 4212(d) of title 38, United States Code, but has not submitted the most recent annual report required by that section to the Secretary of Labor, detailing the employment of certain veterans.

Sec. 513. This provision affects the Department of Education and pertains to a library's eligibility for funding under the Library Services and Technology Act, as amended by the Children's Internet Protections Act.

Sec. 514. This provision prescribes that none of the funds made available to carry out part D of title II of the Elementary and Secondary Education Act of 1965 may be made available to elementary or secondary schools covered by paragraph (1) of section 2441(a), as amended by the

Children's Internet Protection Act and the No Child Left Behind Act, unless the local educational agency with responsibility for such covered school has made the certifications required by paragraph (2) of such section.

Sec. 515. This section states that none of the funds in this Act may be used to employ workers described in section 274A(h)(3) of the Immigration and Nationality Act.

Sec. 516. This provision provides that none of the funds appropriated in this Act may be expended or obligated by the Commissioner of Social Security for purposes of administering Social Security benefit payments under title II of the Social Security Act, to process claims for credits for quarters of coverage based on work performed under a social security account number that is not the claimant's number and the performance of such work under such number has formed the basis for a conviction of the claimant of a violation of section 208(a)(6) or (7) of the Social Security Act.