DEPARTMENT of HEALTH and HUMAN SERVICES

FY 2002 PERFORMANCE PLAN and PERFORMANCE REPORT SUMMARY

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THIS IS A SUMMARY DOCUMENT.

HHS administers approximately 300 program activities, with over 950 annual performance goals. To best accommodate the linkage of these performance goals to the budget requests for these program activities, HHS has incorporated the performance goals into the budget submissions for the HHS components that administer the programs. For a comprehensive view of all performance goals for all HHS program activities, including the latest performance results and other required information, users must refer to the performance plans and reports included in the budget justification for the individual HHS components.

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USER GUIDE TO THE HHS PERFORMANCE PLANS AND REPORTS

The Department of Health and Human Services (HHS) enhances the health and well-being of all Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services. We accomplish this mission through the collaborative efforts of the over 300 programs that are administered by our operating components and staff offices within the Office of the Secretary.

HHS administers these programs in coordination with partners – State, local, and Tribal governments, grantees, and contractors – who implement these programs in the States and local communities. In fact, the overwhelming majority of the approximately $486.8 billion dollars that will be expended for HHS programs in FY 2002 will be spent by these program partners. Therefore, the strategic goals, performance goals, and results in the HHS Strategic Plan and the annual performance plans and reports reflect the combined commitment and effort of HHS programs and their State, local and Tribal, and non-governmental partners.

The HHS FY 2002 Performance Plan and Report is comprised of the performance plans and reports prepared by the following operating and staff components. The performance plans and reports have been integrated into the component's budget justification in order to facilitate the use of performance information in the budget decision-making process.

Administration on Aging (AoA) serves as the primary federal focal point and advocacy agent for older Americans. Through a network of state and area agencies on aging, AoA funded programs deliver comprehensive in-home and community services; and make legal services, counseling, and ombudsmen programs available to elderly Americans.

Administration on Children and Families (ACF) leads the nation in improving the economic and social well-being of families, children, and communities though federal grant programs like Head Start, Child Support Enforcement, Child Welfare Services, Child Care and Development, and Temporary Assistance to Needy Families.

Agency for Healthcare Research and Quality (AHRQ) enhances the quality, appropriateness, and effectiveness of health services and access to such services, through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions.

Centers for Disease Control and Prevention (CDC) monitors health; identifies and investigates public health problems; promotes healthy behaviors; and develops and advocates sound public health policies to prevent and control disease, injury, and disability.

Food and Drug Administration (FDA) promotes improvement in the health of the American public by ensuring the effectiveness and/or safety of drugs, medical devices, biological products, food, and cosmetics; and by encouraging the active participation of business and the public in managing the health hazards associated with these products.

Health Care Financing Administration (HCFA) pays Medicare benefits; provides states with matching funds for Medicaid benefits; conducts research, demonstrations, and oversight to ensure the safety and quality of medical services and facilities provided to Medicare beneficiaries; and establishes rules for eligibility and benefit payments.

Health Resources and Services Administration (HRSA) promotes equitable access to comprehensive, quality health care for all, with a particular focus on underserved and vulnerable populations.

Indian Health Service (IHS) provides comprehensive health services for American Indian and Alaska Native people, with opportunity for maximum tribal involvement in developing and managing programs to improve health status and overall quality of life.

National Institutes of Health (NIH), through its 25 institutes, centers, and divisions, supports and conducts medical research, domestically and abroad, into the causes and prevention of diseases and promotes the acquisition and dissemination of medical knowledge to health professionals and the public.

Office for Civil Rights (OCR) promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination. Through prevention and elimination of unlawful discrimination, the Office for Civil Rights helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

Office of Inspector General (OIG) improves HHS programs and operations and protects them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations OIG provides timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public.

Program Support Center (PSC) provides a broad range of administrative services to HHS components and other Federal agencies on a competitive, fee-for-service basis. PSC services are provided in three business areas: human resources, financial management, and administrative operations.

Substance Abuse and Mental Health Services Administration (SAMHSA), through its three centers, works to improve quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illness, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society.

General Departmental Management

> ***Departmental Appeals Board*** (DAB) is an independent office established to provide conflict resolution services. These services are basically of two types: 1) adjudicatory hearings, appellate review of decisions of administrative law judges, and similarly structured formal and informal reviews of contested decisions; and 2) alternative dispute resolution (ADR), including mediation and other consensual processes and training related to ADR.

Office of Assistant Secretary for Management and Budget (ASMB) advises the Secretary on all aspects of administration and financial management, and provides general oversight and direction of the administrative and financial organizations and activities of the Department.

Office of Assistant Secretary for Planning and Evaluation (ASPE) provides policy analysis and advice; guides the formulation of legislation; coordinates strategic and implementation planning; conducts regulatory analysis and reviews regulations; oversees the planning of evaluation, non-biomedical research, and major statistical activities; and administers evaluation, data collection, and research projects that provide information needed for HHS policy development.

Office of Public Health and Science (OPHS) provides senior professional leadership across HHS on population-based public health and clinical preventive services by providing scientifically sound advice on health and health policy to the Secretary, Departmental officials and other governmental entities and communicating on health issues directly to the American public; conducting essential public health activities through eleven program offices, and providing professional leadership on cross-cutting Departmental public health and science initiatives.

HHS PLANNING AND MEASUREMENT DOCUMENTS

The following documents support planning and measurement efforts at HHS under the *Government Performance and Results Act of 1993* (GPRA) and are available at www.hhs.gov/topics/planbudget.html. (The FY 2002 Performance Plans and Reports will be available on the Internet by the end of April.)

HHS Strategic Plan – The FY 2001-2006 HHS Strategic Plan was published in September 2000 and contains detailed discussions of HHS' strategic goals and objectives, internal and external coordination, external factors that may affect the achievement of the plan, and other information relevant to strategic planning.

HHS FY 2002 Performance Plan and FY 2000 Performance Report – consists of the individual performance plans and reports prepared by HHS' operating and staff components. These performance plans and reports have been integrated into the component's budget justification in order to facilitate the use of performance information in the budget decision-making process. In addition, the performance reports have been integrated with the performance plans to provide a multi-year picture of planning, reporting, analysis, and reassessment of strategies and goals.

HHS FY 2002 Performance Plan and Report Summary – is provided as a supplement to the component performance plans and reports to provide a Departmental perspective on performance measurement at HHS. The Summary illustrates how the strategies and performance goals of HHS programs support the assessment of HHS' progress in achieving the long-term, strategic goals and objectives in the HHS Strategic Plan. It also contains analyses of several key Departmental measurement issues.

Please note that this is only a summary document. For a comprehensive view of all performance goals for all HHS program activities, including the latest performance results and other required information, users must refer to the performance plans and reports included in the budget justification for the individual HHS components. The Summary includes the following sections:

- *User Guide* – The User Guide provides an overview of HHS components, GPRA planning and measurement documents, and describes the outline for the content of the performance plans and reports of the HHS components.

- *Data Collection* – This analysis provides examples of HHS data collection systems and how they currently support program planning and performance measurement in HHS; reviews efforts that are underway to enhance the data that is available to HHS programs and partners for planning, decision making, and measuring results; describes recent activities by the HHS OIG to review HHS performance data; and discusses the status of final reporting on FY 1999 and FY 2000 performance goals.

- *Management & Coordination* – The *Management* section describes the various tools used by the Department to manage, address, and report on our mission-critical management activities and challenges. The *Coordination* section discusses how coordination among HHS programs and internal and external partners support performance measurement in the Department.

- *Linkage to the HHS Strategic Plan* – Organized by HHS' strategic goals and objectives, this section of the Summary includes selected performance stories and goals from the annual performance plans and reports of the HHS operating and staff components that support the achievement of HHS' long-term strategic goals and objectives.

Performance Improvement 2000: Evaluation Activities of the U.S. Department of Health and Human Services – HHS incorporates this evaluation report by reference into the HHS Summary to meet the GPRA requirement that Federal agencies include a summary of the findings and recommendations of program evaluations in the GPRA performance report. This report provides evaluative information on HHS' programs, policies, activities, and strategies, and is available at aspe.os.dhhs.gov/PIC/gate2pic.htm.

NAVIGATING THE HHS PERFORMANCE PLANS AND REPORTS

The performance plans and reports of the HHS components follow a standardized format that establishes a consistent order of presentation of information across the component plans. The outline for this order of presentation appears below. Under each heading, you will find a description of the types of information that can be found in that section. Within the format, the discussion flows from the broad, component-level perspective, to a program-level view, to a very specific discussion of individual goals. Key themes, such as mission, long-term goals, strategies, resources, and coordination are discussed at each level. Throughout the plans, HHS components have incorporated these key themes with program performance results to present a complete performance story for the program.

HHS components have significant flexibility within the standardized format so that they can tailor their documents to meet unique characteristics of their programs and organization. For example, some components address data issues at the program or goal levels in Part II, some provide this discussion in the Appendix, and some do both. The choice of approach varies depending on the nature of the data systems used and the number of goals those systems support.

Part I – Agency Context for Performance Measurement

Part I focuses on *component*, as opposed to program or goal, issues. This section outlines the role of the HHS component in program implementation, coordination, and planning and sets the context for the program discussions in Part II of the plan.

1.1. Agency Mission and Long-Term Goals. In this section, all HHS components discuss their mission and long-term goals to set the broad context for the performance information that follows.

1.2 Organization, Programs, Operations, Strategies and Resources. This section addresses the strategies, processes, technologies, and resources that will help the component achieve its long-term goals. Detailed program information can be found in Section II; however, you may find some discussion of key program activities here. Some components may also discuss major management efforts in this section, and identify where management improvement goals are presented in the plan and/or in other required planning and reporting documents.

1.3 Partnerships and Coordination. Because most HHS programs are implemented by State, Tribal, and local governments, grantees, and contractors, coordination with these partners is vital in program implementation, assessment, and data collection. In this section, HHS components discuss partnership and coordination activities at the component level.

1.4 Summary FY 2000 Performance Report. This section provides a summary of the component's most significant performance results and key issues influencing the results. Components also include a summary statement concerning the completeness and reliability of performance data, highlight any significant data issues, and report on the status of final data reporting for FY 1999 and FY 2000 performance goals.

Part II – Program Planning and Assessment

Introduction. Part II includes a section for each of the component's program activities or aggregated GPRA program activities. The Introduction explains how the component has organized its program activities for GPRA planning and reporting and sets the context for Part II.

2.1 Program Title

2.1.1 Program Description, Context and Summary of Performance. Key themes – mission, long-term goals, strategies, resources, and coordination – are discussed from the perspective of the program. This section also includes the following information:

Legislative Intent and Broad Program Goals. Legislative intent, or the outcome the program is funded to produce, is important in understanding the program's selection of performance goals. For example, while a program funded to improve coordination of services in States can be expected to affect population outcomes over time, the appropriate annual assessment of the success of the program is a goal measuring improvement in service coordination.

Program Activities, Strategies and Resources. Similar to the component-level presentation described above, this section focuses on the resources (particularly the budget request), activities, and strategies applied to produce results for the program. Components may reference to their budget documents for more detail on these activities, resources, and strategies.

Program Coordination, Partnerships and Crosscutting Issues. Because most HHS programs are implemented by State, Tribal, and local governments, grantees, and contractors, coordination with these partners is vital in program implementation, assessment, and data collection. In this section, HHS programs discuss the partnership and coordination activities that support the achievement of the program's performance goals.

Program-Wide Performance. In this section, the program describes the overall results achieved by the program, key factors influencing the results, and changes in program strategies or future targets that are indicated by the results. When available, trend data, benchmarks, national health statistics, and data from program evaluations are provided as context for the performance goal results and to complete the performance story.

Program-Level Data Issues. In this section, HHS programs identify the data sources for program goals, address any significant data issues, and discuss the means used to verify and validate data. Many programs also discuss activities completed, underway, or planned that will enable the program to move to more sophisticated measures of performance and/or to improve the timeliness, completeness, and reliability of the data. HHS components generally choose to address data issues at the program level rather than goal level when multiple program goals come from the same data source.

Summary Goal Tables. The summary tables provide a multi-year picture of performance goals, measures, targets, baselines, and actual performance for the program. The tables facilitate easy comparison of targets and actual performance and a provide a snapshot of trend data. Where data is not yet available for the just-completed fiscal year, the table will include a date when the data will be available. Although all components have included summary tables, the tables may be located in different places in each plan. Some components also provide additional tables that contain more detailed descriptions of performance.

2.1.2 Goal-by-Goal Presentation of Performance. Some agencies have incorporated the elements of this section into program-level discussions; therefore, not all components have included a goal-by-goal presentation of performance into their plans. When included, you will find the following elements:

Context For the Goal. This section provides context for each program goal, including strategies, resources, coordination, and the significance of the goal for decision making and assessing program results.

Goal-Level Data Issues. Some components address data issues at the goal level rather than the program level, particularly where goals for a program come from different data sources.

Goal-Level Performance. This discussion of performance for individual goals expands on the performance discussions at the component and program level.

Appendix to the Performance Plan

A.1 Approach to Performance Measurement. Although agencies have a considerable amount of flexibility in where they choose to present this information, you may find the following elements in this section:

Methodology and Rationale. This is where HHS components explain the details and rationale for the performance measurement methods and constructs they have chosen.

Data Verification and Validation and Other Data Issues. Data verification and validation are significant and complex management process issues. Several HHS components have chosen to provide substantive information here rather than within the body of the plans, particularly for systems that support performance goals for many programs.

A.2 Changes and Improvements Over Previous Year. This section includes a discussion of significant improvements in the plan from the previous year and a table showing the changes between performance goals in the Final FY 2001 Plan and the Revised Final FY 2001 Plan.

A.3 Linkage to HHS and OPDIV Strategic Plans. Some components include this presentation here rather than in the body of the plans or use this section to provide more detail.

A.4 Performance Measurement Linkages with Budget, Cost Accounting, Information Technology Planning, Capital Planning and Program Evaluation. HHS components address the linkages between these areas and performance measurement in this section.

DATA TO MEASURE PROGRAM PERFORMANCE

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

Generally, for the initial implementation of GPRA, our programs' choice of performance goals was driven by the existing capabilities of systems designed to track the health of the general population, support broad planning objectives, and provide services. Historically, programs and operating components have relied upon data for program management, policy decision making, and intervention development. GPRA reinforced the perspective of data for decision making and encouraged staff throughout HHS to reflect and refine our data systems. As a result, our programs work extensively with their partners in program implementation and data collection – State, local, and Tribal governments, grantees, and Medicare contractors – to identify enhancements to these systems that would improve the timeliness, completeness, and accuracy of our data and enable us to move to more sophisticated measures of performance. Key challenges include:

- These systems need to produce data on a more timely basis and with a frequency relevant to the periods over which performance is being measured. AoA and CDC have established performance goals to reduce time lags for core data collections. CDC has already achieved significant results, shortening the final release of 1998 birth data by three months. In addition, activities currently undertaken by HHS programs and their data collection partners, particularly improvements in information technology, will allow faster reporting of program-level data.

- As the health system continues to change, current data collections may not continue to produce needed data. For example, the move toward managed care may make medical information increasingly proprietary, making access for research and tracking health trends more difficult. Similarly, changes in relationships between different health care providers, as well as laboratories, may make public health surveillance based on case reports more difficult.

- A major challenge in selecting annual performance goals is that many of the interventions for complex chronic diseases or social problems require years of focused efforts to realize significant progress. In addition, measuring outcomes for individuals and populations can be time intensive, costly, and raise issues of confidentiality. It can also be difficult to tie changes in outcomes to programmatic efforts. HHS programs have addressed this issue by selecting performance goals that assess the quantity or quality of program activities that have a scientific, evidenced-based link to improved outcomes, such as immunizations, dental sealants for children, assuring safe drinking water, cancer screenings, meals for Seniors, and folic acid supplements for women of child-bearing age.

- The majority of HHS programs are implemented at the state and local level, and obtaining reliable, systematic data at these levels is crucial to monitor program implementation, performance, and outcomes. HHS continues to work with States and grantees to build the state and local data collection infrastructure needed to enable timely and accurate data reporting. In addition, to ensure completeness of reporting, States and grantees are moving from voluntary to mandatory reporting of performance data. The *Measuring Performance with States and Grantees* section of this report provides examples of these efforts.

- These data systems will need to produce information with sufficient quality and precision to detect what may be relatively small changes in key performance goals. This may require investments in larger sample sizes for surveys, new technology for improving data quality, etc. For instance, HCFA's goal to improve the dissemination of beneficiary information through the National Medicare Education Program will require measurement over five years to detect statistically significant changes.

- Major changes in complex data collection systems take time. Most significant is the time needed to incorporate our state and grantee partners fully into the decision making process. We must work together to develop consensus on the most appropriate performance goals for the program, a system for collecting and reporting data, and a plan for building the needed data infrastructure. After consensus is reached, the Paperwork Reduction Act requires that the program request Office of Management and Budget (OMB) approval to collect the data. The OMB clearance process takes a minimum of six months. Then, the process of putting in place a data collection system that can provide complete, accurate, timely data begins.

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

The HHS Data Council, which includes representatives from all of HHS' operating and staff components, provides oversight for these activities and serves as a department-wide forum for data issues. To facilitate its work, the Council has established a Data Strategy Committee to identify current and emerging needs for data, assess current HHS data capabilities to address these needs, and develop recommendations for a multi-year data strategy. Subcommittees of this group work to coordinate efforts to improve HHS data in particular topic areas. Most HHS components also have a data group that coordinates and addresses data needs.

This analysis begins with examples from the broad range of HHS data collection systems and how they currently support program planning and performance measurement in the Department. We also review efforts that are underway in HHS at the program, operating component, and department level to enhance the data that is available to our programs and partners for planning, decision making, and measuring results. Finally, we look at recent activities by the HHS Office of

Inspector General to review our performance data, and we discuss the status of final reporting on our FY 1999 and FY 2000 performance goals.

HHS' NATIONAL, POPULATION-BASED DATA COLLECTIONS

HHS' national, population-based data collections provide statistics on morbidity and mortality for a wide-range of diseases and the underlying causes or risk factors for these diseases. CDC's National Center for Health Statistics (NCHS), the nation's principal health statistics agency, is responsible for collecting much of this data. In addition to providing data to HHS programs with data for planning and measurement, these national data systems provide data for the broad public health and health policy community including:

- Congress and other policymakers, to track major initiatives, set priorities for prevention and biomedical research programs, and evaluate outcomes;

- Biomedical and health services researchers, to understand trends in diseases, the relationship of observed risk factors to diseases, and the use of health services;

- Public health professionals, to track major preventable illnesses, and evaluate the success of intervention programs;

- Individual physicians, in evaluating the health and risk factors of their patients (for example, reference standards and norms for conditions such as cholesterol, body weight, and blood pressure, and reference growth charts for children);

- Actuaries, including those gauging the health of the Social Security and Medicare trust funds, and setting premiums for health and life insurance;

- Business, such as pharmaceutical and food manufacturers, market research firms, consulting firms, and trade associations.

These national, population-based data systems support program planning by allowing HHS programs to identify and track health problems and identify potential interventions. The data are also used to report on performance goals that assess changes in the national population, as a benchmark for evaluating programmatic achievements in the subsets of the national population the program serves, and as a means of verifying and validating programmatic and state-level data collections.

The following are examples of HHS' national, population-based data collections and how they are used by HHS programs to measure performance.

The *Behavioral Risk Factor Surveillance System* (BRFSS) collects state-level information on health behaviors related to the leading preventable causes of death, including physical inactivity, injury, weight control, alcohol consumption, tobacco use, and HIV/AIDS. It also collects data on preventive health practices such as mammography use. CDC uses BRFSS data to report on a performance goal to increase the percentage of diabetics who receive an

annual eye exam and annual foot exam and OPHS, to reduce injurious suicide attempts among youth grades 9-12.

The *Youth Risk Behavior Surveillance System* (YRBSS) is a biennial, national, school-based survey that measures risk behaviors that contribute to the leading causes of mortality and morbidity among youth and adults in the United States: behaviors that contribute to unintentional and intentional injuries; tobacco use; alcohol and other drug use; sexual behaviors that contribute to HIV infection, other sexually transmitted diseases and unintended pregnancy; dietary behaviors; and physical activity. CDC and OPHS useYRBSS data to report on performance goals to reduce the percentage of teenagers who smoke, increase the percentage of high school students who have been taught about HIV/AIDS prevention in school, and increase the percent of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.

The recently expanded *National Household Survey on Drug Abuse* (NHSDA) provides both national and state estimates of the incidence and prevalence of drugs, alcohol and tobacco, use patterns, age at first use, risk factors, treatment and disability. The data chart progress by age, gender, ethnicity, and rural/urban service setting (at the state and national levels). A FY 2000 mental health supplement to NHSDA will report data on rates of untreated mental illness for adolescents, and in FY 2001, data for adults will be collected. SAMHSA uses data from NHSDA to track the track success of the nation as a whole in improving effective substance abuse and mental health services, and to inform in program planning while the agency works with grantees reach consensus on a set of goals to measure program performance and develop a system to collect and report program-level data.

The *National Health Interview Survey* (NHIS) interviews over 100,000 persons each year to monitor a broad range of health issues. CDC uses NHIS data to report on a performance goal to increase the use of smoke detectors in homes, and OPHS a goal to increase physical activity. HRSA uses NHIS and the National Hospital Ambulatory Medical Care Survey (NHAMCS) indicators in HRSA surveys that monitor various indicators of care in the Health Centers, including performance goals related to mammography and pap smear rates. Data from the HRSA surveys are then benchmarked to national estimates obtained through NHIS and NHAMCS. In addition, HCFA uses NHIS as a secondary data source for its mammography, adult immunization, and diabetes goals.

In the *National Health and Nutrition Examination Survey* (NHANES), sophisticated laboratory and examination centers move around the U.S. to obtain standardized medical information from direct physical examination, diagnostic procedures, and lab tests. CDC uses NHANES data to report on a performance goal to reduce the number of children with elevated blood lead levels.

The *National Hospital Discharge Survey* (NHDS) obtains information on hospitalizations, surgery, procedures, and other information from a representative sample of hospital discharge records. CDC uses NHDS data to report on a goal to reduce the incidence of pelvic imflamatory disease, and HRSA uses NHDS data to report on a performance goal to reduce hospitalizations for ambulatory care sensitive conditions.

CDC uses the *National Immunization Survey* (NIS), a telephone-based survey of U.S. households, to provide data to report on performance goals related to childhood and adult immunization. HCFA, HRSA, and IHS use the NIS, which provides state-level data, and the National Health Interview Survey, which provides national data, to benchmark and to validate program-level data.

The *Medicare Current Beneficiary Survey* (MCBS) is an on-going personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population, and MCBS can be linked to Medicare claims data. Sampled beneficiaries are interviewed every four months to acquire continuous data on services, costs, payments, and insurance coverage. HCFA will use data from the MCBS to report on its performance goals to improve beneficiary understanding of basic features of the Medicare program, improve the effectiveness of dissemination of Medicare information to beneficiaries, and increase adult immunization. HCFA also uses MCBS data to check the consistency of data from the Medicare Consumer Assessment of Health Plans Study (CAHPS), which is used to assess beneficiary satisfaction with health plans.

The *National Survey on Child and Adolescent Well-Being*, a large national study, follows a representative sample of children who enter the child welfare system assessing their social, emotional, cognitive and functional status, as well as service needs and services provided for children and their families at 12 months (baseline) and at 18 months. Follow-up interviews will be conducted from start of study with 6100 children, their caregivers their caseworkers and their teachers. ACF will use this data to gain a better understanding of performance goals related to foster care and adoption.

Enhancing and coordinating HHS' national population-based data collections is key to addressing HHS' data needs, and is a prime focus of the HHS Data Council. Under the auspices of the HHS Data Council, a number of significant improvements have been made in HHS data systems and in HHS-wide data planning and integration. These improvements include the HHS Survey Integration Plan, a comprehensive, department-wide plan for addressing critical needs for race and ethnicity data, an HHS-wide inclusion policy for race and ethnicity data, and HHS wide data improvement initiatives in health system data. The Council has also developed a web-based directory of all of the major data collection systems within HHS with links to programs. In addition, the Health Insurance Portability and Accountability Act (HIPAA) administrative simplification initiative is widely regarded as a successful model of public-private sector collaboration on national data objectives.

However, new data needs are arising and a number of critical data gaps remain. To address these issues in an overall strategic framework, the Council has established a Data Strategy Committee to identify current and emerging needs for data, assess current HHS data capabilities to address these needs, identify opportunities for cost efficiencies, and develop recommendations for a multi-year data strategy and plan reflecting a broad coordinated approach to data planning, investment and decision making in HHS. Through the Data Strategy Committee, AHRQ, ASPE, NCHS, and HCFA are working on a master plan for addressing the need for data on long-term care, including expansion of long-term care data to include assisted living facilities as well as nursing homes, and expansion of HCFA's Medicare Current Beneficiary Survey (MCBS) to get better information about persons transitioning from one site of care to another. AHRQ also is working with HCFA

to use their Minimum Data Set (MDS) to develop quality indicators and disparity measures for two congressionally mandated reports.

The types of improvements to HHS national, population-based data collections that have been identified and are being pursued include:

- Developing new data collections, re-prioritizing or redesigning existing HHS surveys (e.g., integration of related efforts, content revisions, etc) to include new data elements and content, and eliminating data collections that are no longer relevant.

- Developing new tools or approaches, including new sampling techniques, diagnostic approaches, and web-enabled survey administration, etc., to make surveys more responsive and efficient.

- Developing new approaches for making survey data available to users without jeopardizing confidentiality.

- Providing funding to other Departments, States, private entities, or foundations to build on existing data collection mechanisms (e.g., supplementing an ongoing survey conducted outside HHS).

- Increasing sample size to provide state, county or community level data to improve the usefulness of these data to States for planning and measurement.

- Expand data collection to include all States in order to provide accurate national data. For example, at the current time, the only source of data for state estimates of teenage sexual behaviors is the Youth Risk Behavioral Survey (YRBS), which is conducted every two years by the States and CDC. In 1999, 41 States and 4 Territories participated in the survey, limiting its usefulness in preparing national statistics.

- Increase frequency of data collections. For example, the Youth Risk Behavior Surveillance System (YRBSS) is conducted every other year.

- Reduce lag time between data collection and reporting.

VITAL STATISTICS

The *National Vital Statistics System* is based on a partnership between Federal and State agencies, and provides data on births, including teen births, access to prenatal care, maternal risk factors, infant mortality, causes of death, and life expectancy. Vital statistics are often the most complete and continuous public health information available at the national, State, and local levels.

HRSA's Maternal and Child Health Bureau uses Vital Statistics data to report on performance goals related to infant mortality rates, including racial disparities in these rates, use of prenatal care, low birthweight babies, and teen birth rates. OPHS uses this data to report on a

performance goals to reduce births to teens, mothers who smoke during pregnancy, the annual rate of suicide, and increase prenatal care. CDC uses this data to report on a performance goal to reduce fire-related deaths.

To improve the quality and timeliness of these data, CDC provides technical assistance to the States and works with the States to standardize data elements and develop consensus on uniform conventions for coding and data processing. CDC has also reduced lag for reporting final data from this system, reporting final 1998 birth data in 15 months, a 17 percent reduction from the baseline of 18 months.

Current technology in place in States, hospitals, and funeral homes greatly limit efforts to make this data available in real time for performance monitoring, public health intervention and research. Further, this technology limits the ability to rapidly adapt vital records to reflect new needs and approaches such as OMB's revised classification of race and ethnicity. CDC is working with the States to move toward fully automated, web-based systems that capture data at the source and facilitate improved data quality, rapid editing and processing, and rapid distribution of data to users.

SURVEILLANCE SYSTEMS

Disease surveillance systems. Disease surveillance systems rely on case reports from physicians, hospitals, or other sources to identify incident cases of diseases. These diseases are often required to be reported to State health agencies under State authorities. CDC works with States to collect and report this data at the national level. The following are examples of these systems and how they are used to measure performance:

The *National Nosocomial Infections Surveillance System* receives reports from a selected group of hospitals on the incidence and characteristics of hospital-acquired infections. Data from this system alerted health authorities to the emergence of antibiotic-resistant strains of bacteria. This led CDC to develop specific recommendations regarding the use of antibiotics and performance goals to measure an improvement in the appropriate use of antibiotics.

Examples of other disease surveillance systems that provide data for performance goals include, HIV/AIDS Surveillance System, STD Surveillance System, Foodborne Outbreak Reporting System, Sentinel Surveillance for Chronic Hepatitis C, U.S. Sentinel Physician Surveillance for Influenza, and Group B Streptococcal Disease Surveillance, part of the Active Bacterial Core Surveillance.

Through its National Electronic Disease Surveillance System (NEDSS) project, CDC is building a national integrated surveillance system to enable rapid reporting of disease trends. This system creates pubic and private health care sector linkages to increase the volume, accuracy, completeness, and timeliness of the data. In addition, this new system provides local health departments with Internet access to permit rapid sharing of information on infectious disease outbreaks or bioterrorist incidents.

Through NEDSS, CDC is developing and implementing national data standards for surveillance and reporting; providing technical infrastructure support for States and local communities; and establishing local, state, and regional demonstration projects that create linkages between the public health and health care systems. These efforts are increasing the speed and reliability of data collection. CDC has five performance goals related to the development of this system, including electronic reporting of laboratory records and enhancing security to allow transmission of data over the Internet. A key activity related to NEDSS has involved the creation of a Secure Data Network (SDN). The SDN provides for a secure Internet connection and gateway facility. Through a system of tools, policy requirements, and procedures, the SDN enabled 80 percent of surveillance systems to implement the transmission of case-level surveillance data electronically in FY 2001.

Adverse Event Reporting Systems. The *FDA Adverse Event Reporting System (AERS)* is an Oracle-based computerized information system designed to support the Agency's post-marketing safety surveillance program for all approved drug and therapeutic biologic products. FDA uses AERS to report on its performance goal to expedite processing and evaluation of adverse drug events, which allows for electronic periodic data entry and acquisition of fully coded information from drug companies. In 2000, 261,000 individual safety reports were received for entry into AERS. FDA plans to upgrade AERS so that reports will be entered into the database within days, versus weeks with manual entry, which will allow FDA to more quickly identify signals and trends.

NON-HHS DATA COLLECTIONS

Outside data sources used for performance measurement in HHS include:

The National Council on Quality Assurance's (NCQA) *Health Plan Employer Data Information Set* (HEDIS®), an annual survey of individual managed care plans. This is the national standard for plan-based measurement for care delivered to enrollees in managed care organizations. Measures exist for both Medicaid and Medicare+Choice managed care. HCFA uses data from HEDIS® and from the National Health Interview Survey to validate data extracted from its National Claims History File (NCH) for a performance goal on diabetics receiving biennial retinal eye exams.

Data to report on CDC's performance goal related to the consumption of folic acid among women of reproductive age is collected under contract with the March of Dimes Birth Defects Foundation. The data is collected using a pool of respondents that is statistically significant and large enough to allow for appropriate generalization of the data to a national level.

ACF's Head Start program uses the National Center for Education Statistics' *National Household Education Survey* (NHES) and *Early Childhood Longitudinal Study* (ECLS) as a national comparison with information performance goals related to the Family and Child Experiences Survey (FACES). NHES utilizes a home-based data collection method to collect information on early childhood education and school readiness and early childhood program participation. ECLS, which-includes both a kindergarten and birth cohort, provides national data on children's status at birth and various points thereafter; children's transitions to non-

parental care, early education programs and school; and children's experiences and growth through the fifth grade. Additionally, it will provide data to test hypotheses about the effects of a wide range of family, school, community and individual variables on children's development, early learning, and early performance in school.

AoA utilizes data from the Census Bureau's *Current Population Survey* as a benchmark for its service targeting performance goals.

PROGRAM EVALUATIONS

Evaluations conducted by HHS components are generally used to evaluate program effectiveness, develop performance measurements, assess environmental impacts on health and human services (i.e., external factors affecting program performance), and improve program management. The results of these evaluations are used by HHS programs to inform the performance planning process, assist in the interpretation of performance data, and as in the example below, to report on performance goals.

An example is HRSA's *Community Health Center Effectiveness*, which compares data from HCFA's *State Medicaid Research Files* on Health Center Medicaid users and *National Hospital Discharge Survey* for the general population to assess the effectiveness of care at the Health Centers. This study provides data to report on a goal to reduce the rates of hospitalizations for ambulatory care sensitive conditions in the Health Center's Medicaid population and enables HRSA to benchmark against care provided elsewhere.

A 1996 AoA evaluation of nutrition programs for the elderly, which addressed nutrition outcomes for program participants, has significantly influenced the ongoing assessment of these programs and has contributed to AoA's current efforts to develop performance outcome measures. State and area agencies on aging routinely measure the nutritional risk of elderly program participants, and AoA's Performance Outcome Measures project includes the measurement of changes in nutritional risk over a six-month period for new clients.

HHS OFFICE INSPECTOR GENERAL AUDITS AND REVIEWS

The following are two examples of HHS programs that have used the HHS Office of Inspector General's (OIG) audits and reviews to assess program performance and report on performance goals.

HCFA uses OIG's annual estimate of the Medicare fee-for-service error rate as a basis for setting performance goals and for measuring performance. The payment error rate is computed by the OIG as part of their *Chief Financial Officer's Act* audit.

HRSA's *National Practitioner Data Bank* uses data from user surveys conducted by the OIG to report on a performance goal measuring the impact of query information from the database on decision making by licensing boards, hospitals and other health care entities, and professional societies

INTERNAL MANAGEMENT INFORMATION SYSTEMS

HHS programs use internal management information systems to report on goals for management functions. For example:

Recently CDC combined historical workforce data with training data to establish a large data warehouse, the *Workforce Information Zone* (WIZ). WIZ provides managers with a real-time tool to analyze changes in workforce demographics, retirement eligibility, accessions, separations, and much more. Besides providing comprehensive historical reporting capabilities, the system also employs multiple regression analysis to forecast future workforce size and series demographics. WIZ provides data to report on CDC's performance goals to reduce the time it takes to classify positions and the time involved in referring candidates to fill positions.

The FDA *Center-wide Oracle Management Information System (COMIS*) is the Center for Drugs, Evaluation and Research's (CDER) enterprise wide system for supporting premarket and postmarket regulatory activities. FDA/CDER uses COMIS to track a number of its performance goals, such as, its review of standard original New Drug Applications (NDA), priority original NDAs and fileable original generic drug applications. FDA also uses COMIS to report on its performance goal to protect human research subjects' participation in drug studies and assess the quality of data from these studies by conducting on-site inspections and data audits.

ADMINISTRATIVE DATA SYSTEMS

In addition to developing its own information systems, HHS relies on partnerships with State and local agencies, health plans, and providers to collect and manage data. Generally, these data come from administrative data collections. A significant number of HHS programs rely on these data to measure performance.

Administrative data systems are generally maintained by HHS' State and local partners as part of providing services under a grant or contract. These data are the byproduct of processes such as program enrollment, eligibility determination, claims processing, payment, and service provision. For example, the HHS grantees who manage service delivery programs maintain administrative systems that provide ongoing data on clients, services, and populations served. HHS programs have used these systems to provide data to report on goals measuring program performance. HHS grantees report these data on either a voluntary or mandatory basis. To facilitate benchmarking program performance to national data from population-based data collections, these programs frequently use Healthy People 2010, NHIS, and HEDIS indicators as program performance goals. Several examples of administrative data systems and how HHS programs currently use these systems to measure performance follow.

The Medicare *National Claims History File* (NCH) is a 100 percent sample of Medicare fee-for service claims, which have been validated for completeness and consistency. Beginning in FY 2001, HCFA will use Medicare NCH data to report on a performance goal on the percentage of female Medicare beneficiaries age 65 or older who have had a biennial mammography exam. HCFA will also use the NCH to remeasure the percentage of diabetics receiving biennial retinal eye exams for fee for service Medicare beneficiaries, and will use data from HEDIS® and from the National Health Interview Survey to validate the NCH data.

HRSA's HIV/AIDS Bureau has developed and is pilot testing a *Cross-Titles Data Report* that will be implemented for services provided in 2001. This report will replace the administrative data reports required by each of the main Titles of the Ryan White CARE Act, streamlining reporting for programs which participate in more than one Title and reducing the number of data elements which programs must report on.

IHS' *Resource and Patient Management System* (RPMS) collects data for each inpatient discharge, ambulatory medical visit, and dental visit and for community health service programs including health education, community health representatives, environmental health, nutrition, public health nursing, mental health and social services, and substance abuse. IHS uses these data to report on performance goals related to clinical services and prevention activities.

The IHS *Diabetes Audit* is an annual medical record review that assesses diabetes care conducted in more than 75 percent of the IHS and tribal facilities, representing care to nearly 70,000 American Indian and Alaskan Native people with diabetes. The Audit provides data for four IHS performance goals that are key to reducing mortality and morbidity in diabetics. IHS has an initiative underway to automate the Audit by extracting the data from IHS' electronic patient records system.

Because administrative data systems provide program-level data, they are key to HHS' ability to measure program performance. In fact, these systems provide data to report on a significant portion of HHS' performance goals. Frequently, our programs' initial choice of performance goals were limited by the capabilities of these systems. Since these data are collected by HHS' partners who implement HHS programs – State, local, and Tribal governments, grantees, and Medicare contractors – HHS programs have worked in partnership with these organizations to

implement enhancements to these systems. The types of improvements that have been identified and are being pursued include:

- Working with program partners to achieve consensus on a set of performance goals that best measures program performance and then ensuring that a system is in place to collect and report these data. These efforts include enhancing current data collections, developing new data collections, eliminating data collections that are no longer relevant, and combining reporting for programs where possible.

- Assisting the States in building the state and local data collection infrastructure needed to enable timely and accurate data reporting and ensure that all States can report data, and providing technical assistance to States and grantees to improve data quality.

- Developing common definitions, data elements, standards, and uniform coding so that the data can be reliably used and aggregated.

- Addressing confidentiality, policy, security, and technical issues to enable clinical information systems to provide real-time data on quality of care measures.

- Developing the legal, regulatory, and technical means that facilitate data sharing across organizations.

- Addressing issues related to verifying and validating data provided by States and grantees.

- Working with States and grantees to move from voluntary to mandatory collection of performance data under the Paperwork Reduction Act.

- Automating data collection and reporting to reduce the time needed to report aggregated national data and providing program performance data via the Internet to facilitate its use.

MEASURING PERFORMANCE WITH STATES AND GRANTEES

The majority of data used to report on performance for HHS programs is collected and reported by HHS' partners who implement these programs – State, local, and Tribal governments, grantees – and Medicare contractors. In these instances, HHS programs have worked with these organizations to achieve consensus on a set performance goals that best measure program performance and then enhance current data collection systems or developing new systems to collect and report the data. Several major collaborations undertaken by HHS programs highlight the potential and challenges of enhancing these data collection systems:

HRSA's Maternal and Child Health Bureau (MCHB) worked with its State partners to develop performance goals for the MCH block grant that States started reporting on in 1998. As part of this partnership, MCHB developed an electronic reporting program (ERP) that allows the States to submit their grant applications and annual reports electronically, including data for performance measurement. A key feature of the ERP is that States only need to enter

raw data, and the program calculates rates and ratios. It also enables MCHB to make these data available on the Internet in a searchable format.

The standardization of definitions and formats developed as part of this process has already contributed to improvements in the quality of data. However, a continuing difficulty facing MCHB is that different States have different data capabilities. As a result, some kinds of data are collected by some States on a periodic basis - every two or three years, for example - while other kinds of data may vary in currency across States - so that not all States report data from the same year at the same time. In fact, after reviewing the early data reported by the States and sharing that data with HCFA and ASMB, MCHB has discontinued several goals because of variations in the data from State to State. MCHB continues to provide intensive assistance to the States in achieving standard data capabilities, and in FY 2000, MCHB received OMB approval to expand the MCH data collection to include the health status indicators used by the States in conducting state needs assessments.

HCFA, working in conjunction with the States, CDC, and the American Public Human Services Association (APHSA), has developed a three stage process to develop individual State baselines and methodologies for reporting on a performance goal on immunization coverage for two-year-old children enrolled in Medicaid. Because Medicaid is a state-run program and States have significant flexibility to set enrollment criteria, it is best for States to determine how to measure their own immunization rates and to determine their own performance targets.

The methodologies chosen by individual States will depend on a number of factors, for example: the service delivery systems used in that State, the existence of functional State or regional registries, and the average duration a Medicaid beneficiary remains enrolled in the State program. Due to the various data collection and reporting methodologies likely to be used by individual States and differing definitions of children in the various States, immunization coverage levels will not be directly comparable across States. However, each State will measure its own progress, using a consistent measurement methodology. HCFA and CDC are providing technical assistance to the States to develop their baseline methodology to measure immunization rates. The first group of 16 States is expected to have developed their methodology and measured baseline levels by the end of FY 2000 and have their first remeasurements by the end of FY 2001. The second group of 10 States expects to have established the baseline and methodology by the end of FY 2001, and all remaining States will have established the baseline and methodology by the end of FY 2002.

As part of IHS' Y2K conversion efforts, IHS retired the obsolete IBM mainframe computing platform that was used to aggregate health care data nationally and prepare the statistical reports that were used to report on IHS' clinical performance goals. While this change successfully addressed the Y2K data issue, migrating existing data and duplicating the complex set of algorithms used to aggregate data from decentralized collection points proved challenging. IHS has focused intensive efforts on procedures to reestablish essential report generating capabilities.

In addition, IHS has significant efforts underway to improve data quality including: insuring that data are input consistently at service points using standardized screening edits; focusing

on accuracy of coding; refining the process for aggregation and transmission; and standardization of program and data definitions. This has been a challenging process requiring a high level of coordination and cooperation among the local IHS, Tribal, and Urban facilities, Area offices, and IHS Headquarters.

The combination of improvements in the information technology architecture and program improvements have begun to improve the quality, timeliness, and availability of data. This year, data for three performance goals that had been previously reported via a manual chart audit have been successfully extracted from IHS' electronic patient records system. Next year, the chart audit, which was originally planned as the primary approach for reporting on these goals, will be used on a sample basis as a verification process for the electronic approach, saving significant time and funds.

In FY 2002, IHS will further expand its efforts to automate the extraction of clinical performance goals by establishing test sites to assess and improve data quality. Included in this innovative project are efforts to adopt recognized data standards for laboratory and other data that are now uniformly accepted by most of the healthcare industry and will be implemented within IHS in the near future. This project is also developing web-based training to support the efficient diffusion of newly developed technologies across the IHS.

AoA, the State and area agencies on aging, and local centers and service providers are working together to address the challenge of producing performance data for the Older Americans Act (OAA) programs, which coordinate service delivery through approximately 29,000 local providers. Many OAA program services do not require a one-time registration for service on the part of clients; eligible clients may obtain services on an ad hoc and irregular basis. This makes generating unduplicated counts of clients very difficult at the local level, particularly when the local entities lack the information technology that could simplify client and service record-keeping and information management.

Federal and State reviews of data provided for FY 1997, 1998 and 1999 under the National Aging Program Information System (NAPIS) suggest that significant limitations in the information infrastructure at the local level inhibit their ability to consistently produce the data that are required by law for the OAA programs and that form the basis for many of AoA's performance goals. Extensive Federal and State efforts to provide technical assistance and to isolate and correct common data problems have been helpful. In addition, there are now at least two commercial packages available for use in preparing NAPIS data, and this has fostered greater consistency in the data.

AoA and State agency representatives are also investigating ways to streamline the data verification and validation process so that data can be reported on a more timely basis. Currently, following an extensive set of electronic edits, AoA contractors work with State data administrators to correct data elements that fail electronic edits. Following these electronic checks, AoA staff conduct extensive reviews of edited data for reasonableness and to ensure that significant value changes from one year to another reflect program circumstances and not the limitations of the program data. As a result, AoA is just reporting preliminary FY 1999 data in its FY 2000 performance report.

Over the next year, AoA and its program partners will review the data requirements of the OAA and consider alternatives to the collection of the most complicated data that cause most of the burden and validity problems in conjunction with renewing approval of NAPIS data collection efforts under the Paperwork Reduction Act. AoA will pursue efforts to support local information technology improvements, particularly Internet and web-based solutions to data reporting and accessibility. AoA's Performance Outcome Measures Project has been expanded to approximately 30 area agencies in 16 pilot States in FY 2000; nevertheless, routine, annual measurement of performance outcomes will not be initiated within the next year.

SAMHSA's Substance Abuse Prevention and Treatment State Block Grant (SAPTBG) program is working with the States to develop, test, and reach consensus on a core set of performance goals. SAMHSA is utilizing a two-pronged strategy of providing incentives to States to pilot the collection of performance-based goals through grant mechanisms and promoting consensus-building efforts among key stakeholders to refine a list of goals to measure performance. Through the Treatment Outcomes and Performance Pilot Studies (TOPPS) II project, a goal of which is the assessment of data collection and reporting feasibility by States, pilot testing of a core set of performance outcome goals began in FY 2000 in 19 States. The effort resulted in the development of a core set of performance outcome goals. Capitalizing on this experience, the information gathered from TOPPS II then was used as input to an ongoing Delphi consensus building and decision making process with States, coordinated by the National Association of State Alcohol and Drug Abuse Directors (NASADAD). This consensus building process has resulted in a revised set of outcome goals agreed upon by key stakeholders and endorsed as being applicable to the Block Grant and useful to the field as a whole.

SAMHSA expanded its efforts to determine state capacity to report outcome data by obtaining OMB approval to collect data on a small subset of the core goals beginning with the FY 2000 Block Grant application. Of the 60 States and territories, only 24 States were able to report data on the goals. Six States were able to report on all of the goals; 11 States reported on one or more of the goals; and 8 States reported on only one goal. SAMHSA plans additional assistance to States through the TOPPS III project to accelerate the number of States able to report performance information.

This work has placed SAMHSA in a good position to implement the provisions of the Public Law 106-310, contained in the Children's Health Act of 2000. The new law requires SAMHSA to develop a plan for creating flexibility and accountability for States based on a common set of performance goals, and submit the plan to Congress by FY 2002. An internal workgroup has been established to develop needed modifications to the block grant application; to reexamine strategies for implementation of the current set of performance goals, including moving toward mandatory reporting by States in the 2004 Block Grant application; and to implement new provisions of the law, such as waivers of certain of the existing law's requirements.

DELIVERING INFORMATION TO USERS

In addition to efforts to enhance HHS' data collection capabilities, HHS is working to enhance the capacity of our programs and partners to access and use data. The HHS Data Council has identified this issue as a priority and is pursuing the following avenues:

- **Providing easy access to health and human services information via the Internet**. Much of HHS' data is currently available via the Internet or other readily accessible modes, but is typically organized around the data collection mechanism, rather than organized in ways that are intuitive to users seeking answers to substantive questions. HHS can take better advantage of new technologies and bring about "one-stop shopping" to facilitate the use of available information. HHS needs to promote data linking and warehousing strategies to create analytic files to answer critical policy and research questions and encourage the use of techniques to improve access to data without jeopardizing confidentiality.

- **Enabling users through training and technical assistance**. Effective use of many of the information resources that can be made available to users depends, in large part, on the sophistication of users in multiple disciplines. HHS can assist users (e.g., policy analysts in HHS and OMB, State and local program staff, decision-makers, researchers) through training and technical assistance on data use, linking, and analysis.

- **Building expertise to translate data into useful knowledge**. HHS needs to ensure there exists a cadre of expert analysts who can apply statistics to inform decision-making. HHS can also enhance capacity for analytic linkages (e.g., adding contextual variables to survey data, linking administrative data sets to each other or to survey data, linking surveillance data to administrative files) to take better advantage of HHS and non-HHS data resources, and use expanded analytic expertise to help make better sense of findings from multiple sources by cross-walking findings from different data sources and reconciling inconsistent results.

- **Developing improved analytic methods and tools**. HHS needs techniques to assure that data from HHS and other sources can be made available for public use by developing standards and tools for disclosure avoidance, and by conducting research and development on methods of encryption, de-identification, and other technologies that enable analysis without jeopardizing confidentiality. HHS needs to develop improved analytic software and techniques for data linkage and analysis of linked files, and to develop new indicators, and analytic approaches as new topics and priorities emerge. HHS also needs to develop improved techniques to handle difficult problems such as with small geographic areas and small population subgroups.

DATA VERIFICATION AND VALIDATION

Data Discussions in the Performance Plans and Reports

For any given performance goal, the strengths and limitations of the data source used to report on the goal can vary, and the level of statistical reliability needed to assess goal performance and support decision making can also vary. HHS programs have addressed any significant data issues, identified the data source, and discussed the means used to verify and validate data for HHS' performance goals in the FY 2002 performance plans and reports. Many programs also discuss activities completed, underway, or planned that will enable the program to move to more sophisticated measures of performance and/or to improve the timeliness, completeness, and reliability of the data.

HHS Inspector General Review of Performance Data

The HHS Office of Inspector General's work with regard to GPRA focuses on assessing data collection methods and controls over the HHS systems that produce performance data. The OIG's review plan is directed toward those measures related to mission-critical issues and areas at high risk of fraud, waste and abuse. For instance, OIG's continuing financial statement audit work at the Health Care Financing Administration (HCFA) relates directly to assessment of HCFA-generated financial performance data. The HCFA uses OIG's annual estimate of the Medicare fee-for-service error rate as a basis for setting performance goals and for measuring performance.

OIG completed a review of ACF's Adoption and Foster Care Analysis and Reporting System (AFCARS). The ACF performance measures pertaining to children in foster care and children adopted under the auspices of a State welfare agency are based on data from this system. Since States collect and transmit case management information to ACF through this system, OIG assessed the reliability of the AFCARS data submitted by two States for the first half of FY 1999. While some errors were noted in the information from both States, these errors did not affect the data used to develop ACF's performance measures or were not pervasive enough to affect reported measures. The OIG will also be doing additional work in AFCARS.

In addition, OIG is currently assessing the reliability of the data in the State Agency Child Welfare Information System, which is being developed with the Department's financial assistance (75 percent matching). The system is designed to allow child welfare workers online access to other State human service and health programs, such as Temporary Assistance for Needy Families, child support and Medicaid.

The OIG has completed a review of OCR's FY 1999 Performance Report and will be issuing a report shortly. During FY 2001, OIG plans to examine both ACF's and the Administration on Aging's (AoA) use of State-supplied data for performance measurement. The OIG will determine whether these agencies take adequate steps to screen State data for reliability and whether selected States have adequate controls in place to ensure that data are reliable and valid. Also, OIG plans to assess selected Public Health Service agencies' processes for implementing GPRA and to report any deficiencies in internal controls for properly recording, processing, and summarizing performance data. The OIG also notes that an ongoing objective of its audits,

inspections and investigations is to identify performance results and offer recommended improvements.

STATUS OF FINAL REPORTING ON FY 1999 AND FY 2000 PERFORMANCE GOALS

The chart on the next page outlines the status of final reporting on HHS' FY 1999 and FY 2000 performance goals. The delays in reporting on performance goals for HHS programs occur for several reasons:

- The time required for States and grantees to collect, verify, evaluate, and report data to HHS following the end of the reporting year and for HHS programs to verify, aggregate, and evaluate the data before reporting the results in the performance plans. For example, AoA is just reporting preliminary FY 1999 data in its FY 2000 performance report.

- The desire to measure change or accomplishment from point A to point B. For example, data to report on the CDC goal on the percentage of tuberculosis patients reported in 2002 who complete a course of treatment within 12 months of initiation of treatment will be available in June 2004. The last cases reported in 2002 (on December 31) will not have their 12 months treatment period completed until December 31, 2003. Then six to nine months are needed to tabulate, verify, and report the completion of therapy data.

In addition, some HHS performance goals are not reported on annually because the data collections used to report on the goals are not conducted annually. For example, the Youth Risk Behavior Surveillance System, which is used to report on many HHS goals, is conducted every other year.

Where available, HHS programs have provided earlier trend data for performance goals and other related data to facilitate assessment of program results.

STATUS OF FINAL REPORTING ON PERFORMANCE GOALS

Operating or Staff Component	FY 1999			FY 2000		
	Targets	Reported as of 4/01		Targets	Reported as of 4/01	
AoA	18	18	100%	18	3	17%
ACF	47	45	96%	51	15	29%
ARHQ	46	46	100%	52	52	100%
ATSDR	11	11	100%	25	11	44%
CDC	110	109	99%	195	147	75%
DM	54	54	100%	57	55	96%
FDA	70	70	100%	60	42	70%
HCFA	22	20	91%	40	35	88%
HRSA	68	61	90%	77	47	61%
IHS	27	26	96%	34	29	85%
NIH	80	80	100%	83	83	100%
OCR	10	10	100%	19	19	100%
OIG	6	6	100%	5	5	100%
OPHS	13	11	85%	30	11	37%
PSC	40	40	100%	42	42	100%
SAMHSA	45	43	96%	198	91	46%
TOTAL	667	650	97%	986	687	70%

SUMMARY OF FINDINGS AND RECOMMENDATIONS FROM PROGRAM EVALUATIONS

GPRA and OMB Circular A-11, Part 2, require Federal agencies to include a summary of the findings and recommendations of Agency program evaluations in the GPRA performance report. The HHS evaluations that were completed during Fiscal Year 1999 are reported in the Department's annual report to Congress titled: *Performance Improvement 2000: Evaluation Activities of the U.S. Department of Health and Human Services.* For purposes of complying with the GPRA requirement, HHS is incorporating this evaluation report by reference into this HHS Performance Report and Performance Plan Summary. The HHS report on program evaluations provides Congress with evaluative information on the Department's programs, policies, activities, and strategies.

In the era of results-oriented management, evaluations are playing an increasingly important role in strategic planning, performance management, and program improvement. To this end, HHS is committed to ensuring its evaluations yield valuable knowledge, and that knowledge is used to complement annual performance planning and reporting. Evaluations conducted by HHS agencies generally serve one or more of the following purposes: evaluate program effectiveness; develop performance measurements; assess environmental impacts on health and human services (i.e., external factors affecting program performance); and improve program management. The results of these evaluations are increasingly being used by HHS program managers to inform the annual performance planning process and the interpretation and reporting of annual performance data.

Program effectiveness provides a way to determine the impact of HHS programs on achieving intended goals and objectives. For example, the Substance Abuse and Mental Health Services Administration performed a comprehensive study measuring outcomes and cost/benefits of substance abuse treatment. Using data from the National Treatment Improvement Evaluation Study (NTIES), estimates of treatment costs, crime-related and health care costs, and the income of 4,411 substance abusers in the periods before and after treatment were analyzed The study found dramatic reductions in crime-related costs, modest reductions in health-care costs, and modest increases in the earnings of substance abusers in the period after treatment. In addition, findings on other treatment outcomes showed that drug use was cut in half, criminal acts were reduced up to 80 percent, homelessness was reduced, and rates of employment were increased.

Performance measurement is the primary mechanism used to monitor annual progress in achieving departmental strategic and annual performance goals. To support performance measurement, we are investing evaluation funds to develop and improve performance measurement systems and the quality of the data that supports those systems. For example, the Office of the Assistant Secretary for Planning and Evaluation assessed the "state-of-the-art" in performance measurement for the Department's public health, substance abuse, and mental health block grant programs. The results are being used to develop analytical frameworks for HHS and its partners in the States to measure service outcomes, processes, and capacity and address issues of data and information system requirements.

Environmental assessment is the way we monitor and forecast changes in the health and human services environment that will influence the success of our programs and the achievement of our goals and objectives. In turn, this understanding allows us to adjust our strategies and continue to deliver effective health and human services. For example, The Health Resources and Services Administration conducted a study of mandatory Medicaid managed care enrollment systems to assess the effects enrollment policies on federally qualified health centers (FQHC) and their ability to adapt to managed care systems. The study results are being used to better identify policy implications for "access and quality" to health care for the underserved.

Program management reflects the need of program managers to obtain information or data helpful for effectively designing and managing a program. These evaluations generally focus on developmental or operational aspects of program activities and provide understanding of services delivered and populations served. For example, the Office of HIV/AIDS at the Centers for Disease Control and Prevention conducted an evaluation of its five-year demonstration of social marketing techniques for HIV/STD prevention programs targeted to young people under 26 years of age. The results are being used to assess the implementation phase of the program and inform collaborative national partners who provided technical assistance to the local demonstration sites.

Performance Improvement 2000 is available electronically from the HHS Policy Information Center (PIC) website at: <http://aspe.os.dhhs.gov/PIC/gate2pic.htm>. The PIC project database, a centralized source of information on more than 6,000 studies sponsored by HHS, other Federal agencies and private-sector entities, serves as an information source for individual evaluations (either completed or in progress). For additional information about using the PIC database or accessing copies of evaluation reports, please contact the Policy Information Center at (202) 690-6445.

DEPARTMENTAL COMMITMENT TO MANAGEMENT IMPROVEMENT

The Department of Health and Human Services is committed to exemplary management that ensures that programs are delivered in an efficient and effective manner. This commitment is expressed in a number of ways – through improving our financial management, improving our procurement processes, and developing and training our workforce.

This section of the HHS Summary describes the various tools used by the Department to manage, address, and report on our mission-critical management activities and challenges. These include accounting and financial management tools such as those outlined in the *Chief Financial Officers (CFO) Act* and the *Federal Financial Management Improvement Act (FFMIA)*, systems planning tools described in the *Clinger-Cohen Act*, and the performance measurement tools in the GPRA. It presents examples of performance goals used to measure our mission-critical management activities and discusses some of the results we have achieved.

TOOLS FOR IMPROVING MANAGEMENT AND ADMINISTRATION

The Department uses several key tools to improve the management and administration of our program responsibilities:

Financial accountability tools such as the *Chief Financial Officers (CFO) Act*, the *Federal Financial Management Improvement Act (FFMIA)*, the *Federal Managers Financial Integrity Act (FMFIA)* and the *Debt Collection Improvement Act (DCIA)*.

Tools for managing our technology resources such as the *Clinger-Cohen Act* and the *Presidential Decision Directive* (PDD-63), which recognize that addressing computer-based risks to the nation's critical infrastructures requires an approach that involves coordination and cooperation across federal agencies and among public and private-sector entities and other nations.

The *Office of Federal Procurement Policy Act*, which seeks to improve procurement efficiency in support of the mission accomplishments of federal agencies, and instructs agencies to establish clear lines of contracting authority and accountability. The Act promotes electronic commerce in the administration of procurement systems.

INTERACTION BETWEEN GPRA AND OTHER MANAGEMENT TOOLS

These tools have planning and reporting requirements that generate extensive information on key management activities. Much of this information is reflected in or supported by the HHS performance plans. For example, the HHS performance plans contain performance goals for all of our mission-critical activities. In some cases, the performance goals are identical to the benchmarks established by the aforementioned statutes. In other cases, the performance goals

support them by identifying specific strategies or activities that must be implemented to achieve the objectives established by the statutes.

For this reason, the Department's performance goals often appear in multiple documents. For example, the *HHS Chief Financial Officer's Status Report and Five-Year Plan* identifies strategic financial management goals, including goals for FFMIA and debt collection activities. Performance results for these goals are reported in the Accountability Report. Many of the most mission-critical CFO goals are also included as performance goals and reported on in the HHS Performance Plans and Reports.

Performance results are reported in both the Accountability Report and the performance plans and reports with an important distinction. The Accountability Report contains information on key performance goals. The performance plans and reports, by contrast, report on all of the Department's performance goals. In addition, the Accountability Report includes information on achievements in critical management activities, such as grants management, procurement and workforce planning, which are not directly linked to performance goals.

MEASURING MANAGEMENT ACTIVITIES

The current Administration has indicated that it intends to use GPRA to support efforts to improve the functioning of the Federal government and make it more efficient. Since the implementation of GPRA, HHS has measured critical management activities. In fact, for the past two years, Senator Fred Thompson has reviewed reports from GAO and the HHS Office of Inspector General that identified a number of critical management challenges. In FY 2000, Senator Thompson noted that the HHS' FY 2000 Performance Plans contained performance goals for 12 of the 14 high risk and other most serious management problems confronting the Department. A detailed assessment of these challenges and the performance goals that respond to them are included in the *HHS Accountability Report*.

For the most recent list of management challenges identified by the Inspector General, HHS performance plans again contained performance goals addressing all challenges. However, while our performance plans contain goals that address aspects of critical infrastructure protection, which was one of the challenges identified, we will work over the next year to develop goals that address this issue more directly.

The following are examples of performance goals used to measure our mission-critical management activities and highlights of the results we have achieved. The Department looks forward to expanding its measurement of important management activities over the next year.

Financial Management: The following are highlights of the Department's performance goals from the *HHS Chief Financial Officer's Status Report and Five Year Plan*:

- The Department has had a goal to earn a "clean" opinion on its audited financial statements since FY 1999, which it met in FY 1999 and FY 2000. Several of the HHS components include similar performance goals in their performance plans. For example,

HCFA, HRSA and CDC have met goals to obtain"clean" opinions on their financial statements.

- The Department has met or exceeded its FY 2000 goals related to the percentage of payments transferred electronically by processing 100 percent of grant payments, 99 percent of salary payments, 86 percent of vendor payments and 95 percent of travel payments on time. Because HHS' performance for vendor and travel payments significantly exceeded its expectations, it has increased its FY 2001 goals to 90 and 100 percent, respectively.

- The Department has set an annual target to increase total debt collection by 10 percent over the previous year. In FY 1999, $14.27 billion was collected for debts owed to HHS. Although this represents a 7 percent increase over FY 1998, the amount collected is almost $1 billion above FY 1998. In FY 2000, $15.3 billion was collected, which again represents a 7 percent, $1 billion, increase over FY 1999.

IT Systems: HHS has adopted an innovative enterprise infrastructure management approach that centralizes, standardizes and secures continuity and conformity. The Office of the Secretary and the HHS components work together to enhance interoperability within the Department (such as core financial systems), reduce duplication of equipment and services, and provide for secure systems during emergencies (such as supporting a response to Bioterrorism). IT management practices are streamlined through Department-wide IT policies, standard operating procedures and measurable service level agreements. Some of the key activities include automated asset management; Public Key Infrastructure (PKI) for identification; rapid software distribution and recovery; virus detection and defense and response to network intrusion.

- The Office of the Secretary's Office of Information Resource Management (OIRM) has set performance goals to initiate Enterprise Infrastructure Management to provide software distribution, asset, problem, and facilities management and to initiate Enterprise Software Licenses to consolidate duplicative efforts. OIRM has set supporting performance goals to purchase 100% of the targeted Tivoli, Peregrine and SAS software products by FY 2002.

- CDC has set a goal to ensure that critical information systems and IT infrastructure (CDC Data Center, wide area network, e-mail, and Internet/web services) operate reliably and continuously. The reliability rate was approximately 97.3 percent in FY 2000. CDC plans to increase that rate to 99 percent in FY 2001, and 99.5 percent in FY 2002.

- HRSA is developing a goal to reduce the number of security violations that create a major risk to the HRSA technical infrastructure. HRSA plans to measure this activity through an annual target to reduce the "violation ratio" by ten percent each year. HRSA has defined a "security violation" as any activity or incident, whether malicious or unintentional, that has substantial adverse affects upon the performance or configuration of the IT infrastructure or any of its components.

Workforce Planning: HHS, like many other federal agencies, is facing a human capital crisis. At HHS, 26.6 percent of our current workforce is either eligible or will become eligible for retirement within the next five years. HHS has already taken, and will continue to take, concrete steps designed to minimize disruptions from any larger customers' needs. As part of this effort, we are engaged in workforce planning, which consists of comparing employees' current skill and experience base to future departmental needs, and developing a plan to meet them.

- HCFA is creating a workforce planning model that will analyze current and future work; develop a current and future competency framework; identify existing workforce competencies; and conduct an analysis of gaps between current and future requirements and existing workforce skills and knowledge. HCFA is developing an FY 2002 target to reduce the gap between the current and targeted levels of skills and knowledge.

- The CDC achieved its FY 2000 goal to reduce the time it takes to classify positions and refer candidates to fill positions by 25 percent. CDC plans to maintain this reduced level in FY 2001.

- The AoA has engaged in a significant workforce planning effort and is currently developing a performance measure to document that a high percentage of hires are based on a formal AoA workforce plan.

Grants and Acquisition Management: As the largest granting component in the federal government, HHS plays a key role in the federal grants management arena. Through its over 300 assistance programs, HHS awards more than $170 billion of the total federal grants awarded (about $300 billion). Stewardship and oversight responsibilities for HHS grant programs involve a variety of administrative functions being performed on an ongoing basis. These administrative functions include: assisting OMB in its revisions of key OMB Circulars pertinent to grants administration: providing training and developing related guidance documents on these revised OMB Circulars; conducting oversight through a "balanced scorecard" approach; strengthening HHS indirect cost negotiation capabilities; updating internal Departmental grants administrative procedures; and utilizing a department-wide grants management information system to organize and consolidate grants award data across all HHS grant programs.

- In FY 2000, the Office of Grants and Acquisition Management set a goal to increase the effectiveness of HHS grants, procurement, and logistics training. Performance data in this area will be available in October 2001.

- In FY 2000, OGAM achieved its goal to increase access to HHS grants administration policies to 100%. It has set a goal to maintain access at the same level in FY 2001 and FY 2002.

- In FY 2000, HCFA exceeded its goal to increase the use of electronic commerce by maintaining a 97 percent electronic claim rate for Medicare fiscal intermediaries, and 80 percent for carriers.

- In FY 2000, with the implementation of the audit resolution tracking function, the ACF successfully completed the first phase of the Grants Administration Tracking and Evaluation System (GATES). This single comprehensive system replaced 30 separate application systems. All ACF grants are now awarded through GATES. Further enhancements, such as debt collection capability, will be implemented in FY 2001. In addition, ACF has established a performance goal to implement the next generation of electronic grant making with GATES II, which will capture and validate grant information using the Internet.

- Over the next year, HHS will expand its measurement of grants activities to include a number of new initiatives. These include: expanding the use of performance-based contracting and expanding the application of on-line procurement. HHS already has goals pertaining to some aspects of e-government activities. These include ACF's goal to implement GATES II, and a CDC goal to make vital statistics reports available to professionals on the Internet within four months of data release. In addition, OGAM is developing goals to reflect its experience with performance-based contracting.

Facilities: The Department operates many facilities in Washington and around the country, from our headquarters in Washington, DC to the labs at the National Institutes of Health and Centers for Disease Control to Indian Health Service facilities. The Department must ensure that real property assets are protected and utilized effectively; and that HHS employees and visitors have access to a healthy and safe work environment.

- The OS Office of Facilities Services (OFS) achieved its FY 2000 goal to execute 100 percent of acquisitions and disposals in accordance with regulations. OFS will maintain this goal in FY 2001 and FY 2002.

- The OFS also achieved its FY 2000 goal to address 100 percent of service requests within 72 hours. It plans to continue this goal in FY 2001 and FY 2002.

- NIH substantially met its FY 2000 target to continue projects to correct utility system deficiencies, repair the interior and exterior of buildings, and repair off-campus facilities by completing 93 percent of intended FY 2000 repairs. NIH has added a target in FY 2001 to measure the completion of these repairs.

Reducing Erroneous Payments: HHS recognizes the importance of ensuring the integrity of its health care programs to improve services and ensure the proper expenditure of Medicare trust fund dollars. HHS works to achieve this important objective in a number of ways, including: managing programs to improve quality and competition in health care programs, developing and disseminating checklists for use in the review of States' managed care contracts, and researching for new payment systems that can improve services and reduce improper payments.

- In FY 2000, HCFA exceeded its goal to reduce the error rate to 7 percent by achieving a rate of 6.8 percent. Since FY 1996, HCFA has cut the error rate in half. HCFA has set targets to reduce the error rates further, to 6 percent in FY 2001 and 5 percent in FY 2002.

- HCFA is developing a goal to measure and ultimately improve customer satisfaction with the manner in which its program integrity (PI) activities are conducted. The goal aims to ensure that providers who are the subject of a PI-related review are satisfied with the manner in which their cases were handled, even though they may not be satisfied with the outcome of the activity. The goal also aims to ensure that beneficiaries who report suspected cases of fraud are treated in a courteous, professional and responsive manner. In FY 2002, HCFA will conduct a survey of providers and beneficiaries and will develop more concrete targets from the data collected.

CROSSCUTTING PROGRAM COORDINATION

A complex network of health and human service programs and partners at the Federal, State, and local level support the achievement of the goals and objectives in the HHS Strategic Plan. Within HHS alone, over 300 programs support our goals to enhance the health and well-being of Americans. The HHS Strategic Plan provides a matrix that links HHS' programs to the Department's strategic goals and objectives. The Plan also discusses the wide variety of internal and external coordination mechanisms used by HHS programs and provides details of coordination for each HHS strategic objective.

In working together to achieve results, these Federal, State, and community programs fulfill different functions or provide similar services to different populations. For example, to reduce morbidity and mortality from diabetes, NIH conducts research into the biology of diabetes and to identify medical and behavioral interventions. CDC conducts pilot projects to demonstrate the effectiveness of the behavioral interventions in communities and supports the development of state-based diabetes control programs. FDA ensures that new diabetes drugs are safe and brings them to market quickly. HRSA implements clinical and behavioral interventions in the service population of the Community Health Centers, which is primarily low income, minority, and uninsured. IHS implements clinical and behavioral interventions in the American Indian and Alaskan Native population. HCFA, works to improve the quality of care for diabetic Medicare beneficiaries through its network of Peer Review Organizations. Other HHS, Federal, State, and community programs that address heart disease, kidney disease, blood pressure control, eye care, nutrition, fitness, and smoking also contribute to improved outcomes for people with diabetes.

A variety of coordination activities support the integration of these efforts. For example, CDC collaborates with NIH in providing federal leadership in the development, coordination and implementation of the National Diabetes Education Program (NDEP) and the NDEP Partnership Network of over 100 organizations, including ten planning workgroups. CDC also collaborates with IHS and other organizations in a partnership to establish the National Diabetes Prevention Center, which will address the epidemic of diabetes in American Indians and Alaskan Natives. Further, in collaboration with HRSA, CDC's state-based diabetes control programs will partner with the community health centers to improve the health status of people with diabetes who receive care at the centers. In addition to State health departments, CDC collaborates with the American Diabetes Association, Juvenile Diabetes Foundation, American Association of Diabetes Educators, and managed care organizations in the control of diabetes and its complications.

For performance measurement, coordination is particularly critical. In addition to broad coordination across programs and players, HHS programs have worked extensively with their partners in program implementation and data collection – State, local, and Tribal governments, grantees, and Medicare contractors – to achieve consensus on a set of performance goals that best measures program performance and to ensure that a system is in place to collect and report data. The Data Collection section of this Summary provides several examples of these efforts.

Coordination activities with other HHS components have lead to the development of shared goals. For example, CDC and HRSA share a goal to reduce perinatal transmission of HIV/AIDS. CDC and OPHS share performance goals to reduce the percentage of teenagers who smoke and to increase the percent of adolescents who abstain from sexual intercourse or use condoms if

currently sexually active. HRSA and OPHS share a goal to increase prenatal care. HCFA and OPHS share a goal to increase the number of children enrolled in the State Children's Health Insurance Program.

HHS programs provide necessarily brief discussions of coordination with partners in the performance plans. The following discussion of the partnerships and collaborations developed by the Indian Health Services highlights the breadth and depth of coordination – with other HHS components, other Federal agencies, and non-governmental organizations – that support the HHS strategic objective to improve the health of American Indians and Alaskan Natives.

PARTNERSHIPS AND COLLABORATIONS IN SUPPORT OF INDIAN HEALTH

The Indian Health Service (IHS) has developed extensive crosscutting collaborations and partnerships with other agencies and organizations to address the health of American Indians and Alaska Natives (AI/AN). IHS engages in these collaborations to build capacity across institutions; enhance program outreach through shared resources; open dialogue with new partners; develop or disseminate new health care and/or surveillance technologies; secure a variety of training and technical assistance support for Indian Health Service, Tribal, and Urban providers; network to maximize knowledge and resources; disseminate information through activities of mutual concern; and develop tribally specific community-based, community driven research.

These partnerships support the achievement of IHS performance goals related to quality of care for diabetes patients, cancer screenings, alcohol and substance abuse, caridovascular disease, HIV surveillance and counseling, injury prevention, immunizations, childhood obesity, dental care, and water floridation.

Partnerships with HHS Agencies

Administration for Children and Families/Head Start Bureau

- The IHS and the Administration for Children and Families (ACF) have a longstanding collaboration (five years) with the Head Start Bureau. IHS provides health and safety training and technical assistance to the 177 Head Start grantees, which are part of the American Indian Program Branch of the ACF, in the area of Health and Safety, Nutrition, Dental, Behavioral Health and General Medical Services. The collaboration also results in a full-time health and safety specialist position and a computerized data system for the IHS Head Start program.

- The IHS and the ACF are collaborating with the IHS diabetes program, nutrition program and the clinical providers to monitor and develop programs to address the 0-5 age group of AI/AN in prevention. This is an intervention program to address rising trends in obesity in this age group.

Agency for Healthcare Research and Quality

- The IHS and AHRQ co-sponsored a conference entitled "Crafting the Future of American Indian and Alaska Native Health into the Next Millennium." The purpose was to promote

health care partnerships, including research partnerships, between academic medical centers and AI/AN organizations and tribes. IHS and AHRQ are maintaining collaborative efforts; strengthening health services research; increasing opportunities for the Native American population into research; and strengthening the research infrastructure of AI/AN organizations.

- The AHRQ Office of Research Review, Education and Policy (ORREP) is collaborating on potential research training for AI/AN. The ORREP also participated in the Annual IHS Research Conference. Discussions regarding additional research possibilities have been held with other AHRQ staff.

- The AHRQ Center for Practice and Technology Assessment and the IHS have had discussions regarding possible collaboration and services through their evidence-based practice centers, including technology assessment and other related research activities.

- A collaboration with AHRQ is being pursued to support an Indian Primary-Care Based Research Network.

- A collaboration with AHRQ is being discussed for development in 2002 to field an update of the Survey of American Indian and Alaska Natives (SAIAN) as part of the Medical Expenditures Planning Survey (MEPS).

- The collaboration continues on the development of the Healthcare Utilization Project to incorporate IHS data into a large nationwide inpatient database that AHRQ manages with the States.

Centers for Disease Control and Prevention Umbrella Agreement

The IHS and CDC have extensively collaborated in addressing a diversity of health issues over the past decade. As a result, the IHS and CDC now annually develop an umbrella agreement and work plan that currently addresses:

- CDC/Agency for Toxic Substances and Disease Registry Tribal Liaison: The purpose of this position is to strengthen inter-government response to Tribal public health needs through consultation, networking, strategic planning, and improved coordination among Federal and State governments, Tribal communities, urban Indian health programs, and academic institutions. This helps to ensure that Indian health interests are represented in program decisions and policies.

- Epidemiology/Preventive Medicine Training: The IHS National Epidemiology Program hosts CDC Epidemic Intelligence Service (EIS) Officers for their two-year field epidemiology training experience, and Preventive Medicine Residents (PMRs) for a one-year field training. IHS can provide similar assignments for Prevention Specialists (Public Health Prevention Service). It provides the trainees practical experience while providing a service to the IHS. The IHS Epidemiology and the CDC/EPO are currently collaborating on a project to make basic epidemiology training available to Tribal health departments; Navajo Nation is the pilot site.

- CDC/National Center for Chronic Disease Prevention and Health Promotion-Chronic Disease Annual Workplan: This intra-agency agreement/workplan was developed in 1990 consisting of two distinct segments, the R-90 (services provided by IHS to CDC) and the M-90 (services provided by CDC to IHS). Both segments consist of an array of components, the specifics of which are negotiated on an annual basis in the form of a workplan. In many cases IHS provides the FTE and CDC provides salaries for some of the staff supporting these activities. Highlights of this plan follows:

  - Division of Cancer Prevention and Control (DCPC): Provides for a field assignment for a CDC Public Health Advisor (PHA) to provide technical assistance/guidance for capacity building with State health departments, IHS tribes and Tribal organizations. DCPC also provides funds for colposcopy training and other IHS cancer control activities. IHS provides an additional three FTE's to CDC, located in Atlanta, for direct technical assistance and consultation to tribes and Tribal organizations through the National Breast and Cervical Cancer Early Detection Program, which currently funds 14 Tribal screening programs.

  - Division of Adult and Community Health (DACH): IHS provides DACH with four FTE's located in Atlanta to support research, technical assistance, training, and planning. DACH will be the lead in overall planning, coordinating, and monitoring of chronic disease-related activities. The principal activities include a Memorandum of Understanding - IHS CDC/University of New Mexico. The IHS provides an FTE for a field assignee with a doctorate in epidemiology or related field to serve as a Senior Research Scientist for University of New Mexico Prevention Research Center for activities related to AI/AN communities.

  - Health Promotion Activities for Older Adults: This component provides technical assistance in the design, implementation and analysis of surveys for health promotion activities for older adults. Information from these surveys will be used to direct program development and evaluation of the health needs of AI/AN aged 55 and older.

  - Behavioral Surveillance Branch (BSB): Using the CDC Behavioral Risk Factor Surveillance Survey (BRFSS) this collaboration responds to requests from Tribal epidemiology centers (Alaska Native EPI Center, Inter-Tribal Council of Arizona; Northwest Tribal Research Center, and Great Lakes Inter-Tribal Council) to assist in creating and/or analyzing BRFSS data files.

  - Cardiovascular Health: The DACH provides technical assistance in the design, implementation, and evaluation of cardiovascular risk factor prevention and intervention programs. Provides dissemination of lessons learned from the Inter-Tribal Health Project (ITHP) to Tribal communities in the Bemidji service area of IHS and throughout the United States.

  - Division of Oral Health: This agreement includes a component to develop, implement and promote water fluoridation in AI/AN communities for dental disease prevention. A field assignee will be placed in Albuquerque with the IHS Environmental Management Branch.

- Division of Diabetes Translation (DDT): The IHS provides one FTE located in Atlanta, to support CDC/DDT in providing technical consultation and assistance on public health surveillance of diabetes to define the burden of diabetes and diabetes-related complications among the Native population. The DDT calculates age-specific and age-adjusted prevalence by area; hospitalizations and amputations. The CDC/DDT also provides a field assignee to IHS diabetes program in Albuquerque to provide consultation and technical assistance in diabetes epidemiology to IHS.

- Gallup Diabetes Research Center: The IHS provides five FTEs and funding to NCCDPHP to support the National Diabetes Prevention Research Center in Gallup, New Mexico. The IHS and the NCCDPHP will jointly provide national leadership to plan, develop, implement and evaluate the National Diabetes Prevention Research Center under the broad guidance of the Departments of Labor, Health and Human Services, Education, and Related Agencies Congressional Appropriations Act, H.R. 2264, 1998 Conference Report, page S-12088.

- Office on Smoking and Health (OSH): The IHS provides CDC/OSH with one FTE for a field assignee located in Albuquerque, New Mexico, to develop, establish, and maintain a community based program for the prevention and control of tobacco use, and related health problems among AI/AN populations.

- Division of Reproductive Health (DRH): The IHS provides three FTEs to DRH to support a multifaceted approach to addressing reproductive-related health problems in AI/AN, including Sudden Infant Death Syndrome, and to assist tribes in community health surveys. One method is collection and analysis of reproductive health and Behavioral Risk Factor Surveillance (BRFS) information. After data collection, DRH assists tribes and organizations in the analysis, interpretation and dissemination of survey data. The Pregnancy Risk Assessment Monitoring System (PRAMS) conducts state-specific, population-based surveillance of women's behaviors before, during pregnancy and during the child's early infancy. Two FTE's are located in Atlanta and one FTE provides for a field assignee located in Albuquerque, New Mexico.

‣ National Center for HIV, STD and TB Prevention (NCHSTP):

- Division of Sexually Transmitted Disease Prevention: The IHS provides an FTE for the field assignment of a Public Health Advisor (PHA) to assist in the planning, development and implementation of sexually transmitted disease control programs among AI/AN. The PHA is located in Albuquerque, New Mexico.

- Communicable/Sexually Transmitted Disease Prevention and Control: The IHS provides one-half time services of an epidemiologist to share administratively the activities under this agreement. The agreement provides for the prevention and control of communicable and other sexually transmitted diseases among AI/AN. High rates of Chlamydia trachomatis may be found throughout AI/AN populations. Activities will include: developing and implementing surveillance systems for monitoring trends; initiating and managing national evaluation, screening and intervention programs and identifying high risk populations for other sexually transmitted disease including HIV.

- Division of HIV/AIDS Prevention:

  Under another collaborative agreement that has been completed an epidemiologist will be designated to assist in the coordination of national surveillance, prevention, and control activities for HIV/AIDS and related opportunistic infections, STDs, and hepatitis B and C among AI/AN people.

  Further collaboration with CDC/Division of Adolescent and School Health (DASH) is being conducted to provide HIV prevention program activities for the implementation and evaluation of HIV prevention education for AI/AN children and youth in schools on reservations, rural areas, and urban metropolitan areas. Training will be provided to teach in States that have a significant number of Indian students in the use of a curriculum, "Circle of Life HIV/AIDS Curriculum", developed by IHS. The curriculum is for grades K through 6th grade.

- National Center for Infectious Diseases (NCID):

  - Division of Viral and Rickettsial Diseases, Hepatitis Branch: The IHS provides an FTE for a field assignment to be located in Albuquerque, New Mexico, of an epidemiologist to assist in the planning development, and implementation of hepatitis prevention and control programs among AI/ANs. The purpose of this agreement is to provide for collaborative activities related to prevention and control of hepatitis A and C in AI/AN communities. The ultimate goal is to reduce the incidence of hepatitis as a health problem in AI/AN populations.

  - Special Pathogens Branch: The IHS and CDC have an ongoing intra-agency agreement that targets the hantavirus disease. The purpose of this agreement is to assist in the planning, development and implementation of hantavirus prevention and control programs among AI/ANs. Support provided includes assistance in determining trends in hantavirus morbidity and mortality; identifying and responding to outbreaks; and collaborating with Tribal, State and local health departments and community-based organizations.

- National Center for Injury Prevention and Control (NCIPC): The NCIPC has had an intra-agency agreement with IHS since 1985 to help reduce unintentional and intentional injuries among AI/ANs. The CDC has assisted IHS with pilot injury surveillance projects, publishing MMWR reports and Surveillance Summaries, teaching in the IHS Injury Prevention training program to build Tribal capacity, evaluating community-based injury prevention and control initiatives, participating in the IHS's national advisory board on injuries, and collaborating as a national partner to raise awareness of injuries as a leading public health problem among AI/ANs. The CDC and the IHS also collaborated with the American Academy of Pediatrics and several Tribal groups to present the first ever briefing on injury issues to select Senate staff. The IHS provides an FTE for an Atlanta-based Injury Prevention Specialist who collaborates with IHS on these and other projects.

- National Immunization Program (NIP): Vaccine-Preventable Disease Control: The IHS provides an FTE for the field assignment of a Public Health Advisor to assist in the planning, development and implementation of vaccine-preventable disease control programs among

AI/ANs. The PHA, located in Albuquerque, New Mexico, will assist in implementation of the Vaccines for Children (VFC) program among AI/AN children.

- Other IHS/CDC Cooperative Agreements: The IHS and CDC collaborate on various specific projects in partnership with tribes, Tribal coalitions, Alaska Native corporations, and academic institutions who are recipients of CDC and/or IHS cooperative agreement funds. Such activities may or may not occur in direct relationship to the aforementioned formal Intra-agency Agreements.

Food and Drug Administration

The IHS and the FDA collaborated on recommendations to reduce patient and occupational exposures, to promote principles of radiation protection, and to allow the FDA to monitor radiation protection for conformance with existing agency and Federal policies.

The IHS has a collaborative agreement with the FDA Center for Devices and Radiological Health for mutual support in the evaluation and use of medical radiologic equipment. During the past year the FDA provided equipment and training to allow IHS institutional environmental health staff to conduct performances and quality assurance evaluations of 300 medical and 1,000 dental diagnostic x-ray units.

Health Care Financing Administration

The collaboration with HCFA covers an array of issues that critically impact operational issues related to the Indian health care system and the provision of services by the IHS to its stakeholders. Many of the issues were directed at increasing the understanding of Federal and State government agencies about the government-to-government relationship with the 550 federally recognized tribes and the need for consultation with Tribal governments on actions that affected them. Following are current and ongoing collaboration issues.

- The IHS and HCFA Joint Indian Health Steering Committee continues to be an effective tool creating a better understanding of the unique needs of the IHS and, Tribes (I/T) for appropriate, representative policies.

  Legislation Subcommittee: The IHS works with HCFA on legislative initiatives, e.g., reauthorization of IHCIA, using Medicare rates for CHS payments, expanding payments to outpatient ambulatory clinics and for physician services.

  Operations Subcommittee: The IHS works with HCFA on program policy and operation issues such as reimbursement policies, outreach and education, and data sharing and other policy guidance.

  Cost Reports Subcommittee: The IHS in collaboration with HCFA addresses short and long range plans for development of hospital cost reports. This includes short and long range plans for a cost accounting system, and training of IHS finance and management staff.

- The IHS and HCFA continue their collaboration with the National Medical Education program (NMEP) Task Force. The NMEP ensure that beneficiaries receive accurate, reliable

information about their benefits, rights and health plan options; have the ability to access information needed to make informed choices; and perceive the NMEP (the Federal government and our private sector partners) as trusted and credible sources of information. The NMEP activities have included publishing Medicare & You Handbook, Internet activities, Toll-Free Medicare choices Helpline, National Alliance Network, Enhanced Beneficiary Counseling from State Health Insurance Assistance programs, the National Train-the-Trainer Program, and Regional Education About Choices in Health Campaigns.

- The IHS and HCFA formed the Home Health Care workgroup to develop draft regulations to implement the Prospective Payment System. The workgroup will be reviewing amendments to the current regulations.

- The IHS and HCFA work closely on the HHS Value-Based Purchasing Work Group which is part of the Quality Interagency Coordination Council. They have pursued efforts to reduce the number of medical errors in health care environments and to build a safer health system nationally.

- The establishment of an IHS Liaison to advise HCFA managers on policy information respective to health care programs administered by the I/T/U continues to be beneficial and effective.

- The IHS and HCFA collaborated for the Prospective Payment System Minimum Data Sets that include current cost reports. These files are used to calculate hospitals' current Diagnostic Related Group prospective payment rates, etc. The intent of these data sets are to provide IHS with the necessary information to make payments in a timely manner.

- The IHS and HCFA collaboration resulted in new Medicare and Medicaid reimbursement rates for the IHS and IHS-funded Tribal facilities. This revenue source is used for medical staff, improved training, the purchase of additional medical equipment and improved facilities for IHS.

- The IHS and HCFA collaborated on legislative initiatives that resulted in important HCFA policies and enhanced operational issues, i.e Medicaid program waivers, the Children's Health Insurance Program (CHIP), new policy guidance and proposed regulations exempting AI/AN from any cost sharing provisions under CHIP for eligible children.

- The IHS and HCFA collaborated on Medicare enrollment data to provide more accurate information for assessing outreach to Medicare beneficiaries that are AI/AN to establish an accurate database for IHS. This information will be used also for analyzing AI/AN Medicare utilization patters. Also, this database will be used by the IHS in claims processing to reduce the number of IHS Medicare claims rejected by HCFA fiscal intermediaries for errors.

- The IHS/HCFA collaborated together to discuss major issues affecting the policies and operations of each agency such as interfacing with State health care reform initiatives, federal waiver demonstrations, advising HCFA HQs and Regional Officers, State Medicaid Directors on how to consult with tribes in their States when drafting Medicaid waiver proposals.

Health Resources and Services Administration

- The IHS continues to collaborate with HRSA to provide support for PHS Primary Care Policy Fellowship program to bring 30 Federal and private sector primary care leaders to enhance their capabilities to advance the primary care agenda at the local, State, and national level. It also sponsors a mid-year Primary Care Networking Conference for collaborations.

- The IHS and HRSA have recently completed an agreement to provide HIV/AIDS education and training to health care providers that provide health care services to AI/AN.

- The IHS and HRSA-Federal Occupational Health Program (FOHP) partnered to share software enabling IHS to receive occupational health, environmental assessment and health information management support services from various resources. It enables IHS to meet its environmental management responsibilities.

National Institutes of Health

- The IHS and the National Institute of General Medical Sciences (NIGMS) are collaborating on bringing together in partnership academic research institutions, Indian tribes or Indian community based organizations. The purpose is to strengthen capacity for research on diseases of importance to American Indians and to develop a cadre of American Indian scientists and health professionals who will become active participants in competitive NIH funded research.

- The IHS and the National Institute for Dental and Craniofacial Research, in partnership with the State University of New York at Buffalo, have a longstanding (five year) partnership to develop treatment regimens for individuals with diabetes who also suffer from periodontal disease. The first site for the study was Sacaton, Arizona, and the current site is Santa Fe, New Mexico. The results have been reported in the professional literature and the technology is being exported under a grant program.

- The IHS and National Institute of Diabetes and Digestive Kidney Diseases (NIDDK) collaborate on facilities and services to conduct clinical research studies primarily in the areas of diabetes and digestive diseases at the Phoenix Indian Medical Center (PIMC), Arizona. It also facilitates collaborative research interest in diabetic renal disease and epidemiologic surveys and studies.

HHS Office of Women's Health

The National Indian Women's Health Steering Committee is conducting 11 surveys through Indian country to identify women's health issues and will be making recommendations to the Director of IHS.

Substance Abuse and Mental Health Services Administration

The IHS along with other Federal Agencies are working with SAMHSA to support several Native American collaborations in mental health and substance abuse, including the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence."

Partnerships with Other Federal Agencies and Non-Governmental Organizations

American College of Obstetrics and Gynecology

The American College of Obstetrics and Gynecologists (ACOG) Fellows In Service Program recruits and screens Board Certified or Active Candidates for Board Certification obstetrician-gynecologists (OBG's) for short term assignments in IHS facilities. These fellows augment local IHS staff when their OBG's are away for leave, educational training, maternity leave, or prolonged illness or disability. There are approximately 8-12 assignments each year, with 11 having been assigned this past year. A number of requests have already been made for this year's program.

The ACOG Committee on American Indian Affairs meets with IHS Headquarters, Area, and Service Unit staff 2-3 times a year and conducts an Area-wide obstetric and gynecologic quality of care consultation site visit annually. All Areas with full-service obstetrics and gynecology programs are site visited on a rotating schedule. The Billings Area was surveyed last year. The Committee met with the IHS OBG clinicians in Albuquerque in July, 2000, and is scheduling its next site visit to the Phoenix Area in the spring of 2001.

The ACOG-IHS Postgraduate Course on Obstetric, Neonatal, and Gynecologic Care is presented annually by specially recruited and selected ACOG and IHS faculty for approximately 100-110 IHS and Tribal physicians, advanced practice nurses, and clinical nurses. This course is designed to provide a week-long update of obstetric, neonatal, and gynecologic care with the focus on practices appropriate in the primary care setting in often smaller or more remote facilities. Approximately 110 have registered for the next course to be presented in Aurora, CO, in September, 2000.

Department of Interior/Bureau of Indian Affairs

The IHS along with other Federal Agencies are working with the DOI/BIA to support several Native American collaborations in mental health, including the "Indian Self Determination: Summit on Tribal Strategies to Reduce Alcohol, Substance Abuse and Violence." The IHS continues to work with the BIA to provide technical assistance and training for background checks of employees of Tribal health programs, and partner in the support of the IHS/BIA Annual Youth Conference reaching Junior High and High School and college teens with an agenda that covers a wide variety of life issues.

Department of Justice

The IHS and other Federal agencies have partnered with the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention and Office of Community Oriented Policing Services to support coordinated activities in mental health and community safety, targeting AI/AN children, youth, and families. The grant funds are for a three-year period to provide tribes with easy-to access assistance in developing innovative strategies that focus on the mental health, behavioral, substance abuse, and community safety needs of AI/AN young people and their families

The IHS and other federal agencies have partnered with the U.S. Department of Justice, Offices of Tribal Justice, OJP Corrections Program and Office of Justice Program to co-sponsor the "Indian Self Determination: Summit on Tribal Strategies to Reduce Alcohol, Substance Abuse

and Violence." The conference will focus on developing a national agenda on alcohol, substance abuse and violence for Indian country; and an opportunity for Federal agencies to highlight promising practices and strategies on alcohol, substance abuse and violence. Tribes will be given materials, and they will be able to network with researchers.

Environmental Protection Agency

The IHS and EPA have several interagency agreements to coordinate activities of both agencies pertaining to the environment and human health of AI/AN and their lands. Through their joint effort the EPA can provide resources to the Sanitation Facilities Construction Program's national network of staff to promote their mutual interests, create cost-efficiencies and eliminate overlapping responsibilities, i.e. design and construct wastewater treatment projects.

In their partnership with EPA, the IHS also enters into Memorandums of Understanding (MOU) with tribes to apply and manage Clean (CW) Indian Set-Aside grants to develop and manage their water and sanitation facilities program. The IHS and EPA provide technical guidance and support throughout the process.

Federal Emergency Management Agency

The IHS, the Federal Emergency Management Agency (FEMA) and the U. S. Fire Administration (USFA) are collaborating to reduce the rate of fire and burn injuries in American Indian and Alaska native children, ages 0-5 years to half the national average by the year 2010. Fire is the leading cause of childhood injury death in the home and children under five years of age are at the highest risk.

Injury Prevention

The mission of the IHS Injury Prevention Program is to decrease the incidence of severe injuries and death to the lowest possible level and increase the ability of tribes to address their injury problems. The IHS has initiated an aggressive public health attack to prevent traumatic injury among American Indians and Alaska Natives. Primary emphasis is directed to the injuries of the greatest cause, such as motor vehicle crashes, and to the most common risk factors, such as lack of occupant restraints, alcohol impaired driving, and poor road conditions in rural areas. Other emphasis areas are in childhood injury, the prevention of house fire-related injuries, and building the capacity of Tribes to address injuries in local communities through core programmatic funding and training in injury prevention.

To accomplish their mission, the IHS Injury Prevention Program has formed partnerships with many government and non-government agencies. The IHS has a collaborative agreement with the National Center for Injury Prevention and Control of the CDC for the purpose of injury prevention, with specific areas of interest in injury epidemiology and surveillance and in the evaluation of community-based injury prevention and control initiatives. During the past year the CDC and the IHS collaborated with the American Academy of Pediatrics and several Tribal groups to present the first ever briefing on injury issues to staff from the Senate Select Subcommittee on Indian Affairs.

Other formal Interagency Agreements exist between IHS and the U.S. Fire Administration, and the National Highway Traffic Safety Administration. Program staff work with many other agencies and groups including the following; the National Safe Kids Campaign, the Consumer Product Safety Commission; Bureau of Indian Affairs' Law Enforcement Services and Division of Highway Safety; American Academy of Pediatrics, Committee on Native American Child Health and the Committee on Injury and Poison Prevention; Federal Highway Administration; HRSA's Maternal & Child Health Bureau; The Johns Hopkins University; Harborview Injury Prevention Research Center; and private foundations.

U.S. Army Medical Command

The IHS and the U.S. Army Medical Command collaboration permitted the IHS to access the Army's contract with Med-National. Med-National is a health manpower recruiting firm located in San Antonio, Texas. Through Med-National, the IHS has access to an alternate source of dental manpower and has been able to place 6 dentists in IHS and Tribal dental clinics.

United States Department of Agriculture

The IHS continues to work with the USDA for WIC services for Head Start Indian children to provide basic nutrition food items to ensure health physical development of children between ages 1-5 years old.

Uniformed Services University of the Health Sciences

The IHS also has a collaborative agreement with the Uniformed Services University of the Health Sciences (USUHS) for technical assistance in ensuring environmental compliance of IHS health care facilities. During the past year, USUHS staff developed a comprehensive hazardous materials and waste management plan that will be applied in all IHS facilities.

Department of Veterans Affairs

- Nationally, the IHS is collaborating with the VA on targeted data systems and credentialing to increase the number of Native American veterans eligible for services and to identify under-served areas of Indian country where Native Americans reside.

- The IHS, HFCA and the Social Security Administration plan to include the VA in their collaboration to develop an agreement targeting education and outreach of veteran beneficiaries who are underutilizing their benefits and services.

- Many local IHS facilities have care agreements and pharmaceutical supply agreements with nearby VA facilities that maximize capabilities and extends the outreach of services for both agencies.

- The IHS participates in the VA Drug Prime Vendor Program. By collaborating with the VA and being included on the VA prime vendor drug contract, the IHS is able to take advantage of national drug contract prices negotiated by the VA. This allows the IHS to purchase selected pharmaceutical at substantially discounted prices, even lower than Federal Supply Service (FSS) prices in most cases. The IHS has been participating for several years and plans to continue this collaboration indefinitely. The program has resulted in very substantial savings for IHS over the years.

HHS Goal 1: REDUCE THE MAJOR THREATS TO THE HEALTH AND PRODUCTIVITY OF ALL AMERICANS

Research indicates that a significant percentage of premature mortality and morbidity in the United States can be prevented if individuals avoid certain high-risk behaviors (e.g., smoking), adopt healthy ones (e.g., exercise), and reduce exposure to major environmental risks to health (e.g., lead-based paint). The strategic objectives under this goal focus Department efforts on changing behaviors and reducing the risks that are associated with the leading causes of premature mortality and morbidity (e.g., heart disease and stroke) in the United States.

The importance of this goal is evident from the health and economic consequences of the behaviors that are addressed. For example,

- Smoking is estimated to be responsible for more than 400,000 deaths annually (one in every five deaths in the United States is smoking-related), and it is estimated that smoking increases the risk of contracting other diseases, including heart disease and emphysema and other respiratory diseases.

- Unintentional injuries (primarily from fires, falls, drowning, and poisonings) are the leading cause of death in the United States for people between the ages of 1 and 44.

- Violence in intimate relationships is estimated to result in financial losses to women victims of $150 million a year.

- Poor diet and low levels of physical activity are associated with 300,000 deaths each year, second only to tobacco.

- Alcohol abuse exacts a financial toll on the Nation, costing over $166 billion annually, of which approximately $58 billion is attributed to underage drinking.

- Drug abuse, estimated to cost society over $100 billion per year, is linked to other public health problems, such as suicide, homicide, motor-vehicle injury, sexually transmitted diseases, and HIV infection.

- Unsafe sexual behavior is related to more than 12 million cases of sexually transmitted diseases, high teen pregnancy rates, and billions of dollars in preventable health care spending each year. While the actual death rates from HIV infection have declined, the number of new infections (estimated at 40,000 annually) and cost of treatment remain high.

- Finally, infectious disease (e.g., pneumonia and influenza) was the sixth leading cause of death in the United States in 1998.

SUMMARY PERFORMANCE REPORT

HHS Strategic Goal 1

These are selected performance stories from the performance plans of the HHS operating and staff components that support key areas related to the achievement of this strategic goal. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan.

SUBSTANCE ABUSE

Substance Abuse Treatment. Estimates from the Treatment Episode Data Set (TEDS) of 1,564,156 have exceeded the SAMHSA's FY 2000 target of 1,525,688 persons served through the Substance Abuse Prevention and Treatment Block Grant, which provides funding to States for treatment and prevention services for persons at risk of or abusing alcohol and other drugs. TEDS data, which represents admissions to treatment at facilities, are used because not all States are reporting, or have the capacity to report, unduplicated counts of clients served. SAMHSA is working with States to increase the number which can report unduplicated counts.

  Twenty-four States reported some or all information in response to the request for voluntary reporting of selected client outcome data. The FY 2000 target was 19 States; the measures were implemented in FY 2000, so the FY 1999 baseline was zero States. SAMHSA is working with the States to reach closure on a final core data set for the Block Grant, and to improve the number of States which can report data on the current indicators.

  The percentage of SAMHSA technical assistance events that resulted in systems, program, or practice change increased from a baseline of 66 percent in FY 1999 to 84 percent in FY 2000, exceeding the FY 2000 target of 70 percent. Satisfaction with technical assistance was at 97 percent in FY 2000, exceeding the FY 2000 target of 90 percent.

Substance Abuse among Tribal Youth. Because studies indicate that the longer individuals are engaged in treatment (including aftercare/continuing care) the better the prognosis, IHS has developed a goal focused on assuring adequate follow-up care for adolescents discharged from IHS supported Regional Treatment Centers (RTCs). IHS met its FY 2000 goal to increase by 10 percent the youths discharged from adolescent RTCs who have receive adequate (at least three visits) follow-up in the first year following treatment. Forty-eight percent of the youths discharged from RTC received follow-up contacts at 30 days, and at least a second follow-up by 6 months, and at least a third at 12 months after discharge, compared to 40.9 percent in FY 1999, which represents a 17 percent increase in follow-up during FY 2000. In addition, the percentage of youths who received follow-up in the critical first 30 days following discharged also increased from 64.5 percent in FY 1999 to 69.5 percent in FY 2000, an increase of 7.8 percent.

Youth Marijuana Treatment. Preliminary results from SAMHSA's Cannabis (Marijuana) Youth Treatment Models Knowledge Development program, which was initiated in FY 1997 and which will report final results in FY 2001, include actual reduction in marijuana use. In

untreated adolescents, marijuana use typically accelerates until age 20, with outpatient treatment only reducing or leveling the slope of increasing use.

Substance Abuse Prevention. Results for the 20 percent substance abuse prevention portion of SAMHSA's Substance Abuse Prevention and Treatment Block Grant Program include the following:

- The number of States that incorporate needs assessment data into the Block Grant application increased from 13 States at baseline to 26 States in FY 1999 and to 34 States in FY 2000, meeting the FY 2000 target of 34 States. States use their needs assessment data to improve access and target resources to where they are most needed for particular populations. For example, New Hampshire, which has relatively limited resources to conduct needs assessment, is improving the use of its social indicator data; Pennsylvania is conducting a reassessment of the severity of its 23 risk factors as part of the Governor's health improvement planning process; and South Carolina is conducting an internal statewide prevention needs assessment, using focus groups, surveys and quarterly meetings.

- The percentage of States that use funds in each of six prevention strategy areas held steady at 99 percent, meeting the FY 2000 target. The FY 1999 target of 80 percent had been exceeded.

Interventions for Children at Risk for Substance Abuse. The goal of the SAMHSA's Predictor Variables program is to determine at what developmental stage(s) the enhancement of each of the variables being investigated (self-regulation and control; cognitive development/ academic achievement; school bonding; and care giver investment in the child and activities) proves most effective in preventing/reducing negative behaviors that are predictive of substance abuse. Preliminary results show promise in terms of reducing substance abuse in children and adolescents, and particularly positive results for boys; the use of alcohol was 4.5 percent lower in the intervention group compared to the control group; and in the intervention group, the rates of drug use increased by less than .4 percent. Where there was no intervention, the rates of drug use increased from 7 percent to 12 percent.

Substance Abuse Prevention, Intervention, and Treatment Information. SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) provides comprehensive, customer-oriented information about substance abuse prevention, intervention, and treatment. It also serves as the response center for the National Youth Anti-Drug Media Campaign, which has stimulated twice the level of demand as compared to last year. NCADI has implemented call center operations 24 hours a day, 7 days a week, to serve members of the public responding to media campaign and public education campaigns. In addition, NCADI has taken on responsibility for SAMHSA's National Treatment Helpline (1-800-662-HELP).

Information requests per month increased from 17,600 per month in FY 1997, to 25,289 in FY 1998 (a 43 percent increase over baseline), and to 40,285 per month in FY 1999 (135 percent over baseline). Targets have been raised accordingly. Customer satisfaction increased from 85 percent in FY 1997 to 90 percent in FY 1998 and FY 1999, exceeding SAMHSA's 85 percent target. A new and far more comprehensive customer satisfaction survey is being implemented, and new baselines and targets will be established.

Reducing Tobacco Use. Multiple agencies in the Department address tobacco use: CDC conducts surveillance activities and public health interventions, NIH conducts biomedical and applied research, and SAMHSA performs tobacco use surveillance and implements regulations on minors' access to tobacco. This cross-cutting effort also involves other Federal departments: the Federal Trade Commission oversees the testing protocol for tar and nicotine yields in cigarettes and monitors and regulates advertising practices, the Department of Agriculture works with tobacco farming communities, the Department of Commerce is involved with the manufacturing sector and other related businesses, the Treasury Department is involved in customs-related issues and taxation issues; and the Environmental Protection Agency is involved in second hand smoke issues. In addition, State and local governments, non-governmental organizations, (e.g., American Cancer Society, the Robert Wood Johnson Foundation), and health care providers all play an important role in efforts to reduce tobacco use. Therefore, accomplishments in the area of tobacco control are collective, resulting from partnerships between government and non-government organizations.

Between 1991 and 1997, cigarette use among youth (grades 9-12) increased from 27.5 percent to 36.4 percent. The rate was expected to plateau at 36.4 in 1999 and begin to drop after 1999. However, data released from CDC's Youth Risk Behavior Survey indicate the percentage of teenagers (grades 9-12) who smoke dropped from 36.4 percent in 1997 to 34.8 percent in 1999, exceeding CDC's and OPHS's joint goal to reduce teen smoking to 36.4 percent in FY 1999. CDC and OPHS have targeted further reduction in youth smoking to 34.2 percent in FY 2001.

Through SAMHSA's Synar Amendment Implementation Activities, the number of States with retail sales of tobacco to minors violations at or below 20 percent has increased dramatically, from a baseline of 4 States in FY 1997 to 21 States in FY 1999 and 25 States in FY 2000, just short of SAMHSA's FY 2000 target of 26.

DOMESTIC VIOLENCE AND INJURIES

Injury Surveillance. Through the Injury Prevention and Control Program, CDC provides national leadership for the design and implementation of programs that prevent premature death, disability and reduce human suffering and medical costs caused by injuries. As part of its effort to establish a system for collecting Intimate Partner Violence (IPV) surveillance data, CDC has funded a total of six States to explore different ways to collect data to monitor IPV at the State level. The IPV initiative will provide researchers with critical data in FY 2001 to analyze and develop prevention methods. In addition, CDC is in the process of establishing a research program that addresses the understudied aspects of violence against women. CDC set priorities and funded the program in FY 2000, and in FY 2001 CDC anticipates that at least 2 understudied aspects of violence against women, identified in the research, will be addressed at the community and program level.

CDC is also leading a national effort to develop uniform data elements for emergency department (ED) records. CDC published Data Elements for Emergency Department Systems (DEEDS) as a set of recommendations to foster uniformity in the way that emergency department records are created, stored, transmitted, and used. Improvements in the

uniformity, quality, and accessibility of ED data will yield immediate benefits for public health surveillance of injuries. For example, projects in Oregon and North Carolina are using DEEDS in innovative electronic public health reporting projects. In addition, the Health Care Financing Administration (HCFA) has incorporated DEEDS in its plans for implementation of the Health Insurance Portability and Accountability Act (HIPAA), specifically the emergency department claims attachment.

Reducing Injuries in American Indians and Alaskan Natives. Because injuries are a leading cause of hospitalization and death for American Indian and Alaskan Native people, IHS set a FY 1999 goal to assure that the injury death rate was no greater than 93 per 100,000 deaths. While FY 1999 data will not be available until May 2001, the rate for FY 1994-1996 has dropped to 92.6 per 100,000, from 95 per 100,000 in FY 1992-1994. In fact, injuries have dropped from the leading cause of death in the early part of the decade to the second leading cause of death currently. And while seven IHS Areas still have rates that are above the FY 1999 target, most of these areas are in the rural west where travel distances are long and residents are at high risk for motor vehicle-related injury. However, these Area rates have been trending downward, due to efforts to reduce impaired driving, the tribes passing tougher drunk driving and occupant restraint laws, and stricter enforcement of these laws.

Youth Violence Prevention. As the lead entity in injury prevention and control, CDC collaborates with the Department and other State and Federal agencies to coordinate activities and programs designed to prevent and reduce risks of youth violence. Ten National Centers of Excellence on Youth Violence and a National Youth Violence Prevention Resource Center have been funded by CDC. The focus of these Centers is on intervention and evaluation research. A measure of the success of these efforts is exemplified by a 30 percent reduction in reported incidents of physical fighting in a CDC-funded youth violence project.

CDC has also developed an implementation source book on the Best Practices for reducing aggression and violence among youth. The source book covers four strategies: social cognitive programs, mentoring programs, parent/family intervention programs, and nurse home visitation. The source book builds on lessons learned from initial evaluation projects funded by CDC, draws upon the expertise of over 100 of the Nation's leading scientists and practitioners, and includes information from the scientific literature on youth violence prevention.

In light of the recent school shootings, CDC, with the Department of Education and the Department of Justice, has conducted a second national study to determine whether there has been a significant increase in school-associated violent deaths since 1994. Once data analysis is completed CDC will have continuous data from 1992-1998.

Recognizing Domestic Violence. Recognizing that family violence victims (child, spouse or elder) come to the health care system with a variety of physical injuries, illnesses or medical conditions directly related to abuse, IHS developed a goal to assure that providers consistently screen for indications of violence, abuse or neglect and make appropriate referrals. A written protocol makes this more likely because these efforts become part of the local quality assurance process. On aggregate, IHS exceeded its FY 2000 goal to assure that at least 70 percent of IHS, Tribal, and Urban facilities with urgent care or emergency departments have written policies and procedures for routinely identifying, treating and/or referring victims of

family violence, abuse or neglect. However, the more detailed FY 2000 survey identified lower rates for spouse/intimate partner abuse, as well as elder abuse and neglect. One possible reason is a lack of prototype policies and procedures; thus the IHS Women's Health web site will soon function as a repository for 'prototype' policies and procedures for these three areas, and IHS will notify clinical directors about the accessibility of this information on-line.

INFECTIOUS DISEASES

Domestic and Global Public Health Capacity. CDC has funded 43 State health departments to build epidemiologic and laboratory capacity for surveillance and response to infectious disease threats. In addition, CDC increased the number of regional programs that conduct active surveillance for its Emerging Infections Program and trained 73 fellows in Public Health microbiology who are available for employment in local, State, and Federal public health laboratories.

Antimicrobial-Resistance. CDC has made significant progress in reducing the increase of antimicrobial resistance based on strategies published in *A Public Health Action Plan to Combat Antimicrobial Resistance.* The rate of central line associated bloodstream infections in adults in intensive care units was reduced to 3.9 infections, exceeding CDC's target of 4.4 infections. Internationally, CDC established a surveillance system to collect data on antimalarial drug resistance in 54 sub-Saharan African countries. In addition, CDC has made substantial progress in reducing perinatal group B streptococcal disease, the most common cause of severe infections in newborns. Group B streptococcal infections in newborns have declined 70 percent since 1995.

Hepatitis C, Chronic Liver Disease and Viral Hepatitis. CDC provides extramural support for coordinators to initiate hepatitis prevention and control activities at the State/Local health department level. In FY 2000, CDC supported 14 health departments in hepatitis prevention and control, exceeding its target of nine. In addition, in FY 2000 CDC established sentinel surveillance systems in five States, which also exceeded the target of three States to monitor national trends in incidence, risk factors for infection, and outcomes of chronic Hepatitis C Virus (HCV). These successes significantly contribute to the Department's overall goal to lower the incidence of acute Hepatitis C in the United States and reduce the burden of liver disease burden from patients suffering from chronic HCV infection.

Influenza. CDC monitors influenza viruses in domestic and global sites to enhance early detection of influenza viruses with pandemic potential. This active monitoring process improves vaccine decision making helps to prevent pandemic influenza epidemics. In FY 2000, the number of domestic and international sites for influenza surveillance was exceeded. This success is attributable to CDC's increased recruitment for the U. S. Sentinel Physician Surveillance program and consistent follow-up on cases by the CDC influenza program staff.

Food Safety. CDC has made substantial progress in improving food safety through collaborations with Federal, State, and local government partners to promote food safety control measures. CDC led the development and implementation of the PulseNet – a laboratory DNA fingerprinting network that provides for early detection of foodborne disease

outbreaks within and between States. In addition, CDC, FDA, and USDA joined forces with government, industry, and consumers to conduct a broad-based food safety education campaign (Fight BAC!™), and launched a national partnership for school-focused foodborne illness prevention. Estimates of the burden of foodborne diseases in the U.S. using FoodNet, demonstrated that rates of *Campylobacter, Shigella, E. coli,* and *Salmonella enteriditis* have declined since FY 1999.

Eliminating Tuberculosis. In 1999 a total of 17,531 cases of tuberculosis (TB) were reported to CDC, representing the seventh consecutive yearly decline of TB cases. Regaining control of TB has clearly been one of the major public health success stories of the decade. Research indicates that completion of TB therapy is the most effective way to reduce the spread of TB and prevent its complications. CDC's TB performance measures in FYs 1999 and 2000 reflect this perspective. In both years, CDC set a target of 85 percent compliance among TB patients to complete their therapy. Although results for FY 1999 will not be available until mid-2002, trend data suggest that the CDC is making progress in ensuring treatment compliance of TB patients.

Increasing the Availability of Sanitation Facilities. In FY 2000 the IHS provided sanitation facilities to 3,886 new and like-new homes and 14,490 existing homes for a total of 18,376. This exceeded the total FY 2000 goal to provide sanitation facilities for 14,775 homes. This significant increase in existing homes was the result of more projects to upgrade existing community sanitation facilities infrastructure. Compelling evidence supports that reductions in the rates for infant mortality, gastroenteritis morbidity, and other environmentally related diseases of as much as 80 percent since 1973 are attributable to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. In addition, satisfactory environmental conditions (e.g., safe piped water and adequate sewage disposal) place fewer demands on IHS' primary health care delivery system.

SEXUALLY TRANSMITTED DISEASES

HIV/AIDS Prevention in Youth. CDC supports HIV/AIDS school health education programs for 53 million young people who attend more than 117,000 schools across the Nation each day. HIV/AIDS prevention education in schools has been demonstrated to reduce risk behaviors among youth, including behaviors that affect their risk of becoming infected with HIV. In FY 1999, CDC exceeded its target of ensuring that over 90 percent of high school students attended school sponsored training on HIV/AIDS prevention.

Substance Abuse and HIV/AIDS Outreach. The SAMHSA Community-based Substance Abuse and HIV/AIDS Outreach Targeted Capacity Expansion Program which first awarded grants in FY 1999, reports that in the first operating year of the program, over 89,560 client contacts had occurred. This number exceeds the FY 2000 target of 60,000 client contacts. All of the 25 grantee projects awarded in the first year are operational and are serving clients, with enrollment consistent with projections at all sites. Evaluation plans have been implemented, and data are being collected by all grantees.

STD and HIV Prevention Education, Counseling, Screening, and Referral for High-Risk Populations. Title X family planning clinics play a critical role in addressing the prevention of HIV by providing confidential HIV prevention education and counseling, screening and referral for treatment. Title X clinics provide services to a population that matches the demographics of the population of women most at risk for HIV – primarily young (60 percent under the age of 25), low-income (89 percent under 200 percent of the Federal poverty level), and minority (40 percent).

In 1999, 365,883 HIV tests (339,505 tests to females and 26,378 tests to males) were provided to clients in the Title X family planning services grant program. The Program has set a FY 2002 goal to provide 383,360 clients with access to HIV testing services. In 1999, the ratio of HIV tests to total users is .08 or about one test for every twelve users, a ratio that is down slightly from the 1998 ratio of .10 or 1 test for every ten users. (There was a decrease in the number of HIV tests reported between 1998 and 1999. It should be noted that several grantees report that these tests are often provided but not funded with Title X monies and thus not reported.) In addition to monitoring the number of HIV tests provided on-site to clients, the program is examining improved methods for monitoring the proportion of HIV tests which are positive and referral management of HIV positive clients.

Gonorrhea and Chlamydia. CDC and OPHS performance goals focus on women aged 15-44 seen at publicly funded family planning and STD clinics for several reasons: women of child-bearing age experience high incidence rates of gonorrhea and chlamydia; women infected with *Neisseria gonorrhea* or *Chlamydia trachomatis* can develop pelvic inflammatory disease which may, in turn, lead to adverse reproductive consequences (e.g., ectopic pregnancy, tubal factor infertility) family planning and STD clinics represent clinic settings with the highest prevalence rates for these diseases; and CDC and OPHS resources support family planning and STD clinics, therefore, performance measures at these sites are good indicators for program effectiveness.

Chlamydia: More than 50 percent of all preventable infertility among women is a result of sexually transmitted diseases (STDs), primarily chlamydia and gonorrhea. Rates of reported chlamydial infection among women have been increasing annually since the late 1980s when public programs for screening and treatment of women were first established to avert pelvic inflammatory disease and related complications. The increase in reported infections reflects the continued expansion of chlamydia screening programs and the increased use of more sensitive diagnostic tests for this condition.

In 1999, the overall reported rate of chlamydial infection among women (404.5 cases per 100,000 females) was four times the reported rate among men (94.7 cases per 100,000 males), reflecting the large number of women screened for this disease. However, with the increased availability of urine testing, men are increasingly being tested for chlamydial infection. From 1995 to 1999, the reported chlamydial infection rate in males increased by 64.1 percent (from 57.7 to 94.7 cases per 100,000 males) compared with a 27.9 percent increase in women over this period (from 316.3 to 404.5 cases per 100,000 females). Similar to gonorrhea, the highest rates of chlamydia occur among adolescents.

Gonorrhea: Infections due to *Neisseria gonorrhea*, like those resulting from *Chlamydia trachomatis*, are a major cause of pelvic inflammatory disease (PID) in the United States.

Occurrence of PID can lead to serious outcomes such as tubal infertility, ectopic pregnancy, and chronic pelvic pain. Following a 72 percent decline in the reported rate of gonorrhea from 1975 to 1997, in 1999 the gonorrhea rate increased for the second year in a row. The gonorrhea rate for 1999 (133.2 cases per 100,000 persons) was 1.2 percent higher than the 1998 rate (131.6 cases per 100,000 persons) and 9.2 percent higher than the rate reported in 1997 (122.0 per 100,000 persons). Although increased screening (usually associated with simultaneous testing for chlamydial infection), use of more sensitive diagnostic tests and improved reporting may account for a portion of the recent increase, true increases in disease in some populations and geographic areas also appear to have occurred.

Primary and Secondary Syphilis. Rates of primary and secondary (P&S) syphilis in the United States declined by 88 percent from 1990 to 1999. Preliminary data from 2000 indicate a continuation of this trend. Although the 5.4 percent decline in the number of P&S syphilis cases reported in 1999 is less than the declines of approximately 20 percent per year since the last major syphilis epidemic peaked in 1990, it is possible that this smaller decline reflects improved case finding and reporting resulting from the national syphilis elimination effort. The number of cases reported in 1999 is the lowest yearly number of cases reported since 1957. Syphilis remains an important problem in the South and in some urban areas in other regions of the country. In 1999, large outbreaks occurred in several States. Recently, outbreaks of syphilis among men who have sex with men (MSM) have been reported in several cities including Seattle, San Francisco, and Los Angeles, possibly reflecting an increase in risk behavior in this population associated with the availability of highly active antiretroviral therapy for HIV infection.

Congenital Syphilis. Congenital syphilis remains a high priority for programmatic activity and each positive test in a child is considered a medical emergency with immediate health services follow-up. The lack of syphilis serologic testing either during or late in pregnancy, remains the major reason that congenital syphilis persists in the U.S. The absence of testing is often related to lack of, or late, prenatal care. In 1999, 556 cases of congenital syphilis were reported to CDC, for a rate of 14.3 cases per 100,000 live births, significantly exceeding the FY 1999 target of 20/100,000. Effective prenatal screening programs for patients at high risk of syphilis account for a substantial portion of the reduction. CDC and the Department have set targets to reduce the incidence of congenital syphilis to less than 12 per 100,000 births in FY 2000 and FY 2001.

DIET AND PHYSICAL ACTIVITY

Nutrition Services. AoA has initiated a number of activities to help seniors have an active and healthy aging experience by increasing their ability to live independently and reducing the need for instutionalization. One of those activities is nutrition services, which provides seniors with opportunities for better nutrition and improved health. AoA has been steadily increasing the number of home-delivered meals provided - from 119.1 million in FY 1996 to 132.1 million in FY 1999, substantially exceeding the FY 1999 target of 119 million. Data for FY 2000 will be available February 2002.

Physical Activity. According to the NHIS, the level of physical activity among adults has declined over the last few years. From 1995 to 1997, the percent of people aged 18-74 who engage in moderate physical activity for at least 30 minutes per day, five or more times a

week, has decreased from 23% to 15%. OPHS has set an FY 1999 target of 29 percent, based on Healthy People 2000. Although OPHS is concerned about this decreasing trend, the landmark Surgeon General's Report on Physical Activity and Health was launched in 1996 and messages regarding the health benefits of moderate intensity physical activity are just now being integrated into many existing programs and materials. OPHS, in conjunction with enhanced public/private partnerships, recommends the development of public education programs that convey the state of the art consensus on what level of moderate physical activity yields health benefits and, if possible, the benefits accrued with higher levels of activity. OPHS encourages formative research with a variety of target audiences in order to best address motivational barriers; development of innovative and non-traditional approaches for reaching the general public, e.g., using major sports leagues and their events; enhancement of relationships with schools, employers, parks and other community agencies, in order to provide necessary linkages for access and availability of facilities and to make environmental changes at the community level.

HHS 1.1: Reduce Tobacco Use, Especially Among Youth

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Reduce the percentage of teenagers (in grades 9-12) who smoke by conducting an educational campaign, providing funding and technical assistance to State programs, and working with non-governmental entities. *CDC Plan*	FY 03: 32.3% FY 01: 34.2% FY 99: 36.4%	FY 03: FY 01: 7/01 FY 99: 34.8% FY 97: 36.4% FY 95: 34.8% FY 93: 30.5% FY 91: 27.5%
Reduce proportion of mothers who smoke during pregnancy. *OPHS Plan*	FY 02: 8% FY 01: 9% FY 00: 10% FY 99: 12%	FY 02: FY 01: FY 00: 05/02 FY 99: 05/01 FY 98: 12.9% FY 97: 13.2%
Increase number of States whose rate of tobacco sales to minors violations is at or below 20%. *SAMHSA Plan*	FY 02: 30 States FY 01: 26 States FY 00: 26 States FY 99: 8 States	FY 02: FY 01: FY 00: 25 States FY 99: 21 States FY 98: 12 States FY 97: 4 States
Develop at least five regional tobacco control centers to assist American Indian and Alaskan Native health facilities and organizations with tobacco prevention and cessation activities. *IHS Plan*	FY 02: Commence all prescribed control activities in 5 sites FY 01: Establish 5 tobacco control centers FY 00: establish baseline rates for tobacco usage	FY 02: FY 01: FY 00: baseline rates established

HHS 1.2: Reduce the Incidence and Impact of Injuries and Violence in American Society

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Injuries		
Reduce the number of unintentional injuries for AI/AN people. *IHS Plan*	**Hospitalizations** FY 02: 2% < FY 01 FY 01: 70.0/10,000 FY 00: 71.5/10,000 **Deaths** FY 99: 93/100,000	FY 02: FY 01: FY 00: FY 99: 05/01 FY 98: 72.5/10,000 FY 96: 74.7/10,000 FY 99: 12/02 FY 94-96: 92.6/100,000 FY 92-94: 95.0/100,000
Expand the number of tribes/tribal organizations with comprehensive injury prevention programs. *IHS Plan*	FY 02: 30 sites	FY 02: FY 01: FY 00: 25 sites
Increase the use of bicycle helmets by child bicyclists in CDC-funded project areas. *CDC Plan*	FY 02: Disseminate information about the results of the five-State, multi-year project funded FY 99-01 FY 01: 7% increase FY 00: 25% increase FY 99: 30% increase	FY 02: FY 01: FY 00: 8/01 FY 99: California + 7%. Colorado + 33% Florida - 19% Oklahoma + 200% Rhode Is. + 0% FY 98: California + 83%. Colorado + 16% Florida + 3% Oklahoma + 214% Rhode Is. + 15%

Performance Goals	Targets	Actual Performance
The incidence of residential fire-related deaths will be reduced. *CDC Plan*	FY 02: 1.1/100,000 FY 01: 1.1/100,000 FY 00: 1.1/100,000 FY 99: 1.1/100,000	FY 02: FY 01: FY 00: 10/01 FY 99: 1.2/100,000 FY 97: 1.1/100,000 FY 94: 1.4/100,000
Recruit additional hospitals into the MedSun System (Medical Device Surveillance Network) for injury reporting that uses improved data format and collection methods to enhance the validity and reliability of data provided, thus affording a higher level of public health protection. *FDA Plan*	FY 02: Continue implementation of the system. FY 01: Recruit 75 to 100 hospitals to report adverse events associated with medical devices. FY 00: Develop MedSun based on approximately 75 to 90 representative user facilities. FY 99: N/A	FY 02: FY 01: FY 00: Implement Phase II Pilot with 25 Hospitals FY 99: Pilot completed FY 98: Recruited 24 pilot facilities
Increase percentage of IHS, Tribal and Urban programs that have implemented a suicide surveillance system to monitor the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions) which assures those at risk receive services, and that appropriate population-based prevention interventions are implemented. *IHS Plan*	FY 02: 10% > FY 01 FY 01: 50%	FY 02: FY 01: FY 00: baseline 3/01 FY 98: 25% est.
Decrease proportion of injurious suicide attempts among youth grades 9-12. *OPHS Plan*	FY 02: 1.4 FY 01: 1.6 FY 00: 1.8 FY 99: 2.0	FY 02: FY 01: FY 00: DNC FY 99: 2.6% FY 98: DNC FY 97: 2.6% FY 95: 2.8%
Develop and field-test uniform and evidence-based guidelines for the treatment of poisoning. *HRSA Plan*	FY 02: 5 FY 01: 5	FY 02: FY 01: FY 00: 0

Performance Goals	Targets	Actual Performance
Occupational Injuries		
Collect, analyze, and disseminate surveillance information on occupational illnesses, injuries, and hazards to help target and evaluate interventions and prevention efforts. *CDC Plan*	FY 02: Publish surveillance reports addressing 2 major occupational injury or illness issues annually Target one national prevention activity annually Prepare and disseminate public use data sets. FY 01: Initiate web-based surveillance information dissemination. Pilot test improved data collection methods. Initiate hazard surveys targeted by workforce sector. FY 00: Continue to collect, analyze, and disseminate surveillance data. FY 99: Collect, analyze and disseminate surveillance data and produce reports	FY 02: FY 01: FY 00: Achieved. Examples: (1) Simple Solutions: Ergonomics for Farm Workers (2) MMWR pertaining to pesticide poisoning using data collected through the Toxic Exposure Surveillance System (TESS) 6/900 Vol 29). (3)1999 Work Related Lung Disease Surveillance Report (4) NIOSH Worker Health 2000 Chartbook of Occupational Surveillance Information FY 99: Achieved
Foster safe and healthful working conditions by transferring scientific and technical information to employers, workers, the public and the occupational safety and health community. *CDC Plan*	FY 02: Improve over baseline FY 01: Establish baseline of information transferred via web, phone, and print	FY 02: FY 01:
Violence		

Performance Goals	Targets	Actual Performance
Reduce the number of students reporting incidents of physical fighting among program participants in CDC- funded youth violence project. *CDC Plan*	FY 00: 30% of students report being involved in a physical fight.	FY 00: Achieved FY 96: A 30% reduction in physical fighting reported in the initial phase FY 94: 50% of students report being involved in a physical fight
Develop best practices protocols for implementation and evaluation of youth violence prevention programs in 1999. *CDC Plan*	FY 02: Develop capacity for technical assistance in implementing the best practices Sourcebook nationwide through CDC's National Youth Violence Prevention Research Center. FY 01: Provide technical assistance to at least 5 communities in implementing Best Practices. FY 00: Disseminate Best Practices protocols to at least one target audience FY 99: Develop Best Practices protocols for implementation and evaluation of prevention programs	FY 02: FY 01: FY 00: Publication completed; distribution in FY 01. FY 99: Protocols developed and compiled into a Sourcebook of Best Practices.
Increase the percent of IHS, Tribal, and Urban medical facilities with Urgent Care or Emergency departments or services that have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (child, spouse, elderly) and train staff in their use. *IHS Plan*	**Staff Training** FY 02: 56% **Policies and Procedures** FY 02: 80% FY 01: 75% FY 00: 70% FY 99: 60%	FY 02: FY 01: establish baseline FY 02: FY 01: FY 00: 72% FY 99: 64% FY 98: 47%

Performance Goals	Targets	Actual Performance
Increase the number of Federally recognized Indian Tribes that have family violence prevention programs. *ACF Plan*	FY 02: 205 FY 01: 189 FY 00: 174 FY 99: 162	FY 02: FY 01: FY 00: 187 FY 98: 174 FY 96: 120
Increase the monthly capacity of the National Domestic Violence Hotline to respond to calls. *ACF Plan*	FY 02: 12,000 FY 01: 11,000 FY 00: NA FY 99: NA	FY 02: FY 01: FY 00: 11,000 FY 99: 11,000 FY 98: 8,000
Decrease the percentage of children with substantiated reports of maltreatment that have a repeated substantiated report of maltreatment within six months. *ACF Plan*	CY 02: 7% CY 01: 7% CY 00: NA CY 99: NA	CY 02: CY 01: CY 00: 9/01 CY 99: 8% CY 97: 8%
Maintain the number of recipients of child protective services that are funded wholly or in part by the Social Services Block Grant. *ACF Plan*	FY 02: 1,302,895 FY 01: 1,302,895 FY 00: NA FY 99: NA	FY 02: FY 01: FY 00: 5/02 FY 99: 5/01 FY 98: 1,302,895 FY 97: 1,037, 860
Enhance State and coalition capability to deliver effective sexual assault prevention programs. *CDC Plan*	FY 03: Conduct at least one training session based on needs assessment FY 02: Assess training needs of sexual assault prevention program staff	FY 03: FY 02:

Performance Goals	Targets	Actual Performance
Establish innovative programs to address prevention of violence against women. *CDC Plan*	FY 02: Projects ongoing: no milestones to report. FY 01: Develop/publish progress report on funded projects with a long-term goal of developing recommendations for key components of successful programs by 2005. FY 00: Implement and begin evaluation of 2 innovative community-based programs to address violence against women: (1) Community-coordinated response to intimate partner violence and (2) community-based primary prevention programs.	FY 02: FY 01: FY 00: 10 projects were funded 09/00 FY 99: No evaluations done to date.
Emergency Medical Services		
Conduct needs assessments in areas considered in highest need. (Developmental) *HRSA Plan*	FY 02: TBD FY 01: 1	FY 02: FY 01:
Increase the number of States that have implemented Statewide pediatric protocols for medical direction. *HRSA Plan*	FY 02: 15 Statewide FY 01: 15 Statewide FY 00: 20* FY 99: 18 * *Statewide and Partial	FY 02: FY 01: FY 00: 12 Statewide FY 99: 25* FY 98: 16*
Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support (ALS) Ambulances. *HRSA Plan*	FY 02: 23 FY 01: 23 FY 00: 10 FY 99: 7	FY 02: FY 01: FY 00:19 FY 99: 18 FY 98: 5

See also:

- Objective 3.8, Increase the Availability and Effectiveness of Mental Health Care Services

HHS 1.3: Improve the Diet and the Level of Physical Activity of Americans

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase percent of people aged 18-74 who engage in moderate physical activity for at least 30 minutes per day, five or more times a week. *OPHS Plan*	FY 02: 24.5% FY 01: 26%* FY 00: 30% FY 99: 29% *Targets reflect change in Healthy People 2010	FY 02: FY 01: FY 00: (12/02) FY 99: (12/01) FY 98: (12/01) FY 97: 15% FY 95: 23%
Increase the number of home-delivered meals provided to older Americans (numbers in millions). *AoA Plan*	FY 02: 183.0 FY 01: 176.0 FY 00: 155.0 FY 99: 119.0	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 132.1 FY 98: 129.7 FY 97: 123.4 FY 96: 119.1
Increase the number of congregate meals provided to older Americans (numbers in millions). *AoA Plan*	FY 02: 115.2 FY 01: 115.2 FY 00: 113.1 FY 99: 123.4	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 113.3 FY 98: 114.1 FY 97: 113.1 FY 96: 118.6
Increase the number of home delivered meals provided to elderly Native Americans (numbers in thousands). *AoA Plan*	FY 02: 1,850 FY 01: 1,795 FY 00: 1,632 FY 99: 1,456	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 1,698 FY 98: 1,624 FY 97: 1,525
Increase the number of congregate meals provided to elderly Native Americans (numbers in thousands). *AoA Plan*	FY 02: 1,650 FY 01: 1,583 FY 00: 1, 439 FY 99: 1,322	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 1,327 FY 98: 1,354 FY 97: 1,386

Performance Goals	Targets	Actual Performance
Maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites, as part of an overall assessment of the ongoing childhood obesity prevention project's effectiveness. *IHS Plan*	FY 02: continue implementation and access community acceptance FY 01: implement program and monitor pilots and comparison sites FY 00: develop five pilot sites FY 99: develop approach and baselines	 FY 01: FY 00: pilot sites established FY 99: accomplished
Increase the percent of women of reproductive age who will be consuming 400 micrograms of folic acid. *CDC Plan*	FY 02: 36% FY 00: 40% FY 99: 35%	FY 02: FY 00: 34% FY 99: biennial survey FY 98: 32% FY 96: 25%
Collaborate with NIH and American Indian and Alaska Native sites in developing and implementing culturally sensitive, community-directed pilot cardiovascular disease prevention programs. *IHS Plan*	FY 02: 3 sites implementing interventions FY 01: 3 sites with intervention plan	FY 02: FY 01:

HHS 1.4: Reduce Alcohol Abuse and Prevent Under Age Drinking

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase proportion of youth not using alcohol or any illicit drugs during the past 30 days. *OPHS Plan*	FY 02: 88.6% FY 01: 88%	FY 02: FY 01: FY 00: (12/01) FY 99: 90.9% FY 98: 90.1%% FY 97: 77% FY 96: 78% FY 95: 75% FY 94: 76%
Number of clients served in the Substance Abuse Prevention and Treatment Block Grant. *SAMHSA Plan*	FY 02: 1,751,537* FY 01: 1,635,422* FY 00: 1,525,688*	FY 02: FY 01: FY 00: (8/02) FY 99: (8/01) FY 98: 1,564,156* FY 97: 1,537,143* FY 96: 1,601,214* FY 95: 1,635,963*
Maintain the rates and intensity of follow-up for adolescents discharged from IHS supported Regional Treatment Centers and to assure reduced rates of alcohol and drug use. *IHS Plan.*	**Abstinence** FY 02: 5% over FY 01 FY 01: 5% over FY 00 FY 00: establish baseline **Follow-up Rates** FY 02: FY 01 or higher FY 01: FY 00 or higher FY 00: 45% (+10% FY 99) FY 99: establish baseline	FY 02: FY 01: FY 00: 5/01 FY 02: FY 01: FY 00: 48%@12 months (+17%) FY 99: 64.5% 30 days 55.2% 6 months 40.9% 12 months

Performance Goals	Targets	Actual Performance
Program Management and Data Collection		
In the Substance Abuse Prevention and Treatment Block Grant, *SAMHSA Plan*		
Increase the percent of technical assistance events that result in systems, program or practice change.	FY 02: 87% FY 01: 85% FY 00: 70% FY 99: Establish baseline	FY 02: FY 01: (9/01) FY 00: 84% FY 99: 66%
Increase percentage block grant applications that include needs assessment data from CSAT needs assessment program.	FY 02: 90% FY 01: 85% FY 00: 80%	FY 02: FY 01: (9/01) FY 00: 80% FY 99: 72% FY 98: 72% FY 97: 62%
In the Prevention Set-Aside for the Substance Abuse Prevention and Treatment Block Grant, *SAMHSA Plan*		
Increase number of States that incorporate needs assessment data into block grant application.	FY 02: 40 States FY 01: 38 States FY 00: 34 States	FY 02: FY 01: FY 00: 34 States FY 99: 26 States FY 94: 13 States
Increase percentage of States that use funds in each of 6 prevention strategy areas.	FY 02: 100% FY 01: 100% FY 00: 90%	FY 02: FY 01: FY 00: 90% FY 99: 90% of States (52 of 58 jurisdictions) FY 96: 34 States (56%)

Performance Goals	Targets	Actual Performance
Substance Abuse Prevention, Intervention, and Treatment Information		
In the National Clearinghouse for Alcohol and Drug Information, *SAMHSA Plan*		
Increase the number of information requests.	FY 02: +270% over baseline FY 01: +260% over baseline FY 00: +245% over baseline	FY 02: FY 01: FY 00: 10/01 FY 99: +135% over baseline; 40,285 requests/month: 59% by phone; 3% by mail; and 2% by fax/in-person FY 98: + 43 percent; 25,289 requests/month: phone: 14,437, mail: 2887, E-mail: 6810, PREVLINE: 1155 FY 97: 17,600 requests/ month: phone, 3,750; mail, 2,750; PREVLINE: 1,100
Maintain customer satisfaction. *The new OMB-approved customer satisfaction will be used for the first time in FY00, which is why the performance measure remains at 85% until a new baseline is established.	FY 02: 85%* FY 01: 85%* FY 00: 85%*	FY 02: FY 01: FY 00:10/01 FY 99: Exceeded 90% FY 98: Exceeded 90% FY 97: 85%

See also:

- Objective 2.4, Improve the Safety and Security of Children and Youth
- Objective 3.8, Increase the Availability and Effectiveness of Mental Health Care Services

HHS 1.5: Reduce the Abuse and Illicit Use of Drugs

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase proportion of youth not using alcohol or any illicit drugs during the past 30 days. *OPHS Plan*	FY 02: 88.6% FY 01: 88%	FY 02: FY 01: FY 00: (12/01) FY 99: 90.9% FY 98: 90.1%% FY 97: 77% FY 96: 78% FY 95: 75% FY 94: 76%
Number of clients served in the Substance Abuse Prevention and Treatment Block Grant. *SAMHSA Plan*	FY 02: 1,751,537* FY 01: 1,635,422* FY 00: 1,525,688*	FY 02: FY 01: FY 00: (8/02) FY 99: (8/01) FY 98: 1,564,156* FY 97: 1,537,143* FY 96: 1,601,214* FY 95: 1,635,963*
Maintain the rates and intensity of follow-up for adolescents discharged from IHS supported Regional Treatment Centers and to assure reduced rates of alcohol and drug use. *IHS Plan.*	**Abstinence** FY 02: 5% over FY 01 FY 01: 5% over FY 00 FY 00: establish baseline **Follow-up Rates** FY 02: FY 01 or higher FY 01: FY 00 or higher FY 00: 45% (+10% FY 99) FY 99: establish baseline	 FY 02: FY 01: FY 00: 5/01 FY 02: FY 01: FY 00: 48% @12 months (+17%) FY 99: 64.5% 30 days 55.2% 6 months 40.9% 12 months

Performance Goals	Targets	Actual Performance
Among persons with HIV/AIDS attributed to injecting drug use, increase the proportion of persons diagnosed with HIV prior to disease progression to AIDS.	FY 02: 77% FY 01: 76%	FY 02: FY 01: FY 00: FY 99:75% in areas with HIV reporting FY 98:73% in areas with HIV reporting
Program Management and Data Collection		
In the Substance Abuse Prevention and Treatment Block Grant, *SAMHSA Plan* Increase the percent of technical assistance events that result in systems, program or practice change. Increase percentage block grant applications that include needs assessment data from CSAT needs assessment program.	 FY 02: 87% FY 01: 85% FY 00: 70% FY 99: Establish baseline FY 02: 90% FY 01: 85% FY 00: 80%	 FY 02: FY 01: 9/01 FY 00: 84% FY 99: 66% FY 02: FY 01: 9/ 01 FY 00: 80% FY 99: 72% FY 98: 72% FY 97: 62%
In the Prevention Set-Aside for the Substance Abuse Prevention and Treatment Block Grant, *SAMHSA Plan* Increase number of States that incorporate needs assessment data into block grant application. Increase percentage of States that use funds in each of 6 prevention strategy areas.	 FY 02: 40 States FY 01: 38 States FY 00: 34 States FY 02: 100% FY 01: 100% FY 00: 90%	 FY 02: FY 01: FY 00: 34 States FY 99: 26 States FY 94: 13 States FY 02: FY 01: FY 00: 90% FY 99: 90% of States (52 of 58 jurisdictions) FY 96: 34 States (56%)

Performance Goals	Targets	Actual Performance
Substance Abuse Prevention, Intervention, and Treatment Information		
In the National Clearinghouse for Alcohol and Drug Information, *SAMHSA Plan* Increase the number of information requests.	FY 02: +270% over baseline FY 01: +260% over baseline FY 00: +245% over baseline	FY 02: FY 01: FY 00: 10/01 FY 99: +135% over baseline; 40,285 requests/month: 59% by phone; 3% by mail; and 2% by fax/in-person FY 98: + 43 percent; 25,289 requests/month: phone: 14,437, mail: 2887, E-mail: 6810, PREVLINE: 1155 FY 97: 17,600 requests/ month: phone, 3,750; mail, 2,750; PREVLINE: 1,100
Maintain customer satisfaction. *The new OMB-approved customer satisfaction will be used for the first time in FY00, which is why the performance measure remains at 85% until a new baseline is established.	FY 02: 85%* FY 01: 85%* FY 00: 85%*	FY 02: FY 01: FY 00:10/01 FY 99: Exceeded 90% FY 98: Exceeded 90% FY 97: 85%

See also:

- Objective 3.8, Increase the Availability and Effectiveness of Mental Health Care Services

HHS 1.6: Reduce Unsafe Sexual Behaviors

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Adolescent Sexual Activity		
In all 13 community demonstrations funded by the Prevention Research Center, the hub organization and at least five partners will collaboratively have begun implementing 3 or more interventions to prevent teen pregnancies in response to specific needs identified via a community assessment in at least two neighborhoods. *CDC Plan*	FY 02: 13 programs FY 01: 13 FY 00: 13 FY 99: 7	FY 02: FY 01: FY 00: 9 of 13 FY 99: 7 of 13 FY 98: 1 of 13
In the Abstinence Education Program, achieve State-set targets for reducing the proportion of adolescents who have engaged in sexual intercourse. *HRSA Plan*	FY 02: 50% FY 01: 50%	FY 02: FY 01: FY 00: 1/02 FY 99: 5/01 FY 98: 71.4% (15 of 21 States reporting)
In the Abstinence Education Program, achieve State-set targets for reducing the rate of births to teenagers aged 15-17. *HRSA Plan*	FY 02: 50% FY 01: 50%	FY 02: FY 01: FY 00: 1/02 FY 99: 5/01 FY 98: 44.8% (13 of 28 States reporting)

Performance Goals	Targets	Actual Performance
Reduce the percentage of adolescents (grades 9-12) who abstain from sexual intercourse or use condoms if currently sexually active. *CDC Plan*	FY 03: 89% FY 01: 89%	FY 03: FY 01: 7/02 FY 99: 85% FY 97: 85% FY 95: 83%
Black or African American adolescents.	FY 03: 87% FY 01: 87%	FY 03: FY 01: 7/02 FY 99: 83% FY 97: 80% FY 95: 82%
Hispanic or Latino Adolescents.	FY 03: 88% FY 01: 88%	FY 03: FY 01: 7/02 FY 99: 84% FY 97: 82% FY 95: 77%
HIV/AIDS		
Reduce the annual incidence of new HIV infections. *CDC Plan*	FY 02: 37,900 FY 01: 40,000 FY 00: 40,000 FY 99: Measure transmission rates of new HIV infections	FY 02: FY 01: 9/01 FY 00: est. 40,000 FY 99: est 40,000 new infections per year
Increase the number of female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal AIDS transmission. *HRSA Plan*	FY 02: 21,884 females FY 01: 21,844 FY 00: 14,470 FY 99: 13,900	FY 02: FY 01: FY 00: FY 99: 18,948 FY 98: 12,690 FY 97: 9,469
Decrease by 5 percent annually the number of newly reported AIDS cases in children as a result of perinatal transmission. *CDC and HRSA Plan*s	FY 02: 141 cases FY 01: 151 FY 00: 161 FY 99: 214	FY 02: FY 01: FY 00: 1/02 FY 99: 171 cases FY 98: 235 FY 97: 310 FY 96: 502
Increase the percentage of high risk sexually active persons who know their HIV status and have received risk reduction counseling. *IHS Plan*	FY 02: + 10% FY 01: Establish baseline	FY 02: FY 01:

Performance Goals	Targets	Actual Performance
Achieve and maintain the percentage of high school students who have been taught about HIV/AIDS prevention in school at 90% or greater. *CDC Plan*	FY 03: 90% or greater FY 01: 90% or greater FY 99: 90% or greater	FY 03: FY 01: FY 99: 91% FY 97: 92% FY 95: 86%
Sexually Transmitted Diseases		
In the Abstinence Education Program, achieve State-set targets for reducing the incidence of youths 15-19 years old who have contracted selected sexually transmitted diseases *HRSA Plan*	FY 02: 50% FY 01: 50%	FY 02: FY 01: FY 00: 1/02 FY 99: 5/01 FY 98: 44.8% (13 of 29 States reporting).
The prevalence of *Chlamydia trachomatis* among women under the age of 25 in publicly funded family planning clinics will be reduced. *CDC and OPHS Plans*	FY 02: < 5% FY 01: < 6% FY 00: < 6% FY 99: < 6%	FY 02: FY 01: FY 00: 6/01 FY 99: 5.5%* FY 98: 5.4%* FY 97: 5% FY 96: 9% *median all States
The incidence of gonorrhea in women aged 15-44 will be reduced. *CDC and OPHS Plans*	FY 02: <250/100,000 FY 01: <250/100,000 FY 00: <250/100,000 FY 99: <250/100,000	FY 02: FY 01: FY 00: 6/01 FY 99: 286/100,000 FY 98: 292/100,000 FY 97: 261/100,000 FY 96: 259/100,000 FY 95: 299/100,000
Increase the percentage of U.S. counties that will have an incidence of primary and secondary syphilis in the general population of less than or equal to 4 per 100,000. *CDC Plan*	FY 02: >92% FY 01: >90% FY 00: >90% FY 99: 85%	FY 02: FY 01: FY 00: 6/01 FY 99: 91% FY 98: 90% FY 97: 87% FY 96: 90% FY 95: 81%
As part of a larger goal to eliminate syphilis in the U.S., CDC will reduce the racial disparity in syphilis. *CDC Plan*	FY 02: -15% to 17.8%. FY 01: -15% to 20.9% FY 00: -15% to 24.6% FY 99: -15% to 28.9%	FY 02: FY 01: FY 00: 4/02 FY 99: 4/01 FY 98: 34.2%

See also: Objective 3.7, Increase the Availability and Effectiveness of Services for the Treatment and Management of HIV/AIDS

HHS 1.7: Reduce the Incidence and Impact of Infectious Diseases

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Domestic and Global Public Health Capacity		
The Emerging Infections Program (EIP), a network of regional population-based programs, will be established to conduct active surveillance, engage in applied epidemiologic and laboratory research and pilot and evaluate prevention and intervention measures. *CDC Plan*	FY 02: n/a FY 01: 9 EIP sites. FY 00: 9 EIP sites. FY 99: 8 EIP sites.	FY 01: FY 00: 9 EIP sites. FY 99: 7 EIP sites.
Extramural domestic and global surveillance networks will monitor conditions including antimicrobial resistance, threats from transfusion of blood and blood products, infectious diseases among travelers and immunosuppressed and underserved populations. *CDC Plan*	**Extramural Networks** FY 02: 6 FY 01: 6 FY 00: 5 FY 99: 4 Overall target: 10 networks.	FY 02: FY 01: FY 00: 6 FY 99: 4 FY 98: 3 FY 97: 3
State/local health departments will have increased epidemiologic and laboratory capacity (ELC) for surveillance and response to infectious disease threats. *CDC Plan*	**Health Departments** FY 02: 58 FY 01: 53 FY 00: 43 FY 99: 33 Overall target: 55-60 health departments	FY 02: FY 01: FY 00: 43 FY 99: 33 FY 98: 30
Global Polio Eradication		
To help achieve WHO's goal of global polio eradication by December 31, 2000, purchase doses of oral polio vaccine needed to assist in conducting mass immunization campaigns in Asia, Africa, and Europe. *CDC Plan*.	FY 02: 558 million FY 01: 625 FY 00: 750 FY 99: 445	FY 02: FY 01: FY 00: 593 FY 99: 427 FY 98: 390

Performance Goals	Targets	Actual Performance
National Electronic Disease Surveillance System		
Pilot projects will be conducted to develop and test electronic linkages between public health agencies and the health care sector. *CDC Plan*	FY 02: 10 States with linkages to managed care, hospitals, or other clinical providers. FY 01: 5 States with linkages to managed care, hospitals, or other clinical care providers. FY 00: 1 State with linkages to managed care, hospitals, emergency departments or other clinical care providers	FY 02: FY 01: FY 00: Fall 2000. FY 99: 0 projects
Electronic Laboratory Reporting (ELR) used by States. *CDC Plan*	**States Using ELR** FY 02: 15 FY 01: 15 FY 00: 10	FY 02: FY 01: FY 00: 10
HIV/AIDS		
Reduce the annual incidence of new HIV infections. *CDC Plan*	FY 02: 37,900 FY 01: 40,000 FY 00: 40,000 FY 99: Transmission rates of new HIV infections will be measured.	FY 02: FY 01: 9/01 FY 00: est. 40,000 FY 99: est 40,000 new infections per year
Number of States that conduct HIV case reporting. *CDC Plan*	FY 02: 50 States FY 01: 45 FY 00: 30	FY 02: FY 01: FY 00: 41 States, Puerto Rica, Guam and Virgin Islands 99: 34 States; 4 States and Puerto Rico report cases of HIV infection using coded identifiers.
Surveillance for unusual HIV variants will be expanded. *CDC Plan*	FY 02: 8 countries FY 01: 6 FY 00: 6	FY 02: FY 01: FY 00: 6/01 FY 99: 2 FY 98: 0

Performance Goals	Targets	Actual Performance
Expand the number of States that are able to measure access to HIV care; adherence to treatment; and impact of antiretroviral therapy (ART) on long-term survival. *CDC Plan*	FY 02-01: Continue to expand the numbers of States that collect data and can measure care and treatment outcomes.	**HIV Access to Care** FY 02: FY 01: 6 FY 00: 5 FY 99: 4 **HIV Adherence to Treatment** FY 02: FY 01: 16 FY 00: 15 FY 99: 12 **HIV Impact of ART** FY 02: FY 01: 11 FY 00: 11 FY 99: 11
Hepatitis C, Chronic Liver Disease and Viral Hepatitis		
Support will be provided to State/local health departments to assess the effectiveness of integration of HCV counseling, testing, and referral programs to established public health programs. *CDC Plan*	**Health Departments** FY 02: 15 FY 01: 9 FY 00: 4 Overall Target: 20 health departments.	FY 02: FY 01: FY 00: 12 FY 99: 0
Sentinel surveillance systems for chronic Hepatitis C Virus (HCV) will be established to monitor national trends in incidence, risk factors for infection, and outcomes of disease. *CDC Plan* Overall Target: 10 States with sentinel surveillance systems.	**States with Sentinel Surveillance Systems** FY 02: 5 States FY 01: 5 States FY 00: 3 States FY 99: 1 system developed and pilot tested	FY 02: FY 01: FY 00: 5 States FY 99: 2 pilot tests were conducted FY 98: 0
Influenza		
Monitoring influenza viruses will be conducted in domestic and global sites to enhance early detection of influenza viruses with pandemic potential and improve vaccine decision-making. *CDC Plan*	FY 02: 550 sites. FY 01: 550 sites. FY 00: 510 sites. Overall Target: 1 site per 250,000 population domestically and increasing numbers internationally.	FY 02: FY 01: FY 00: 514 sites. FY 99: 410 sites. FY 96: 0 sites.

Performance Goals	Targets	Actual Performance
The rate of vaccination among persons >65 years will be increase for influenza and pneumococcal pneumonia. *CDC Plan*	**Influenza** FY 02: 74% FY 01: 72% FY 00: 70% FY 99: 60% **Pneumococcal Pneumonia** FY 02: 66% FY 01: 63% FY 00: 60% FY 99: 54%	FY 02: FY 01: FY 00: 09/02 FY 99: 09/01 FY 98: 63% FY 97: 63% FY 95: 58% FY 02: FY 01: FY 00: 09/02 FY 99: 90/01 FY 98: 46% FY 97: 42% FY 95: 34%
Increase the percentage of Medicare beneficiaries age 65 years and older who receive vaccinations. Increase rate of annual influenza (flu) vaccination. (NHIS) Increase annual influenza (flu) and lifetime pneumococcal vaccinations. (MCBS) -- Flu/Pneumococcal *HCFA Plan*	FY 01: Switched to new data source. (see below) FY 00: 60% FY 99: 59% FY 02: 73%/65% FY 01: 72%/63% FY 00: Not Applicable	FY 00: Summer 2002 FY 99: Summer 2001 FY 98: 64% FY 97: 63% FY 95: 58% FY 94: 55% (NHIS) FY 02: 12/03 FY 01: 12/02 FY 00: 12/01(Interim) FY 99: 69.1%/61.2% (interim*) FY 98: 68.5%/56.1%* FY 97: 67.1%/50.9%* FY 96: 65%/44.1% FY 95: 61%/34.6% FY 94: 59%/24.6% * includes community dwelling beneficiaries only

Performance Goals	Targets	Actual Performance
Increase overall pneumococcal and influenza vaccination levels among diabetics and adults aged 65 years and older. *IHS Plan*	**Influenza** FY 02: 1% over FY 01 FY 01: 1% over FY 00 FY 00: 65% **Pneumococcal** FY 02: 1% over FY 01 FY 01: secure electronic baseline FY 00: 65%	FY 02: FY 01: FY 00:30.7% (new baseline from automated process) FY 98: 63% (baseline from diabetes audit) FY 02: FY 01: FY00: data source inadequate FY 98: 63% (baseline from diabetes audit)
Antimicrobial Resistance		
The rate of central line associated bloodstream infections in adults in intensive care unit patients will be reduced as measured through the National Nosocomial Infections Surveillance (NNIS) System. *CDC Plan*	FY 02: 3.80 infections FY 01: 3.86 FY 00: 4.40 FY 99: 5.20 Overall Target: 3.80 infections.	FY 02: FY 01: FY 00: 3.92 FY 99: 4.40 FY 98: 5.30
Diminish the rapid rise in the proportion of enterococci resistant to vancomycin (VRE rate) among pathogens associated with nosocomial infections in intensive care unit patients. *CDC Plan*	FY 02: 26.0% increase FY 01: 27.2% FY 00: 25.2% FY 99: 40.0% Overall Target: 26% increase.	FY 02: FY 01: FY 00: 25% FY 99: 40.9% Five year historical mean 47%.
Reduce the number of courses of antibiotics for ear infections for children under the age of 5 years. *CDC Plan*	**Antibiotic Courses per 100 Children** FY 02: 102 FY 01: 104 FY 00: 106 Overall Target: 88 antibiotic courses per 100 children.	FY 02: FY 01: FY 00: 3/2001. FY 97: 108 antibiotic courses per 100 children.

Performance Goals	Targets	Actual Performance
Reduce the incidence of perinatal Group B streptococcal infections. *CDC Plan*	**Infections per 1,000 Live Births** FY 02: n/a FY 01: 0.3 FY00: 0.8 FY 99: 0.9 Overall Target: 0.3 perinatal Group B streptococcal infections per 1,000 live births.	FY 02: FY 01: FY 00: 9/01 FY 99: 0.4 FY 95: 1.3
Make available to consumers and health professionals more easily-understandable information on choosing and taking prescription and OTC drugs to prevent and reduce their misuse, take more of an activist role in how consumers use these drugs, and improve drug risk management, analysis, and communication procedures. *FDA Plan*	FY 02: Give consumers and health professionals more easily understandable OTC drug information. FY 01: Give consumers and health professionals more easily understandable OTC drug information. FY 00: Make new drug approval information increasingly available via the Internet. Develop partnerships with national organizations to disseminate educational information to consumers.	FY 02: FY 01: FY 00: OTC label education campaigns were targeted to grassroots consumers and key health professional organizations.
Tuberculosis		
The percentage of tuberculosis (TB) patients that will complete a course of curative TB treatment within 12 months of initiation of treatment (some patients require more than 12 months). *CDC Plan*	FY 02: 90% FY 01: 88% FY 00: 85% FY 99: 85%	FY 02: FY 01: FY 00: Mid/03 FY 99: Mid/02 FY 98: Mid/01 FY 97: 77.2% FY 96: 75.1% FY 95: 72.4% FY 94: 67.6%
Increase minimum percentage of contacts of infectious cases who are placed on therapy for latent tuberculosis infection will complete a treatment regimen. *CDC Plan*	FY 02: 80% FY 01: 78% FY 00: 75% FY 99: 75%	FY 02: FY 01: FY 00: Late/02 FY 99: Late/01 FY 98: 74.0% FY 97: 71.6% FY 93: 68.4%

Performance Goals	Targets	Actual Performance
Childhood Immunization		
Increase the percentage of Medicaid two-year old children who are fully immunized. (To be achieved in 3 phases for State groupings.)		
– Group 1 States (Set State-specific methodology and baseline: 1999-2000; first report: 2001)	FY 02: Second Report FY 01: First Report FY 00: Set State-specific methodology and baseline	FY 02: FY 01: FY 00: 13 Group I States developed State-specific methodology, targets and measured baselines. 3 States will complete these efforts in FY 2001
	FY 99: Not Applicable	FY 99: Identified Group I States. Began developing State-specific methodology and baselines
– Group 2 States (Set State-specific methodology and baseline: 2000-2001; first report: 2002)	FY 02: First Report FY 01: Set baseline FY 00: Begin State-specific methodology and baseline activities	FY 02: FY 01: FY 00: Identified Group II States. Began developing State-specific methodology and baselines
– Group 3 States (Set State-specific methodology and baseline: 2001-2002; first report: 2003)	FY 02: Set baseline FY 01: Begin State-specific methodology and baseline activities	FY 02: FY 01:
HCFA Plan	FY 00: N/A	FY 00: N/A FY 99: N/A
Increase the proportion of American Indian and Alaskan Native children who have completed all recommended immunizations by age two. *IHS Plan*	FY 02: 1% over FY 01 FY 01: 1% over FY 00 FY 00: 2% over FY 99 FY 99: 91%	FY 02: FY 01: FY 00: 86% 12/12 Areas FY 99: 89% 12/12 Areas 87% 11/12 Areas FY 98: 88% 11/12 Areas

Performance Goals	Targets	Actual Performance
Achieve or sustain the following immunization coverage of at least 90% among children 19- to 35-months of age for each vaccine: 1. 4 doses of Diphtheria-Tetanus-Pertussis containing vaccine 2. 3 doses of *Haemophilus influenzae* type b vaccine 3. 1 dose of Measles-Mumps-Rubella vaccine* 4. 3 doses of Hepatitis B vaccine 5. 3 doses of Polio vaccine 6. 1 dose of Varicella vaccine* 7. 4 doses of Pneumococcal Conjugate vaccine* **Performance targets for newly recommended vaccines will begin 5 years after the ACIP recommendation. The varicella measure will begin in 2001, even though coverage is being reported earlier. The pneumococcal conjugate measure will begin in 2006, even though coverage will be reported earlier. *CDC plan*	FY 02: 90% FY 01: 90% FY 00: 90% FY 99: 90%	FY 02: FY 01: 8/02 FY 00: Provisional data. Final 08/01 1. 83% 2. 94% 3. 91% 4. 90% 5. 90% 6. 63%* FY 99: 1. 83% 2. 94% 3. 92% 4. 88% 5. 90% 6. 58%* FY 98: 1. 84% 2. 93% 3. 92% 4. 87% 5. 91% 6. 43%*
Vaccine Safety Surveillance		
Use new data mining techniques to increase the number of detected true and false signals of adverse events associated with vaccination. *CDC Plan*	FY 02: 5 new techniques	FY 02: FY 01: FY 01: FY 00: 1-2 new techniques

See also:

- Objective 1.6, Reduce Unsafe Sexual Behaviors
- Objective 3.7, Increase the Availability and Effectiveness of Services for the Treatment and Management of HIV/AIDS
- Objective 5.2, Improve the Safety of Food, Drugs, Medical Devices and Biological Products

HHS 1.8: Reduce the Impact of Environmental Factors on Human Health

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase the toxic substances that can be measured by CDC's environmental health laboratory so state-of-the-art laboratory methods can be employed to prevent avoidable environmental disease. *CDC Plan*	FY 02: 12 new substances FY 01: 12 FY 00: 8 FY 01: 8	FY 02: FY 01: FY 00: 8 FY 99: 9 FY 97: 200
Increase the priority substances included in exposure assessment so that a representative sample of 1,500 Americans can be tested for exposure to high-priority substances. *CDC Plan*	FY 02: 75 substances; issue report on the 50 from FY 01 FY 01: 50 substances; issue report on 27 from FY 00 FY 00: 25 toxic substances	FY 02: FY 01: FY 00: 27 FY 98: 0
Increase understanding of the human health effects of exposure to pesticides. *CDC Plan*	FY 02: Complete 1 study	FY 02: FY 01: 0 studies
Increase the understanding of the relationship between environmental exposure and health effects. *CDC Plan*	FY 02: 5 studies	FY 02: FY 01 0 studies
The number of children with elevated blood lead levels will have been reduced. *CDC Plan*	FY 03: 35% reduction FY 99: 25% *No data available in FY 99 NHANES. NHANES results will next be available FY 03.	FY 03: FY 01: FY 99: * FY 91- 94: 890,000 children with blood lead levels greater than 10 micrograms per deciliter
Increase community awareness and knowledge, and promote behavioral changes that can eliminate or mitigate adverse human health outcomes associated with hazardous substances in the environment.using health education and communication strategies and materials. *ATSDR Plan*	FY 02: 35% of sampled population aware of environmental exposures FY 01: 35% FY 00: 35%	FY 02: FY 01: FY 00: 100% FY 99: 35%

Performance Goals	Targets	Actual Performance
Conduct community involvement activities at sites with an urgent public health hazard. *ATSDR Plan*	FY 02: 95% of sites FY 01: 90 % FY 00: 75%	FY 02: FY 01: FY 00:100%
Increase the science base of occupational safety and health through publications, innovations, and research partnerships. *CDC Plan*	FY 02: Increase peer-reviewed publications by NIOSH and NIOSH-sponsored researchers over baseline FY 01: Establish baseline	FY 02: FY 01:
Collect, analyze, and disseminate surveillance information on occupational illnesses, injuries, and hazards to help target and evaluate interventions and prevention efforts. *CDC Plan*	FY 02: Publish surveillance reports addressing 2 major occupational injury or illness issues annually Target one national prevention activity annually Prepare and disseminate public use data sets. FY 01: Initiate web-based surveillance information dissemination. Pilot test improved data collection methods. Initiate hazard surveys targeted by workforce sector. FY 00: Continue to collect, analyze, and disseminate surveillance data. FY 99: Collect, analyze and disseminate surveillance data and produce reports	FY 02: FY 01: FY 00: Achieved. Examples: (1) Simple Solutions: Ergonomics for Farm Workers (2) MMWR pertaining to pesticide poisoning using data collected through the Toxic Exposure Surveillance System (TESS) 6/900 Vol 29). (3)1999 Work Related Lung Disease Surveillance Report (4) NIOSH Worker Health 2000 Chartbook of Occupational Surveillance Information FY 99: Achieved

Performance Goals	Targets	Actual Performance
Foster safe and healthful working conditions by transferring scientific and technical information to employers, workers, the public and the occupational safety and health community. *CDC Plan*	FY 02: Improve over baseline FY 01: Establish baseline of information transferred via web, phone, and print	FY 02: FY 01:
Provide sanitation facilities to new or like-new homes and existing Indian homes. *IHS Plan*	FY 02: 2,528 New/Like 12,727 Existing 15,255 Total FY 01: 3,800 New/Like 10,930 Existing 1 6,527 Total FY 00: 3,740 New/Like 11,035 Existing 14,775 Total FY 99: 5,900 New/Like 9,330 Existing 15,230 Total	FY 02: FY 01: FY 00: 3,886 New/Like 14,490 Existing 18,376 Total FY 99: 3,557 New/Like 13,014 Existing 16,571 Total
Develop environmental health surveillance system and complete community environmental assessments in 90% of American Indian and Alaskan Native communities. *IHS Plan*	FY 02: +10% over FY 01 FY 01: 15% of communities assessed FY 00: Develop protocol and plan	FY 02: FY 01: FY 00: protocol and plan partially completed FY 99: no systems in place

HHS Goal 2: IMPROVE THE ECONOMIC AND SOCIAL WELL-BEING OF INDIVIDUALS, FAMILIES AND COMMUNITIES IN THE UNITED STATES

The focus of this goal is to promote and support interventions that help disadvantaged and distressed individuals, families, and communities improve their economic and social well-being. We stress interventions that are related to improving job skills, access to social services, family and community stability, and independent living. We also recognize the importance of health care in achieving many of the objectives under Goal 2 and illustrate this with appropriate strategies in a number of areas such as Head Start. The objectives further prioritize Department efforts by targeting interventions toward low-income families (including those receiving welfare), children, the elderly, persons with disabilities, and distressed communities.

While substantial progress has been made in the past several years in helping welfare recipients move to work, increasing child support payments, and providing childcare and early learning services to low and moderate income families, evidence supports a continued focus on helping those who need help. For example, data (1999) indicate that 17 percent of all children still live in poverty. Preschool enrollment for these children is still at only 40 percent. Affordable childcare for low and moderate income working families is still largely inaccessible. In 1998, only 1.5 million of 9.9 million children eligible for childcare assistance received it. Almost one million children were the victims of substantiated or indicated child abuse or neglect in 1997. Thirty three percent of children in foster care remain without permanent placement with a family for as long as three years or more.

As the American population ages, evidence points to the need to extend efforts to help the growing number of elderly persons remain as active and healthy as possible and delay or avoid chronic medical problems. An aging society means that the number of persons needing long-term-care services will increase and the availability of these services in the home and community will be a significant challenge if we are to help these citizens maintain their independence and quality of life. The need for long-term support is not limited to the elderly. As survival rates increase among people who are born with or acquire disabilities, and with more opportunities for them to lead better-quality lives in the community (rather than in institutions), there will be greater need to expand the options for home and community-based support structures for people of all ages.

SUMMARY PERFORMANCE REPORT
HHS Strategic Goal 2

These are selected performance stories from the performance plans of the HHS operating and staff components that support key areas related to the achievement of this strategic goal. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan.

ECONOMIC INDEPENDENCE FOR FAMILIES

Temporary Assistance for Needy Families (TANF). A primary goal of the TANF legislation (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) is to move recipients of assistance from welfare to work and self-sufficiency. Congress established work participation performance standards and created a High Performance Bonus incentive system to facilitate the achievement of this goal. The early TANF performance measures have focused on employment and more than adequately demonstrate the early success of the program. In FY 1999, 49 States reported 1.2 million job entries. In addition, all of the States met the Congressionally established all-families work participation target of 35 percent. Only 74 percent of the States with two-parent family programs met the target rate of 90 percent. The statutory two-parent participation target of 90 percent remains a rigorous standard. Also in FY 1999, the percentage of adult TANF recipients who became newly employed increased to 42.9 percent (from 38.7 percent in FY 1998); 76.8 percent of adult TANF recipients employed in one quarter of the year continued to be employed in another quarter and the rate of earnings gained from one quarter to the second subsequent quarter was 22 percent. ACF states that FY 2000 data will be available in December of 2001.

Child Support Enforcement. The Child Support Enforcement program broke new records in nationwide collections in FY 2000 by reaching $17.9 billion. The government collected a record $1.4 billion in overdue child support from Federal income tax refunds. More than 1.42 million families benefitted from these collections. In addition, a program to match delinquent parents with financial records identified more than one million accounts with a value in excess of $3 billion. The number of paternities established or acknowledged reached a record 1.6 million in FY 1999. Of these, over 754,000 were established through in-hospital acknowledgment programs and 845,000 paternities were established through the Child Support Enforcement program.

Child Care. The Child Care and Development Fund (CCDF) was established under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to help working low-income families achieve and maintain economic self-sufficiency and to improve the overall quality of child care. The number of children served through the CCDF will have grown from 1.51 million in FY 1998 to 1.76 million in FY 1999 to a projected target of 1.92 million in FY 2000. In FY 1999 one half of the 1.76 million children served were preschoolers between two and six, 15 percent were infants and toddlers, and 35 percent were school age. Also in FY 1999, 975,000 families were working or pursuing training/education with support of CCDF subsidies and the percentage of potentially eligible children who received CCDF subsidies

increased to 12 percent (from 10 percent in FY 1998). ACF states that data for FY 2000 will be available in April of 2001. While the CCDF is serving an increasing number of children and families each year, there is still a great need for quality, affordable child care for low-income working families. New presidential initiatives are expected to increase the number of children served by CCDF subsidies to 2.6 million by FY 2002.

Employment Intervention. The goal of SAMHSA's Employment Intervention Demonstration Program, a Knowledge Development program initiated in FY 1995, is to determine the most effective approaches for assisting adults with serious mental illness to find and maintain competitive employment. The program will report final results in FY 2001 or FY 2002, however, interim results show:

- The employment rate of participants rose from a FY 1995 baseline of zero (with the exception of one site, to enter the study participants were not working) to 55 percent in FY 2000. On average, 28 percent of EIDP participants were employed after 3 months, 40 percent after six months, 47 percent after 9 months, 51 percent after 12 months, and 56 percent after 18 months.

- The total hours worked by participants increased from 346,405 hours in FY 1998 to 863,435 hours in FY 2000, and the total dollars earned increased from $1.8 million in FY 1998 to $5.0 million in FY 2000.

Transition from Homelessness. Clients served though SAMHSA's Projects for Assistance in Transition from Homelessness formula grant program have increased from 105,000 in FY 1997 to 115,000 in FY 1998. Also of great significance is the percentage of persons contacted who become enrolled in mental health services. The population of individuals who are homeless and who have serious mental illness has multiple and complex needs, and is extremely difficult to engage in services. In FY 1996 and FY 1997, 41 percent of those contacted became enrolled in services. This percentage dropped slightly in FY 1998 to 37 percent. These percentages are considered to represent an excellent rate of success for this population. FY 1999 data for these goals will be available in June of FY 2001. Based on these results, it is expected that SAMHSA will meet or exceed its FY 1999 targets.

CHILDREN'S HEALTH AND DEVELOPMENT

Safety and Security of Children and Youth. ACF funds a number of programs that focus on preventing maltreatment of children in troubled families, protecting children from abuse, and finding permanent placements for those who cannot return safely to their homes. Programs such as Foster Care, Adoption Assistance and Independent Living provide stable environments for those children who cannot remain safely in their homes. The implementation of the Adoption and Safe Families Act of 1997 (which encourages speedier permanency decisions for children) has resulted in some demonstrable improvements in program performance. For example, the annual number of adoptions for children in the public foster care system has increased from 36,000 in FY 1998 to 46,000 in FY 1999. Further, of the children who exit foster care through reunification, the percent who do so within one year has increased from 63 percent in FY 1998 to 65 percent in FY 1999. Data for FY 2000 will be available in September of 2000.

IHS Well Child Visits. A recognized standard of care, well child visits have been associated with improved post-neonatal mortality and opportunities to improve family health and safety in the longer term. Of particular importance are educational interventions with parents concerning diet and nutrition, injury prevention, and prevention of family violence. As part of larger efforts to improve child and family health, IHS set a FY 2000 goal to increase by five percent the proportion of the American Indian and Alaskan Native children receiving a minimum of four well-child visits by 27 months of age. In FY 2000, provisional data show that 5, 840 children or 47.7 percent out of 12, 237 children received a minimum of four well-child visits by 27 months of age, an increase of 9.2 percent over the FY 1999 proportion of 38.5 percent (3, 799 of 9,873 children).

IHS – Head Start Obesity Prevention Programs. In FY 2000, five tribal Head Start programs were selected to pilot obesity prevention and intervention approaches in their communities, meeting IHS' FY 2000 goal. Each pilot site will tailor a multidisciplinary approach to test strategies to reduce the incidence of obesity in Head Start children, their parents, Head Start staff and the tribal community at large. The community-based initiatives will include nutrition, physical activity, and behavioral health interventions For example, the Northern Cheyenne Head Start has engaged their local markets to allow staff to label healthy food in their store so tribal members are able to quickly identify healthy food choices for their families while shopping. This intervention was piloted in one store at the permission of the retailer. It was so popular, other vendors in the community requested assistance in establishing the same service. Each site will also develop a strategic plan that includes an evaluation plan to monitor objectives and outcomes.

Comprehensive Community Mental Health Services for Children and Their Families. Results for the Comprehensive Community Mental Health Services for Children and Their Families Program, a Targeted Capacity Expansion program, indicate that children in services for at least twelve months show significant improvements after one year:

- Inpatient treatment days decreased by 44 percent from baseline in 1998; this decrease has been maintained, and FY 2001 and FY 2002 targets have been increased accordingly.

- The baseline for regular school attendance was 70 percent in FY 1997. In FY 1998 following 12 months of services, regular school attendance had risen to 78.8 percent. In FY 1999, the figure was 88.9 percent, and in FY 00 it was 82 percent - all substantially above the baseline level and exceeding the annual targets.

- The FY 1997 baseline for children having more than one living arrangement after six months of service was 76 percent. After 12 months in this program, the FY 1998 figure was 23.7 percent. For FY 1999, the figure was 27 percent, and for FY 2000, 26 percent. These data show that the program has been able to maintain these very substantial decreases from baseline. FY 2001 and FY 2002 targets have been increased accordingly.

Childhood Immunizations. Efforts to protect children in the U.S. from vaccine-preventable disease have been a success. Cases of most vaccine-preventable diseases of childhood are down more than 97 percent from peak levels before vaccines were available. No cases of

paralytic polio due to indigenous transmission of wild polio virus have been reported in the U.S. since 1979. *Haemophilus influenzae* type b (Hib) invasive disease, the main cause of bacterial meningitis, has declined by more than 99 percent in children under five since the introduction of the vaccine. Measles hit a low of 67 reported cases in 1999. Coverage levels for preschool children are at an all-time high for all racial and ethnic groups. The reduction in the number of indigenous cases of mumps has exceeded our goal of 500 cases. In 1999, there were only 387 cases of mumps; in 2000, the incidence was further reduced to 323 cases. This reduction is linked to the effectiveness of the Measles-Mumps-Rubella vaccine and its coverage rate.

CDC met its FY 2000 goal of at least 90 percent immunization coverage among children 19- to 35-months of age for four of five vaccines. The coverage rate for four doses of Diptheria-Tetanus-Pertussis (DTaP) containing vaccine did not achieve the 90 percent goal. However, the rate has steadily increased since the change to a four dose schedule, as recommended by Advisory Committee on Immunization Practices (ACIP) in 1991. This goal has been the one of the most difficult for CDC to achieve because it requires that the fourth dose be given to the child after the second year of life. The administration of DTaP tends to coincide with regular well-baby visits through the third dose; however, the fourth dose does not, requiring a visit specifically for this purpose. CDC does have coverage rates of 95 percent for the first three doses. These are considered to be the most critical, however, CDC and the ACIP feel strongly that the fourth and fifth doses are important for full vaccination. Varying state requirements for the four-dose vaccine schedule may have also led to a slower increase in coverage.

IHS set a FY 2000 goal to increase to 91 percent the proportion of American Indian and Alaskan Native (AI/AN) children who have completed all recommended immunizations by the age of two; however, the FY 2000 rate was 86 percent. Reasons include problems with the infrastructure to deliver vaccines, such as vacancies in positions essential for the delivery, increasingly complex immunization schedules as new vaccines are added, and incomplete tracking due to the multiple sources of health care (many non-IHS). Among steps taken to address these challenges are addressing agency-wide recruitment and retention problems and developing informational materials specific to AI/AN communities in order to educate parents on the importance and safety of new vaccines.

HCFA, working in conjunction with the States, CDC, and the American Public Human Services Association (APHSA), has developed a three stage process to develop individual State baselines and methodologies for reporting on a performance goal on immunization coverage for two-year-old children enrolled in Medicaid. The first group of 16 States is expected to have developed their State-specific methodology and measured baseline levels by the end of FY 2000 and have their first re-measurements by the end of FY 2001. The second group of 10 States expects to have established the baseline and methodology by the end of FY 2001, and all remaining States will have established the baseline and methodology by the end of FY 2002.

THE AGING POPULATION

Older Americans Act Community-based Services. Under this program activity, the Administration on Aging and the Aging Network provide numerous services to older Americans including for example, information and assistance, outreach, transportation, meals, chores, home health, and adult day care. The program provides some services to roughly one half of the poor elderly population of the United States. The Aging Network successfully leverages funds ($1.80 or greater of leveraged funds for each $1.00 of AoA funding for FY 1997-1999) and generates income ($.33 or greater for each $1.00 of AoA funding for FY 1997-1999). Finally, the Aging Network, striving to serve the most vulnerable elderly, has been steadily increasing the number of home-delivered meals provided - from 119.1 million in FY 1996 to 132.1 million in FY 1999, substantially exceeding the FY 1999 target of 119 million. Data for FY 2000 will be available February 2002.

Vaccinations for Senior Citizens. To reduce the incidence of deaths related to influenza and pneumoccoccal disease, health professionals recommend lifetime vaccination for pneumoccoccal disease and annual vaccination for influenza for persons aged 65 and over. CDC plays a critical role in developing immunization policy by providing technical and scientific support to groups that recommend immunization policy in the United States and globally. CDC supports immunization programs to increase community participation, education, and partnerships through public information campaigns, education and training for providers, assistance to communities on building coalitions, and partnerships with community-based organizations, national minority organizations, volunteer groups, vaccine companies, professional organizations and Federal agencies. CDC, HCFA, and IHS share complementary goals to increase the number of annual influenza and lifetime pneumoccoccal vaccinations among selected populations aged 65 and over; however, annual targets are specific to the populations served.

CDC has demonstrated an increase in the percentage of persons 65 years of age or older receiving vaccine against influenza (from 33 percent in 1989 to 64 percent in 1998). Similarly, the coverage rate for pneumococcal vaccine increased from 15 percent to 46 percent over the same period. CDC will report data on its FY 1999 targets of 60 percent and 54 percent, respectively, in September of 2001.

Although performance data on HCFA's goal to increase the rate of influenza vaccination to 60 percent will not be available until 2002, NHIS trend data indicates that vaccination rates in this population have risen from 55 percent in FY 1994 to 64 percent in FY 1998. In FY 2001, HCFA will begin using data from the Medicare Current Beneficiary Survey, which will support separate targets for rates of influenza and pneumococcal vaccinations for nursing home residents as well as beneficiaries in the community. Adult immunizations are being examined by the Peer Review Organizations as part of HCFA's quality improvement efforts.

IHS established a FY 2000 baseline of 30.7 percent of all American Indians and Alaskan Natives over 65 vaccinated against influenza by extracting this data from its electronic medical records, and has set targets for a one percent increase in both FY 2001 and FY 2002. Pneumococcal immunization, which is only recommended once every five years, is more difficult to ascertain from IHS electronic medical records, and IHS was not able to develop a baseline. In FY 2001, IHS will pilot and validate methods using influenza vaccination, and based on the outcome of these studies, will begin measuring pneumococcal vaccination rates to establish a baseline in FY 2001.

Targeting Elderly and High-Risk American Indians/Alaskan Natives. (AI/AN). Elders, newborns, infants, and pregnant women are high risk populations in AI/AN communities and the target of IHS' public health nursing (PHN) services. Because PHN services can be provided in any setting where the patient is accessible, this is especially effective for high-risk patients and families (e.g., substance abusing patients, families with dysfunctional life styles, including elder abuse). Settings include homes, schools, jails, bars, and other community locations in addition to the health clinic. The ability to meet the patient in their own environment allows the PHN to fully assess socioeconomic and quality of life variables that affect health status and facilitates rapport with patients who often distrust the formal health care system. In FY 2000, IHS provided 371,548 total PHN visits (9.5 percent increase) and 127,873 home PHN visits (7 percent increase), exceeding its goal to increase PHN visits by seven percent. Services provided included primary and secondary treatment and preventive services, counseling, education, community development and referral follow-up.

Mammograms. Encouraging breast cancer screening for women age 65 and over, including regular mammograms, is critical to reducing breast cancer deaths. HCFA's Peer Review Organizations have been directed to monitor and improve the percentage of female Medicare beneficiaries age 65 and older who receive a mammogram within two years as an indicator of the quality of preventive care. In FY 1998 the National Health Interview Survey (NHIS) indicated that 63.8 percent of women age 65 or over received a biennial mammogram, a considerable increase from the baseline of 55 percent in 1994. Data indicating HCFA's progress in meeting its FY 2000 target of 60 percent will be available from NHIS in Summer of 2000. Beginning in FY 2001, HCFA will use Medicare claims data for this measure rather than self-reported NHIS data. Baseline reports show mammography rates of 45 percent in FY 1998 and 49 percent in FY 1999. HCFA has revised its targets accordingly. In FY 2002, it has set a target to increase biennial mammography rates to 52 percent.

Nursing-home care. While HHS focuses significant attention on avoiding institutional care, the Department is fully committed to protecting the rights of nursing home residents and enhancing their care. Both the reduced use of physical restraints on nursing home patients and the lowered prevalence of pressure ulcers in nursing homes are widely accepted as indicators of quality of care. HCFA has reported the achievement of its FY 1999 goal to reduce the prevalence of the use of physical restraints among all nursing homes from 17.2 percent in 1996 to 14 percent in 1999. With reported prevalence of under 12 percent in 1999, HCFA has adopted a more rigorous target of 10 percent for FY 2000 and FY 2001. Interim data for FY 2000 show a reduction to 9.8 percent. HCFA has reported baseline data showing a 9.8 percent prevalence of pressure ulcers in nursing homes, and has established targets of 9.6 percent and 9.5 percent for FY 2001 and FY 2002 respectively.

ECONOMIC AND SOCIAL DEVELOPMENT OF DISTRESSED COMMUNITIES

Improving Access for American Indians and Alaskan Natives Through Facilities Construction. Construction of new health care facilities to replace old, inadequate facilities is the first step in improving access for underserved locations. Efficient space for health care delivery allows for more appointments and for patients to see more health care providers in one trip. Likewise, modern facilities help recruit and retain health care providers, which means more continuity of health care delivery. Once a facility has been completed, IHS has experienced an average increase of approximately 60 percent more patient visits than in the old facility. Facilities are selected through a priority ranking system determined by workload, age, isolation or alternatives to construction, and existing space data. IHS met its FY 2000 goal to continue construction of the replacement hospital in Fort Defiance, Arizona; start construction of the replacement hospital in Winnebago, Nebraska; continue construction of the replacement health center in Parker, Arizona; design the new health center in Red Mesa, Arizona; design and start construction of the staff quarters to support the hospital in Zuni, New Mexico; and continue the design and construction of dental units.

Providing Sanitation Facilities for American Indian and Alaskan Native Homes. In FY 2000, IHS provided sanitation facilities to 3,886 new and like-new homes and 14,490 existing homes for a total of 18,376. These exceeded the total goal of providing sanitation facilities for 14,775 homes. This significant increase in existing homes was the result of more projects to upgrade existing community sanitation facilities infrastructure. Compelling evidence supports that reductions in the rates for infant mortality, gastroenteritis morbidity, and other environmentally related diseases of as much as 80 percent since 1973 are attributable to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. In addition, satisfactory environmental conditions (e.g., safe piped water and adequate sewage disposal) place fewer demands on IHS' primary health care delivery system.

HHS 2.1: Increase the Economic Independence of Low Income Families, Including Those Receiving Welfare

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
All States meet the TANF work participation targets (the targets are statutory) for FY 2002. *ACF Plan*	**All Families** FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100% **Two parent families** FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100%	 FY 02: FY 01: FY 00: 12/01 FY 99: 100% FY 98: 100% FY 02: FY 01: FY 00: 12/01 FY 99: 74% FY 98: 66%
Maintain the increase in the percentage of adult TANF recipients and former recipients employed in one quarter of the year who continue to be employed in the next two consecutive quarters from the FY 1998 baseline year. *ACF Plan*	FY 02: 84% FY 01: 84% FY 00: 83% FY 99: N/A	FY 02: FY 01: FY 00: 12/01 FY 99: 76.8% FY 98: 80%
Maintain the increase in the percentage of adult TANF recipients who become newly employed from the FY 1998 baseline year. *ACF Plan*	FY 02: 43% FY 01: 43% FY 00: 42% FY 99: NA	FY 02: FY 01: FY 00: 12/01 FY 99: 42.9% FY 98: 38.7%
Increase the number of refugees entering employment through ACF-funded refugee employment services by at least 5% annually. *ACF Plan*	FY 02: 59,730 FY 01: 56,885 FY 00: 54,176 FY 99: 51,597	FY 02: FY 01: FY 00: 4/01 FY 99: 50,208 FY 98: 52,298 FY 97 46,800 (baseline)
Maintain the number of child recipients of day care services funded wholly or in part by Social Services Block Grant funds at the FY 1998 baseline. *ACF Plan*	FY 02: 2,399,827 FY 01: 2,399,827 FY 00: NA FY 99: NA	FY 02: FY 01: FY 00: 5/02 FY 99: 5/01 FY 98: 2,399,827

Performance Goals	Targets	Actual Performance
Increase the number of children served by CCDF subsidies from the 1998 baseline average of 1.5 million served per month. *ACF Plan*	FY 02: 2.6 million FY 01: 2.1 FY 00: 1.92 FY 99: N/A	FY 02: FY 01: FY 00: 4/01 FY 99: 1.76 million FY 98: 1.51
Increase the number of families working and/or pursuing training/education with support of CCDF subsidies from the FY 1998 baseline. (Target number expressed in millions). *ACF Plan*	FY 02: 1.2 million FY 01: 1.1 FY 00: NA FY 99: NA	FY 02: FY 01: FY 00: 4/01 FY 99: 975,000 FY 98: 802,000
Increase the number of Matching Grant refugee families (cases) that are self-sufficient (not dependent on any cash assistance) within the first 4 months after arrival by at least 4% annually. *ACF Plan*	CY 02: 6,423 CY 01: 6,176 CY 00: 5,938 CY 99: 5,710	CY 02: CY 01: CY 00: 5/01 CY 99: 6,497 CY 98: 5,194 CY 97: 5,279 baseline
Increase compliance of State and local TANF agencies and service providers with Title VI, Section 504 and ADA. Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 139 FY 01: 135	FY 02: FY 01: FY 00: 242 (baseline)
Increase access to HHS services for limited English proficient (LEP) persons (compliance with Title VI by recipients of Federal financial assistance). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 423 FY 01: 413	FY 02: FY 01: FY 00: 403 (baseline)

See also:

- Objective 2.2, Increase the Parental Involvement and Financial Support of Noncustodial Parents in the Lives of Their Children

HHS 2.2: Increase the Parental Involvement and Financial Support of Noncustodial Parents in the Lives of Their Children

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase the paternity establishment percentage among children born out-of-wedlock. ** *ACF Plan*	FY 02: 97% FY 01: 96.5% FY 00: 96% FY 99: 96%	FY 02: FY 01: FY 00: 10/1 FY 99: 106%*
Increase from the FY 1999 baseline the percentage of IV-D cases having support orders. *ACF Plan*	FY 02: 64% FY 01: 62% FY 00: 76% FY 99: 74%	FY 02: FY 01: FY 00: 10/1 FY 99: 60%*
Increase from the FY 1999 base the IV-D collection rate for current support due. *ACF Plan*	FY 02: 55% FY 01: 54% FY 00: 71% FY 99: 70%	FY 02: FY 01: FY 00: 10/1 FY 99: 52%*
Increase the percentage of paying cases among IV-D arrearage cases. *ACF Plan*	FY 02: 55% FY 01: 54.5% FY 00: 46% FY 99: 46%	FY 02: FY 01: FY 00: 10/1 FY 99: 54%*
Increase the number of child support enforcement task forces in operation (each task force several States). *OIG Plan*	FY 02: 6 FY 01: 5	FY 02: FY 01: FY 00: 5 FY 99: 2 FY 98: 1 FY 97: 0 (baseline)

* ACF is recalculating its baseline based on 1999 performance.
** The percentage calculated includes current cases and completion of backlogs of older cases.

See also:

- Objective 2.1, Increase the Economic Independence of Low Income Families, Including Those Receiving Welfare

HHS 2.3: Improve the Healthy Development and Learning Readiness of Preschool Children

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Learning Readiness		
Increase by 1 percent from the CY 2000 baseline the number of regulated child care centers and homes accredited by a nationally recognized early childhood development professional organization. *ACF Plan*	CY 02: 9,725 CY 01: 9,630 CY 00: NA CY 99: NA	CY 02: CY 01: 9/01 CY 00: 9,535 CY 99: NA
Increase by 8 percent over the previous year the number of Child Development Associate credentials awarded nationwide. *ACF Plan*	CY 02: 149,175 CY 01: 138,125 CY 00: NA CY 99: NA	CY 02: CY 01: 9/01 CY 00: 127,893 CY 99: 112,130
Improve emergent literacy, numeracy and language skills of Head Start children. * *ACF Plan* Maintain at the FY 1999 baseline of 10 points the average gain in word knowledge. Maintain at the FY 1999 baseline of 3 points the average gain in mathematical skills. Increase over the FY 1999 baseline of 1.5 points the average gain in letter identification. Note: See ACF Plan for description of "point" scales. * Data for these measures is derived from the Family and Child Experiences Survey (FACES) a replicated longitudinal study which will yield the next set of data in FY 2002.	**Vocabulary** FY 01/02: 10 FY 99/00: N/A **Math** FY 01/02: 3 FY 99/00: NA **Letter identification** FY 01/02: 3.4 FY 99/00: NA	 FY 01/02: FY 99/00: 10 FY 01/02: FY 99/00: 3 FY 01/02: FY 99/00: 1.5
Increase to 1.24 points the average gain in fine motor skills for Head Start children.* *ACF Plan* * See note on FACES Survey above	FY 01/02: 1.24 FY 99/00: N/A	FY 01/02: FY 99/00: 1.05

Performance Goals	Targets	Actual Performance
Increase from the FY 1999 baseline the percentage of Head Start parents who read to child three or more times per week. * *ACF Plan* * See note on FACES Survey above	FY01/02: 70% FY99/00: NA	FY 01/02: FY99/00: 66%
Maintain at the FY 1999 baseline of 1.4 points the average gain in social skills for Head Start children.* *ACF Plan* * See note on FACES Survey above..	FY 01/02: 1.4 FY 99/00: N/A	FY 01/02: FY 99/00: 1.4
Healthy Development		
Increase the percentage of Head Start classroom teachers with a certificate, a degree, or appropriate training related to early childhood education. *ACF Plan*	FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100%	FY 02: FY 01: FY 00: 94% FY 99: 93% FY 98: 95%
Increase the percentage of Head Start children who receive necessary medical treatment after being identified as needing medical treatment. *ACF Plan*	FY 02: 94% FY 01: 92% FY 00: 90% FY 99: 88%	FY 02: FY 01: FY 00: 88% FY 99: 87 % FY 98: 88%
Increase the percentage of Head Start children who receive necessary treatment for emotional or behavioral problems after being identified as needing such treatment. *ACF Plan*	FY 02: 85% FY 01: 83% FY 00: 81% FY 99: 81%	FY 02: FY 01: FY 00: 77% FY 99: 75% FY 98: 75%
Increase the proportion of American Indian and Alaskan Native children receiving a minimum of four Well Child Visits by 27 months of age and expand coverage. *IHS Plan*	FY 02: 2% over FY 01 FY 01: 2% over FY 00 FY 00: 2% over FY 99 FY 99: establish baseline	FY 02: FY 01: FY 00: 47.7% FY 99: 38.5%
Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program. *HRSA Plan*	FY 02: 11.5 million FY 01: 10.5 million FY 00: 9.6 million FY 99: 8.9 million	FY 02: FY 01: FY 00: (8/01) FY 99: 9.0 million FY 98: 8.7 million FY 97: 8.3 million
Decrease the percentage of low birth weight babies born to Healthy Start clients. *HRSA Plan*	FY 02: 11.3% FY 01: 11.4%	FY 02: FY 01: FY 00: 5/01 FY 99: 11.58% FY 98: 12.06 %

Performance Goals	Targets	Actual Performance
Achieve or sustain the following immunization coverage of at least 90% among children 19- to 35-months of age for each vaccine: 2. 4 doses of Diphtheria-Tetanus-Pertussis containing vaccine 3. 3 doses of *Haemophilus influenzae* type b vaccine 4. 1 dose of Measles-Mumps-Rubella vaccine* 5. 3 doses of Hepatitis B vaccine 6. 3 doses of Polio vaccine 7. 1 dose of Varicella vaccine* 8. 4 doses of Pneumococcal Conjugate vaccine* **Performance targets for newly recommended vaccines will begin 5 years after the ACIP recommendation. The varicella measure will begin in 2001, even though coverage is being reported earlier. The pneumococcal conjugate measure will begin in 2006, even though coverage will be reported earlier. *CDC Plan*	FY 02: 90% FY 01: 90% FY 00: 90% FY 99: 90%	FY 02: FY 01: 8/02 FY 00: Provisional data. Final 08/01 1. 83% 2. 94% 3. 91% 4. 90% 5. 90% 6. 63%* FY 99: 1. 83% 2. 94% 3. 92% 4. 88% 5. 90% 6. 58%* FY 98: 1. 84% 2. 93% 3. 92% 4. 87% 5. 91% 6. 43%*

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicaid two-year old children who are fully immunized. (To be achieved in 3 phases for State groupings.) *HCFA Plan*		
– Group 1 States (Set State-specific methodology and baseline: 1999-2000; first report: 2001)	FY 02: Second Report FY 01: First Report FY 00: Set State-specific methodology and baseline FY 99: Not Applicable	FY 02: FY 01: FY 00: 13 Group I States developed State-specific methodology, targets and measured baselines. 3 States will complete these efforts in FY 2001 FY 99: Identified Group I States. Began developing State-specific methodology and baselines
– Group 2 States (Set State-specific methodology and baseline: 2000-2001; first report: 2002)	FY 02: First Report FY 01: Set baseline FY 00:Begin State-specific methodology and baseline activities	FY 02: FY 01: FY 00: Identified Group II States. Began developing State-specific methodology and baselines
– Group 3 States (Set State-specific methodology and baseline: 2001-2002; first report: 2003)	FY 02: Set baseline FY 01: Begin State-specific methodology and baseline activities FY 00: N/A	FY 02: FY 01: FY 00: N/A FY 99: N/A
Increase the proportion of American Indian and Alaskan Native children who have completed all recommended immunizations by the age two. *IHS Plan*	FY 02: 1% over FY 01 FY 01: 1% over FY 00 FY 00: 2% over FY 99 FY 99: 91%	FY 02: FY 01: FY 00: 86% 12/12 Areas FY 99: 89% 12/12 Areas 87% 11/12 Areas FY 98: 88% 11/12 Areas

Performance Goals	Targets	Actual Performance
The number of children with elevated blood lead levels will have been reduced. *CDC Plan*	FY 03: 35% reduction FY 99: 25% *No data available in 1999 NHANES.	FY 03: FY 99: * FY 91- 94: 890,000 children with blood lead levels greater than 10 micrograms per deciliter

See also:

- Objective 1.1, Reduce Tobacco Use, Especially Among Youth
- Objective 3.3, Increase the Availability of Primary Health Care Services for Underserved Populations
- Objective 4.1 Enhance the Appropriate Use of Effective Health Services

HHS 2.4: Improve the Safety and Security of Children and Youth

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Make progress towards doubling the number of adoptions for children in the public foster care system between FY 1997 and FY 2002. *ACF Plan*	FY 02: 56,000 FY 01: 51,000 FY 00: 46,000 FY 99: 24,000	FY 02: FY 01: FY 00: 9/01 FY 99: 46,000 FY 98: 36,000 FY 97: 31,000 FY 96: 28,000 FY 95: 26,000
Of the children who exit foster care through reunification, increase the percentage of children who exit within one year of placement. *ACF Plan*	FY 02: 67% FY 01: 67% FY 00: 67% FY 99: NA	FY 02: FY 01: FY 00: 6/01 FY 99: 65% FY 98: 63%
Of the children who exit foster care through adoption, increase the percentage of children who exit within two years of placement. *ACF Plan*	FY 02: 28% FY 01: 28% FY 00: 27% FY 99: NA	FY 02: FY 01: FY 00: 6/01 FY 99: 19% FY 98: 23%
Increase the number of HHS adoption service providers who provide nondiscriminatory placements for minority children (Small Business Job Protection Act). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 44 FY 01: 42	FY 02: FY 01: FY 00: 40 (baseline)
Establish an Infant Adoption Awareness Training Program for designated staff of eligible health centers. (Developmental) *HRSA Plan*	FY 02: Development FY 01: Development	FY 02: FY 01: FY 00: N/A
Decrease the percentage of children with substantiated reports of maltreatment who have a repeat substantiated report of maltreatment within 6 months. *ACF Plan*	CY 02: 7% CY 01: 7% CY 00: NA CY 99: NA	CY 02: CY 01: CY 00: 9/01 CY 99: 8% CY 98: 8%

Performance Goals	Targets	Actual Performance
Maintain the proportion of youth living in safe and appropriate settings after receiving ACF-funded services. *ACF Plan*	FY 02: 96% FY 01: 96% FY 00: 95% FY 99: 95%	FY 02: FY 01: FY 00: 6/01 FY 99: 86% FY 98: 81% FY 97: 82%
Maintain the number of recipients of child protective services funded wholly or in part by by Social Services Block Grant funds at the FY 1998 baseline. *ACF Plan*	FY 02: 1,302,895 FY 01: 1,302,895 FY 00: NA FY 99: NA	FY 02: FY 01: FY 00: 5/02 FY 99: 5/01 FY 98: 1.302,895 FY 97: 1,037,860 FY 96: 1,147,397
For children receiving services through the Comprehensive Community Mental Health Services for Children and Their Families, *SAMHSA Plan.*		
Increase the percent of children attending school 75% or more of the time after 12 months.	FY 02: Maintain 18% FY 01: 18% increase FY 00: Maintain 10% FY 99: 10% increase FY 98: 5% increase	FY 02: FY 01: FY 00: 82.0% (+17%) FY 99: 88.9% (+27%) FY 98: 78.8% (+12%) FY 97: 70% (at 6 months)
Increase the percent of children with law enforcement contacts at entry who have no law enforcement contacts after 12 months.	FY 02: Maintain 43% FY 01: 43% FY 00: Maintain 57% FY 99: 57% FY 98: 52%	FY 02: FY 01: FY 00: 44% FY 99: 43% FY 98: 54.8% FY 97: 47% (at 6 months)
Increase stability of living arrangements by decreasing the percent of children having more than one living arrangement after 12 months in services.	FY 02: Maintain 65% FY 01: 65% decrease FY 00: 25% decrease FY 99: 20% decrease FY 98: 10% decrease	FY 02: FY 01: FY 00: 26% (-65.8%) FY 99: 27% (-64.5%) FY 98: 23.7% (-68%) FY 97: 76% (at 6 months)
Increase the percentage of IHS, Tribal, and Urban medical facilities with Urgent Care or Emergency departments or services that have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (child, spouse, elderly) and train staff in their use. *IHS Plan*	FY 02: 80% FY 01: 75% FY 00: 70% FY 99: 60%	FY 02: FY 01: FY 00: 72% FY 99: 64% FY 98: 47%

See also: Objective 1.2, Reduce the Incidence and Impact of Injuries and Violence in American Society

HHS 2.5: Increase the Proportion of Older Americans Who Stay Active and Healthy

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicare beneficiaries aged 65 and older who receive a mammogram every two years. *HCFA Plan*	FY 01: Switched to new data source (see below) FY 00: 60% FY 99: 59% FY 02: 52% FY 01: 51% FY 00: N/A	FY 01: N/A FY 00: Summer 2002 FY 99: Summer 2001 FY 98: 63.8% FY 94: 55% (NHIS) 01-02: 8/03 00-01: 8/02 99-00: 8/01 (Interim) 98-99: 49% 97-98: 45% (MCBS)
Improve the rate of biennial diabetic eye exams. *HCFA Plan*	FY 02: 69.5% FY 01: 69.0% FY 00: New in 2001	00-02: 12/02 99-01: 12/01 98-00: 3/01 (Interim) 97-99: 68.5%
The rate of vaccination among persons >65 years will be increase for influenza and pneumococcal pneumonia. *CDC Plan*	**Influenza** FY 02: 74% FY 01: 72% FY 00: 70% FY 99: 60% **Pneumococcal Pneumonia** FY 02: 66% FY 01: 63% FY 00: 60% FY 99: 54%	 FY 02: FY 01: FY 00: 09/02 FY 99: 09/01 FY 98: 63% FY 97: 63% FY 95: 58% FY 02: FY 01: FY 00: 09/02 FY 99: 09/01 FY 98: 46% FY 97: 42% FY 95: 34%

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicare beneficiaries age 65 years and older who receive vaccinations. Increase rate of annual influenza (flu) vaccination. (NHIS) Increase annual influenza (flu) and lifetime pneumococcal vaccinations. (MCBS) -- Flu/Pneumococcal *HCFA Plan*	FY 01: Switched to new data source. (see below) FY 00: 60% FY 99: 59% FY 02: 73%/65% FY 01: 72%/63% FY 00: Not Applicable	 FY 00: Summer 2002 FY 99: Summer 2001 FY 98: 64% FY 97: 63% FY 95: 58% FY 94: 55% (NHIS) FY 02: 12/03 FY 01: 12/02 FY 00: 12/01 (Interim) FY 99: 69.1%/61.2% (interim*) FY 98: 68.5%/56.1%* FY 97: 67.1%/50.9%* FY 96: 65%/44.1% FY 95: 61%/34.6% FY 94: 59%/24.6% * includes community dwelling beneficiaries only
Increase overall pneumococcal and influenza vaccination levels among diabetics and adults aged 65 years and older. *IHS Plan*	**Influenza** FY 02: 1% over FY 01 FY 01: 1% over FY 00 FY 00: 65% **Pneumococcal** FY 02: 1% over FY 01 FY 01: secure electronic baseline FY 00: 65%	 FY 02: FY 01: FY 00:30.7% (new baseline from automated process) FY 98: 63% (baseline from diabetes audit) FY 02: FY 01: FY00: data source inadequate FY 98: 63% (baseline from diabetes audit)

Performance Goals	Targets	Actual Performance
Provide Older Americans Act Title III services to a significant percentage of U.S. poor elderly individuals. (Developmental) *AoA Plan*	FY 02: 45% FY 01: 45% FY 00: NA	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 48.1% FY 98: 53.1% FY 97: 59.8%
Maintain a high ratio of leveraged funds to Administration on Aging program funds. (Developmental) *AoA Plan*	FY 02: $1.50 to $1.00 FY 01: $1.50 to $1.00 FY 00: NA FY 99: NA	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: $1.90 to $1.00 FY 98: $1.90 to $1.00 FY 97: $1.80 to $1.00
A high percentage of funding for personal care services, home-delivered meals and adult day care will come from leveraged funds. (Developmental) *AoA Plan*	FY 02: 70% FY 01: 70% FY 00: NA	FY 02: 2/04 FY 01: 2/03 FY 00: 4/02 FY 99: 75% FY 98: 75% FY 97: 74%
Increase the number of rides provided to the elderly by the Aging Network. (Numbers in millions). *AoA Plan*	FY 02: 50.7 million FY 01: 50.7 FY 00: 46.6 FY 99: 39.5	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 42.9 million FY 98: 45.7 FY 97: 46.6
Maintain the number of rides provided to Native American older Americans. (Numbers in thousands) *AoA Plan*	FY 02: 732 FY 01: 732 FY 00: 665 FY 99: 763	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 739 FY 98: 719 FY 97: 680
Increase the number of public health nursing services (primary and secondary treatment and preventive services) provided to infants and elders. *IHS Plan*	**Total Visits** FY 02: 2% > FY 01 FY 01: 3% > FY 00 FY 00: 7% > FY 97 or 363,033 **Home Visits** FY 02: 2% > FY 01 FY 01: 3% > FY 00 FY 00: 7% > FY 97 or127,846	 FY:02: FY 01: FY 00: 375,965 (10.8%) FY 99: 336,134 FY 97: 339,283 FY 02: FY 01: FY 00: 130,933 (+9.6%) FY 99: 111,836 FY 97: 119,482

Performance Goals	Targets	Actual Performance
Increase the percentage of IHS, Tribal, and Urban medical facilities with Urgent Care or Emergency departments or services that have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (child, spouse, elderly) and train staff in their use. *IHS Plan*	FY 02: 80% FY 01: 75% FY 00: 70% FY 99: 60%	FY 02: FY 01: FY 00: 72% FY 99: 64% FY 98: 47%

See also:

- Objective 3. 6, Improve the Health Status of American Indians and Alaska Natives
- Objective 4.1, Enhance the Appropriate Use of Effective Health Services

HHS 2.6: Increase Independence and Quality of Life of Persons with Long-Term Care Needs

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Decrease then sustain the reduced prevalence of the use of physical restraints in nursing homes. *HCFA Plan, AoA Plan*	FY 02: 10% FY 01: 10% FY 00: 10% FY 99: 14%	FY 02: FY 01: FY 00: 9.8% (Interim) FY 99: 11.9% FY 96: 17.2% (baseline)
Reduce the prevalence of pressure ulcers (bed sores) among patients in nursing homes. *HCFA Plan, AoA Plan*	FY 02: 9.5% FY 01: 9.6 % FY 00: Establish baseline/targets FY 99: New in 2000	FY 02: FY 01: FY 00: 9.8% (baseline) FY 99: N/A
Increase provision of health and human services in the most integrated settings for persons with disabilities. Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 01/02 FY 01: Setting baseline	FY 02 FY 01: FY 00: New in FY 2001, based on June 1999 Supreme Court decision

See also:

- Objective 3.1, Increase the Percentage of the Nation's Children and Adults Who Have Health Insurance Coverage
- Objective 3.2, Eliminate Disparities in Health Access and Outcomes

HHS 2.7: Improve the Economic and Social Development of Distressed Communities

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase the number of volunteer hours contributed by CSBG consumers in one or more community groups by one percent over the previous year (expressed in millions of hours). *ACF Plan*	FY 02: 27.4 million FY 01: 27.13 FY 00: 28.93 FY 99: 28.64	FY 02: FY 01: FY 00: 7/02 FY 99: 7/01 FY 98: 26.86 million FY 97: 27 (baseline) FY 96: 28.06
Increase the amount of non-Federal resources brought into low-income communities by the Community Services Network (non-Federal funds mobilized expressed in billions). *ACF Plan*	FY 02: $1.68 FY 01: $1.66 FY 00: $1.38 FY 99: $1.36	FY 02: FY 01: FY 00: 7/02: FY 99: 7/01 FY 98: $1.64 FY 97: $1.26 (baseline) FY 96: $1.20
Maintain a high percentage of senior centers that are community focal points. (Developmental) *AoA Plan*	FY 02: 50% FY 01: 50% FY 00: NA FY 99: NA	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 59.8% FY 98: 58.8% FY 97: 57.9%
Maintain high percentage of volunteer staff among area agencies on aging. (Developmental) *AoA Plan*	FY 02: 40% FY 01: 40% FY 00: NA FY 99: NA	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 45.8% FY 98: 43.8% FY 97: 50.7%

Performance Goals	Targets	Actual Performance
Provide sanitation facilities to new or like-new homes and existing Indian homes. *IHS Plan*	FY 02: 2,528 New/Like 12,727 Existing 15,255 Total FY 01: 3,800 New/Like 10,930 Existing 14,730 Total FY 00: 3,740 New/Like 11,035 Existing 14,775 Total FY 99: 5,900 New/Like 9,330 Existing 15,230 Total	FY 02: FY 01: FY 00: 3,886 New/Like 14,490 Existing 18,376 Total FY 99: 3,557 New/Like 13,014 Existing 16,571 Total
Improve access to health care by construction of the approved new health care facilities. *IHS Plan*	FY 99 - 02: Complete scheduled phase of construction of appropriated facilities	FY 02: FY 01: FY 00: 5 of 6 projects completed on schedule FY 99: Accomplished

HHS Goal 3: IMPROVE ACCESS TO HEALTH SERVICES AND ENSURE THE INTEGRITY OF THE NATION'S HEALTH ENTITLEMENT AND SAFETY NET PROGRAMS

In addition to changing behavior and reducing environmental health risks, improving health in the United States involves assuring that everyone has access to health care. The focus of Goal 3 is to promote increased access to health care, especially for persons who are uninsured, underserved, or otherwise have health care needs that are not adequately addressed by the private health care system.

The access challenges are substantial, particularly for some groups. Overall, approximately 45 million Americans lack health insurance. Although recent efforts to cover the Nation's children are beginning to show success, many children still lack coverage. Over 2,000 counties in the United States are designated health profession shortage areas where access to primary health care for 45 million residents would be limited without HHS community programs. A 1998 Harvard School of Public Health/CDC study found that the lowest life expectancies in the country (including inner city ghettos) for both men and women exist in American Indian communities, and mortality disparities for American Indian/Native American people are worsening. Access to treatment for persons with HIV/AIDS, estimated to cost as much as $20,000 per year, would be severely limited without support for the cost of drug therapies and associated services. Less than one-third of the adults with diagnosable mental disorders receive treatment in a given year. Many families cannot afford the cost of care for children with special health care needs.

Minorities have particular problems with access and they face a range of disparities in health care. Approximately 38 percent of Hispanic and 24 percent of African-American adults are without health insurance, compared with 14 percent of white adults. Infant mortality rates are higher for minority groups, as are the incidence of illness and deaths associated with certain chronic diseases such as cancer, cardiovascular disease, and diabetes.

The major source of health insurance coverage for older Americans is Medicare. Ensuring the fiscal integrity of the program is critical to continued access to care. Significant accomplishments in reducing the financial drain from fraud, waste, and abuse have been recorded. Still, we can do more to reduce improper payments, which in fiscal year 1999 were estimated at $13.5 billion.

In addition to Medicare, the Department addresses the access challenge through a variety of entitlement and safety net programs, such as Medicaid, the State Children's Health Insurance Program, and Community Health Centers, that provide access to health care for uninsured and low income individuals.

SUMMARY PERFORMANCE REPORT
HHS Strategic Goal 3

These are selected performance stories from the performance plans of the HHS operating and staff components that support key areas related to the achievement of this strategic goal. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan.

ACCESS TO PRIMARY HEALTH CARE SERVICES

Access For Minority, Low Income, and Uninsured Americans. HRSA's Health Centers and the National Health Service Corps form a cost-effective, integrated safety net for underserved and uninsured children, adults, migrant workers, homeless individuals, public housing and U.S./Mexico border residents in approximately 4000 communities across the country. In FY 2001 they will serve nearly 12 million persons who would otherwise lack access to primary care clinicians. These 12 million persons represent about 10 percent of the Nation's uninsured; 10 percent of its 33 million Medicaid recipients; and 20 percent of the 43 million underserved people in Federally designated areas lacking access to primary care providers.

Health Centers provide preventive services and risk reduction to a population that is largely minority and low income and disproportionately uninsured. There is mounting evidence that access to a usual and regular source of care can reduce and even eliminate health status disparities among subsets of the population, and Health Center patients are far more likely to have a usual and regular source of care than poor people of color in the Nation. The high quality primary health care received in HRSA's Health Centers has been shown to reduce hospitalizations and emergency room use, reduce annual Medicaid costs, and helps prevent more expensive chronic disease and disability for these populations. The most recent data indicates:

- In FY 1999 HRSA's Health Centers exceeded their goal of serving 8.9 million persons by 100,000. They substantially met their FY 1999 goals by serving 86 percent low income individuals, 64 percent minority individuals, and 41 percent uninsured individuals. About 75 percent of patients are either uninsured or on Medicaid.

- The National Health Service Corps (NHSC) met their FY 1999 goal of maintaining field strength at over 2500 clinicians, with a reduction of about 150 in FY 2000, and substantially met their goal of retaining NHSC clinicians in service to the underserved at 70.1 percent.

- In FY 1997, Health Center Medicaid patients were 22 percent less likely to be hospitalized for potentially avoidable conditions than Medicaid beneficiaries who obtain care elsewhere. Low rates of avoidable hospitalizations indicate access to appropriate ambulatory services and are a measure of the high quality of care delivered. Low rates also indicate fewer access barriers that cause patients to postpone needed services, delay

needed services, and fail to comply with treatment regimens. In part because of lower rates of hospitalization, reductions in Medicaid costs range from 30 to 34 percent. HRSA has set ambitious goals to reduce the rate of avoidable hospitalization further, and expect to have follow-up data available in April 2001.

- Monitoring performance in chronic disease management serves as a marker for the quality of care delivered at Health Centers and ultimately measure their ability to eliminate health disparities within the population served. Patients at Health Centers have rates of hypertension and diabetes that far exceed national prevalence rates for comparable racial/ethnic and socioeconomic groups. Yet, Health Center diabetics are three times as likely to have their glycohemoglobin tests performed at regular intervals (60 percent FY 1999) than the national norm, and hypertensives are more than three times as likely (90 percent FY 1995) to report that their blood pressure is under control. HRSA will repeat the User Survey in FY 2002, and has initiated a medical study which will yield information about hypertension control early in CY 2001.

- Breast and cervical cancer screening are effective measures for reducing future morbidity and mortality and are indicative of the ability of the Health Centers to reduce or eliminate disparities in early detection of disease. In FY 1995 female patients at Health Centers received age-appropriate breast and cervical cancer screening – 88.5 percent up-to-date Pap tests; 62.5 percent up-to-date mammograms; 80.5 percent up-to-date clinical breast exams – at rates exceeding the Healthy People 2010 goals. Data for FY 1999 are expected to be available in June 2001.

Working towards HHS' goal of eliminating health disparities, the Health Centers will report on performance measures focusing on chronic disease management, preventive care, and avoidable hospitalizations for low income, minority and uninsured individuals. FY 1999 data on these measures will be available in FY 2001.

Breast Exams and Pap Test for Low Income Women. The Title X Family Planning Program provides a broad range of preventive reproductive health services, including breast examinations and ap tests, to a population that is predominately low-income and who have less access to appropriate health screening and preventive services. Access to these services can help eliminate disparities in health and prevent breast and cervical cancers in women of reproductive age. Although all sexually active women are at risk for cervical cancer, the disease is more common among women of low socioeconomic status, those with a history of multiple partners or early onset of sexual intercourse, and smokers. In 1999, Title X clinics provided 2.9 million ap tests and 2.8 million breast examinations to family planning clients. The Program has added a FY 2002 goal to provide approximately 7 ap tests and over 6 breast exams for every 10 female family planning users. The Program is also developing goals that will monitor the number of abnormal tests and appropriate referrals for followup.

Access to Dental Services for American Indians and Alaskan Natives. Improving access and thus increasing utilization of dental services can also result in less costly care, improved oral health status, and quality of life. In FY 2000, 25.3 percent of the American Indian/Alaskan Native population received dental services, exceeding IHS' target of 23 percent. The approximately 18 percent vacancy rate for dental providers is the key determinant limiting access to care. A full time dental recruiter has been hired; many new

strategies to decrease vacancy rate are in the process of being implemented. These include recruitment visits to every U.S. dental school, a professionally designed and produced recruitment package, increased remuneration for incoming dentists, increased opportunities for loan repayment, and other strategies. The FY 2001 goal has been raised to 27 percent to reflect the FY 2000 accomplishment.

Syphilis Elimination. CDC collaborates with NIH, SAMHSA, HRSA, the National Institute of Justice, the Association of Public Health Laboratories, and the American Social Health Association to implement syphilis elimination efforts. This disease is currently at the lowest level ever reported. (2.5 per 100,000 in 1999 for primary and secondary syphilis). Nevertheless, syphilis is extremely concentrated geographically (half of all new cases are reported from only 25 of the 3,115 U.S. counties -- less than 1 percent of counties). Approximately 79 percent of U.S. counties have already eliminated syphilis and 91 percent of U.S. counties have a P&S syphilis rate of less than or equal to 4 per 100,000. Of those counties that have not eliminated syphilis, the largest numbers of cases of P&S syphilis were reported from 22 counties, and the three independent cities of Baltimore, MD, Danville, VA, and St. Louis, MO. These 25 areas account for half of the total number of P&S syphilis cases that were reported in the U.S. in 1999.

Syphilis remains one of the most glaring examples of racial disparities in health, with 1999 rates among African-Americans 30 times those among white Americans. This racial disparity (30:1) is extreme compared to most other health outcomes including AIDS (9:1), infant mortality (2.5:1), and deaths attributable to heart disease (1.5:1). Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to health care are often disproportionately affected by syphilis. These larger social issues often impact individual behavior, placing members of these communities at increased risk. Few programs in the U.S. have as great a potential to affect racial disparities in health as CDC's effort to eliminate domestic transmission of syphilis.

An example of a collaborative effort is the Community Health Outreach Education Services (CHORES) led by HRSA to develop a comprehensive health promotion, health education and disease prevention program for *use in primary care settings*. These collaborative efforts have resulted in the reduction of Primary and Secondary syphilis from 3.2/100,000 in 1997 to 2.2/100,000 in 2000. In addition, the percentage of syphilis free counties has increased from 75 percent in 1997 to 80 percent in 2000 and the number of counties responsible for 50 percent of new cases has reduced from 31 in 1997 to 22 in 2000.

Improving Access for American Indians and Alaskan Natives Through Facilities Construction. Construction of new health care facilities to replace old, inadequate facilities is the first step in improving access for underserved locations. Efficient space for health care delivery allows for more appointments and for patients to see more health care providers in one trip. Likewise, modern facilities help recruit and retain health care providers, which means more continuity of health care delivery. Once a facility has been completed, IHS has experienced an average increase of approximately 60 percent more patient visits than in the old facility. Facilities are selected through a priority ranking system determined by workload, age, isolation or alternatives to construction, and existing space data. IHS met its FY 2000 goal to continue construction of the replacement hospital in Fort Defiance, Arizona; start construction of the replacement hospital in Winnebago, Nebraska; continue construction of

the replacement health center in Parker, Arizona; design the new health center in Red Mesa, Arizona; design and start construction of the staff quarters to support the hospital in Zuni, New Mexico; and continue the design and construction of dental units.

ACCESS TO CARE FOR PERSONS WITH HIV/AIDS

Access to HIV Care. HRSA's HIV/AIDS Bureau is the focal point for the Federal response to the needs of persons living with HIV disease. The Bureau's programs provided HIV health care and related services to an estimated 500,000 persons in FY 2000. Goals for the six Ryan White CARE Act programs focus on increasing access to health care services and anti-retroviral therapy and reducing perinatal transmission. The programs have also established goals to serve women and minorities in proportions that exceed their representation in overall AIDS prevalence by a minimum of five percent. Despite the reduction seen in overall AIDS morbidity, the proportion of AIDS cases among women and minorities continue to increase, and the benefits provided by new combination drugs have not uniformly reduced the incidence of AIDS among minorities. The performance noted below reflects significantly increased efforts across all of the programs to target communities of color.

- Access to primary medical, dental, mental health, substance abuse, rehabilitative and home health care: The HIV Emergency Relief Grants (Title I) which provide the core response to metropolitan areas hardest hit by the AIDS epidemic and HIV Care Grants to States (Title II) have identical performance goals in increasing the number of health-care related visits and increasing the proportion of women and minorities served. Title I reported 2.73 million visits in FY 1999, 40,000 fewer than in FY 1998, and short of the target of 2.88 million visits. Title II reported 1.23 million visits in FY 1999, 220,000 fewer than in FY 1998, and but exceeding the target of 1.22 million visits. In March 1999 a new policy permitted the use of funds for necessary and appropriate diagnostic and laboratory tests, which increased the overall cost and complexity of care for each patient.

- In FY 1999, both programs exceeded their FY 1999 targets to serve women and minorities. Title I served 32 percent women and 68.9 percent minorities, exceeding targets of 30 percent and 64 percent, respectively. Title II served 31.2 percent women and 66.4 percent minorities, exceeding targets of 27 percent and 59 percent respectively.

- *Access to Primary Care*: In FY 1999, the Title III HIV Early Intervention program provided primary care services to 108,945 persons, exceeding its FY 1999 target by 20.5 percent. The FY 2000 goal has been set substantially higher, at 110,398 persons served. In addition, the program provided services to 73,456 minorities in FY 1999, exceeding its FY 1999 target to serve 60,000 minorities for the third year in a row.

- Access to Antiretroviral Therapy: In FY 2000 an average of 65,387 persons received anti-retroviral therapies each month through the AIDS Drug Assistance Program (ADAP), a slight increase over FY 1999, but the program did not meet its FY 2000 target of 71,900 served per month. However, the program's overall ability to provide medications to underserved populations increased as some States eliminated waiting lists for patients to participate in the program, increased the number of drugs available, set higher financial

eligibility criteria, reduced medical eligibility criteria and recovered increased savings through cost recovery strategies including the Section 340B Drug Discount Program.

- Access to Comprehensive Services for Women: In FY 1999, the Title IV Comprehensive Services to Women, Children and Families program continued to increase to 18,948 the number of women receiving comprehensive services, including appropriate services before, during or after pregnancy to reduce perinatal transmission if HIV, doubling the number of women enrolled over FY 1997.

Reduction in Perinatal Transmissions. CDC and the Title IV program share a goal to ensure that pregnant women have access to services to reduce perinatal transmission of HIV from mother to child. The number of pediatric AIDS cases as a result of perinatal transmission continues to decrease, demonstrating the effectiveness of the these perinatal HIV transmission reduction activities. The program reports a 27.2 percent decline in Pediatric AIDS cases as a result of mother-to-child HIV perinatal transmission from 235 in FY 1998 to 171 in FY 1999, continuing a 24.2 percent decline shown in FY 1998, and exceeding its FY 1999 target of 214 perinatal transmissions.

ACCESS TO MENTAL HEALTH SERVICES

Community Mental Health Services. SAMHSA's Community Mental Health Services Block Grant Program continues to work with 16 States to pilot a set of 32 key mental health indicators. CMHS is working with the States to reach closure on a final core data set for the Block Grant and to improve the number of States which can report data on the current indicators. The 16- State Pilot represents significant progress in pioneering the collection of uniform State mental health data and has produced significant data such as hospital utilization, hospital readmissions, community service program utilization, and important consumer survey information. However, considerable work remains in assisting States to improve data systems and adapt existing systems to report uniform data.

Comprehensive Community Mental Services for Children and Their Families. Results for SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families Program, a Targeted Capacity Expansion program, indicate that children in services for at least twelve months show significant improvements after one year:

- Inpatient treatment days decreased by 44 percent from baseline in 1998; this decrease has been maintained, and FY 2001 and FY 2002 targets have been increased accordingly.

- The baseline for regular school attendance was 70 percent in FY 1997. In FY 1998 following 12 months of services, regular school attendance had risen to 78.8 percent. In FY 1999, the figure was 88.9 percent, and in FY 00 it was 82 percent - all substantially above the baseline level and exceeding the annual targets.

- The FY 1997 baseline for children having more than one living arrangement after six months of service was 76 percent. After 12 months in this program, the FY 1998 figure was 23.7 percent. For FY 1999, the figure was 27 percent, and for FY 2000, 26 percent.

These data show that the program has been able to maintain these very substantial decreases from baseline. FY 2001 and FY 2002 targets have been increased accordingly.

Systems Integration. SAMHSA's Access to Community Care and Effective Services and Supports Program, a prototype Knowledge Development program, was established to identify promising approaches to systems integration and evaluate their effectiveness in providing services to persons who are homeless and seriously mentally ill. Initiated in 1993, the program will be completed and final reporting will occur in FY 2001. Results to date show major improvements in client outcomes at 12 months for four successive cohorts of clients. The percentage of clients stably housed was 6 to 7 percent at baseline. The number stably housed at 12 months increased by 528 to 600 percent. The number of days that clients used drugs decreased an average of 26 percent. Days in outpatient psychiatric services increased an average of 33 percent, a key measure for ensuring that these clients are obtaining needed services. The percent committing a minor crime decreased, with the decrease varying from a low of 42.9 to a high of 55.5 percent.

Information on Mental Health Treatment and Services. SAMHSA's Knowledge Exchange Network is an ongoing Knowledge Application program that provides information about mental health to users of services, their families, the general public, policy makers, providers, and researchers. Information requests increased to 52,252 in FY 2000, from a baseline of 10,324 in FY 1996. Publications distributed increased to 549,955 from a baseline of 53,952 in FY 1996. Web hits increased to 706,919, from a baseline of 11,108 in FY 1996. SAMHSA has developed a baseline and established FY 2001 and FY 2002 targets to increase the usefulness of the information provided by 10 percent.

MEDICARE PROGRAM INTEGRITY AND MANAGEMENT

Medicare Fee-For-Service Error Rate. A key Medicare program integrity goal of HCFA and the Department is to pay Medicare claims properly the first time. Paying right the first time reduces the resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. HCFA's FY 1999 performance of a 7.97 percent error rate more than achieved its FY 1999 target of a 9 percent error rate for Medicare fee-for-service payments. In FY 2000, performance of a 6.8 percent error rate met the target of 7 percent for FY 2000. Based on this successful performance, HCFA has developed increasingly rigorous targets for FY 2001 (6 percent) and FY 2002 (5 percent).

Improper Payment for Home Health Services. The partnership between HCFA and the HHS Office of Inspector General (OIG) to reduce Medicare errors and fraud has been critical to reestablishment financial integrity in that program. HCFA adopted a goal to reduce major payment errors for home health services specifically in response to an OIG review for the four States cited immediately below. For home health agencies in California, Illinois, New York and Texas, HCFA exceeded projected performance for FY 1999 and reduced the proportion of home health services for which improper payment was made from 40 percent to 19 percent, which is significantly lower than the FY 1999 target of 35 percent. HCFA staff anticipate that the more rigorous target of 10 percent in FY 2000 will be met as well.

Comprehensive Plan for Program Integrity. Instances like that identified by the OIG for home health services have contributed to HHS's commitment to a comprehensive approach to addressing program integrity for Medicare and Medicaid. In FY 2001, HCFA will expand measurement to 100 percent of the initiatives in its Comprehensive Plan for Program Integrity, and measure the effectiveness of each initiative based on successfully achieving at least 90 percent of the performance measures established for each of the ten initiatives in the Comprehensive Plan.

Electronic Commerce. Continually improving the efficiency of Medicare transactions is a fundamental management objective of HCFA and HHS. Increasing standardization and the percentage of transactions performed electronically will increase the efficiency of the Medicare contractors and save Medicare administrative dollars. Performance data indicate that HCFA continued to increase the rate of electronic media claims (EMC) overall, slightly exceeding its FY 2000 targets of maintaining a 97 percent EMC rate for fiscal intermediaries and 80 percent EMC rate for carriers. Performance showed a 97.4 percent EMC rate for fiscal intermediaries and an 80.9 percent EMC rate for carriers. HCFA seeks to maintain the targeted rates for both FY 2001 and 2002, and in FY 2001 will expand performance measurement to the following additional transactions: electronic coordination of benefits, electronic remittance advice, eligibility inquiries and response, and claims status inquiries and response as required by HIPAA.

Medicare Senior Patrols. AoA and HCFA have partnered with the Office of the Inspector General to combat fraud, waste and abuse through Medicare Senior Patrol program, formerly called Operation Restore Trust. During FY 2000, AoA and its grantees trained 25,600 volunteers to serve as Medicare and Medicaid educators in their communities, bring the total of trained volunteers to 39,300. During FY 2000, 1241 substantiated complaints which resulted in some action taken were generated through AoA's activities. This represented a dramatic increase over the FY 1999 baseline of 133 and the FY 2000 target of 200 substantiated complaints, because of a large number of new projects added during the year. The rate of increase in trained volunteers and substantiated cases is expected to be smaller in FY 2001 and 2002 since a large pool of trained volunteers exists and the number of existing projects will remain the same.

HHS 3.1: Increase the Percentage of the Nation's Children and Adults Who Have Health Insurance Coverage

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Improve access to care for elderly & disabled Medicare beneficiaries who do not have public or private supplemental insurance. *HCFA Plan*	FY 02: TBD FY 01: Exceed national enrollment growth rates collectively in areas under HCFA outreach and enrollment grant; Increase enrollment by 4 percentage points in States where FY 2000 target was not met FY 00: Increase enrollment by 4 percentage points nationally FY 99: Establish target	FY 02: FY 01: FY 00: Goal met, 5,499,349 dual eligible beneficiaries, a 4.4% enrollment increase FY 99: Goal met, target established *5,270,000 dual eligible beneficiaries FY 98: *5,167,000 dual eligible beneficiaries (baseline) *FY 98 & 99 data approximated based on trend of 2% increase per year

Performance Goals	Targets	Actual Performance
Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program. *HRSA Plan*	FY 02: 11.5 million FY 01: 10.5 FY 00: 9.6 FY 99: 8.9	FY 02: FY 01: FY 00: (8/01) FY 99: 9.0 million FY 98: 8.7 FY 97: 8.3
Increase the percent of children with special health care needs in the State program with a source of insurance for primary and specialty care. *HRSA Plan*	FY 02: 91% FY 01: 90%	FY 02: FY 01: FY 00: (1/02) FY 99: 87% FY 98: 85% FY 97: 83%
Ensure Compliance with HIPAA Requirements by increasing the percent of insurers which have had their policy forms reviewed in direct enforcement States. *HCFA Plan*	FY 02: 80% FY 01: 60% FY 00: 30% FY 99: New in 2000	FY 02: FY 01: FY 00: 30% FY 99: N/A FY 98: 0 (baseline)

HHS 3.2: Eliminate Disparities in Health Access and Outcomes

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Access to Care		
Assure access to preventive and primary care for minority individuals (racial minorities or of Hispanic origin) in the Health Centers. *HRSA Plan*	**HC NHSC** FY 02: 65% 7.48M 1.38M FY 01: 65% 6.83M 1.34M FY 00: 65% 6.24M 1.25M FY 99: 65% 5.79M 1.33M	FY 02: FY 01: FY 00:8/01 FY 99: 64%* (NHSC 4/01) FY 98: 64% * FY 97: 65%* * HC Only
Assure access to preventive and primary care for low income individuals (i.e., at or below 200 % of poverty) in the Health Centers. *HRSA Plan*	**HC NHSC** FY 02: 86% 9.89M 1.82M FY 01: 86% 9.03M 1.77M FY 00: 86% 8.26M 1.26M FY 99: 86% 7.65M 1.8M	FY 02: FY 01: FY 00: 8/01 FY 99: 86%*(NHSC 4/01) FY 98: 86% * FY 97: 86% * *HC only
Assure access to preventive and primary care for uninsured individuals in the Health Centers. *HRSA Plan*	**HC NHSC** FY 02: 46% 5.29M .98M FY 01: 45% 4.73M .93M FY 00: 43% 4.10M .83M FY 99: 42% 3.74M .86M	FY 02: FY 01: FY 00: 8/01 FY 99: 41% FY 98: 41%* FY 97: 39%* *HC only

Performance Goals	Targets	Actual Performance
Increase the number of children served by Title V, Maternal and Child Health Block Grant. *HRSA Plan*	FY 02: 24.5 million FY 01: 24	FY 02: FY 01: FY 00: 01/02 FY 99: 04/01 FY 98: 21.6 million FY 97: 20.2
Serve a proportion of women and racial/ethnic minorities with HIV/AIDS in Title I-funded programs that exceed their representation in national AIDS prevalence data, as reported by the CDC, by a minimum five percent (e.g., if 15 percent of current overall AIDS cases area among women, serve 20 percent women in Title I programs). *HRSA Plan*	Women FY 02: 33% FY 01: 32% FY 00: 30% FY 99: 30% Minorities FY 02: 70% FY 01: 69% FY 00: 64% FY 99: 64%	Women FY 02: FY 01: FY 00: (1/02) FY 99: 32% FY 98: 30.7% FY 97: 30.3% FY 96: 30.7% Minorities FY 02: FY 01: FY 00: (1/02) FY 99: 68.9% FY 98: 67.7% FY 97: 67.8% FY 96: 66.5%

Performance Goals	Targets	Actual Performance
Serve women and racial and ethnic minorities with HIV/AIDS in Title I and II-funded programs in proportions that exceed their representation in overall AIDS prevalence by a minimum five percentage points (i.e., 16 percent of current overall AIDS cases are among women, 56% are minorities). *HRSA Plan*	**HIV Emergency Relief Grants** FY 02: 33% women FY 01: 33% FY 00: 30% FY 99: 30%	 FY 02: FY 01: FY 00: 1/02 FY 99: 32% FY 98: 30.7% FY 97: 30.3% FY 96: 30.7%
	FY 02: 70% minorities FY 01: 69% FY 00: 64% FY 99: 64%	FY 02: FY 01: FY 00: 1/02 FY 99: 68.9% FY 98: 67.7% FY 97: 67.8% FY 96: 66.5%
	HIV Care Grants to States	
	FY 02: 33% women FY 01: 33% FY 00: 27% FY 99: 27%	FY 02: FY 01: FY 00: 1/02 FY 99: 31.2% FY 98: 29.4% FY 97: 30.3% FY 96: 26.3%
	FY 02: 68% minorities FY 01: 68% FY 00: 59% FY 99: 59%	FY 02: FY 01: FY 00: 1/02 FY 99: 66.4% FY 98: 64.1% FY 97: 63.1% FY 96: 59.9%

Performance Goals	Targets	Actual Performance
Improve American Indian and Alaskan Native consumer satisfaction with the acceptability and accessibility of health care as measured by IHS consumer satisfaction survey. *IHS Plan*	FY 02: secure baseline FY 01:secure OMB clearance FY 00: OMB clearance and establish baseline FY 99: develop instrument and protocol	FY 02: FY 01: FY 00: submitted but clearance not completed FY 99: Completed
Increase access for minorities and persons with disabilities to nondiscriminatory services in managed care settings (managed care plans' compliance with Title VI, Section 504 and the Americans with Disabilities Act). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 89 FY 01: 87	FY 02: FY 01: FY 00: 85 (baseline)
Increase access to HHS services for limited English proficient (LEP) persons (compliance with Title VI by recipients of Federal financial assistance). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 423 FY 01: 413	FY 02: FY 01: FY 00: 403 (baseline)
Increase nondiscriminatory, quality health care for minorities. Measure: Increased number of providers complying with Title VI and the number of stakeholders working coalitions. *OCR Plan*	FY 02: 01/02 FY 01: Setting baseline	FY 02 FY 01: FY 00: New in FY 2001
Health Outcomes		
Decrease the ratio of the black infant mortality rate to the white infant mortality rate. *HRSA Plan*	FY 02: 2.1 to 1 FY 01: 2.1 to 1	FY 02: FY 01: FY 00: 9/02 FY 99: 9/01 FY 98: 2.4 to 1 FY 97: 2.3 to 1 FY 96: 2.4 to 1 FY 95: 2.4 to 1

Performance Goals	Targets	Actual Performance
Decrease proportion of Health Center users who are hospitalized for potentially avoidable conditions. *HRSA Plan* Health Centers serve a population that is: 65% minority, 86% low income, 41% uninsured	FY 02: 12.5/1000 FY 01: 13 FY 00: 13.5 FY 99: 14	FY 02: FY 01: FY 00: 4/03 FY 99: 4/02 FY 98: 4/01 FY 97: 14.7/1000 **Norm:** 18.9/1000
Increase proportion of Health Center women receiving age-appropriate screening for cervical and breast cancer. *HRSA Plan* Health Centers serve a population that is: 65% minority, 86% low income, 41% uninsured	**Up-to-date Pap Tests** FY 02: 95% FY 01: 94% FY 00: 92% FY 99: 90% **Up-to-date Mammograms** FY 02: 75% FY 01: 70% FY 00: 67.5% FY 99: 65% **Up-to-date Clinical Breast** FY 02: 86% FY 01: 85.5% FY 00: 84% FY 99: 82.5%	 FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 88.5% FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 62.5% FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 80.5%

Performance Goals	Targets	Actual Performance
Ensure women receive screening for cervical and breast cancer in Family Planning clinics. *HRSA Plan* These clinics serve a population that is approximately 40% minority and nearly two-thirds have incomes below 100% of the poverty level and 89% have incomes below 200% of poverty level.	**Pap tests** FY 02: 3 million **Breast Exams** FY 02: 3 million	**Pap tests** FY 02: FY 01: FY 00: 11/01 FY 99: 2.970 million FY 98: 2.937 FY 97: 3.130 **Breast Exams** FY 02: FY 01: FY 00: 11/01 FY 99: 2.812 million FY 98: 2774 FY 97: 2.961
Increase percent of Health Center users with diabetes with up-to-date testing of glycohemoglobin – % adults with diabetes tested at recommend intervals. *HRSA Plan*	FY 02: 90% FY 01: 90% FY 00: 80% FY 99: 60%	FY 02: FY 01: FY 00: 3/01 FY 99: 60% FY 98: 43% **Norm**: 20%
Increase proportion of Health Center adults with hypertension who report their blood pressure is under control. *HRSA Plan* Health Centers serve a population that is: 65% minority, 86% low income, 41% uninsured	FY 02: 96% FY 01: 96% FY 00: 93% FY 99: 92%	FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 90%
Increase by 5% per year the number of minority organ donors nationally. *HRSA Plan*	FY 02: 1,578 FY 01: 1,503 FY 00: 1,638 FY 99: N/A	FY 02: 5/03 FY 01: 5/02 FY 00: 5/01 FY 99: 1,344 FY 98: 1,375
Increase by 10% the number of unrelated minority bone marrow donors (national registry of potential donors) over previous year totals. *HRSA Plan*	FY 02: 1.18M donors FY 01: 1.07 M FY 00: 1.00 M FY 99: .90M	FY 02: FY 01: 10/01 FY 00: 1.05M FY 99: .92M FY 98: .8M FY 96: 526,000

Performance Goals	Targets	Actual Performance
As part of a larger goal to eliminate syphilis in the U.S., CDC will reduce the racial disparity in syphilis. *CDC Plan*	FY 02: -15% to 17.8%. FY 01: -15% to 20.9% FY 00: -15% to 24.6% FY 99: -15% to 28.9%	FY 02: FY 01: FY 00: 4/02 FY 99: 4/01 FY 98:34.2%
Collect and establish baseline and comparison data for all OPHS Plan Priority Area 3 goals, including relevant racial and ethnic subgroups for which no data are currently available. *OPHS Plan*	FY 02: 11 of 11 FY 01: 11 of 11 FY 00: 11 of 12 FY 99: 9 of 12	FY 02: FY 01: FY 00: 6 of 11 FY 99: 5 of 11 FY 98: 5 of 11
CDC will fund selected communities to implement interventions based on community planning activities to eliminate racial and ethnic health disparities for the following focus areas: breast and cervical cancer screening and management, cardiovascular disease, diabetes, child and/or adult immunizations, HIV/AIDS, and infant mortality. *CDC Plan*	FY 02: Provide continuation funding to Phase II grantees. Announce the availability of funding for new intervention phase coalitions. FY 01: Provide continuation funding to Phase II grantees. Announce the availability of funding for new intervention phase coalitions. FY 00: Fund selected communities to implement interventions (Phase II) based on community planning activities. Fund an additional 4-6 Phase I grantees. FY 99: Develop a community planning RFA and fund a community to conduct planning activities (Phase I).	FY 02: FY 01: FY 00: 14 coalitions funded for Phase I. 25 coalitions funded for Phase II. FY 99: 32 coalitions funded for Phase I.

See also:

Objective 3.6, Improve the Health Status of American Indians and Alaskan Natives

HHS 3.3: Increase the Availability of Primary Health Care Services for Underserved Populations

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Access to Care		
Assure access to preventive and primary care for low income individuals (i.e., at or below 200 % of poverty) in the Health Centers. *HRSA Plan*	**HC NHSC** FY 02: 86% 9.89M 1.82M FY 01: 86% 9.03M 1.77M FY 00: 86% 8.26M 1.65M FY 99: 86% 7.65M 1.8M	FY 02: FY 01: FY 00: 8/01 FY 99: 86%* (NHSC 4/01) FY 98: 86%* FY 97: 86%* *HC only
Assure access to preventive and primary care for minority individuals (racial minorities or of Hispanic origin) in the Health Centers. *HRSA Plan*	**HC NHSC** FY 02: 65% 7.48M 1.38M FY 01: 65% 6.83M 1.34M FY 00: 65% 6.24M 1.25M FY 99: 65% 5.79M 1.33M	FY 02: FY 01: FY 00: 8/01 FY 99: 64%* NHSC 4/01 FY 98: 64%* FY 97: 65%* *HC only
Assure access to preventive and primary care for uninsured individuals in the Health Centers. *HRSA Plan*	**HC** **NHSC** FY 02: 46% 5.29M .98M FY 01: 45% 4.73M .93M FY 00: 43% 4.10M .83M FY 99: 42% 3.74M .86M	FY 02: FY 01: FY 00:8/01 FY 99: 41% (NHSC 4/01) FY 98: 41%* FY 97: 39%* *HC only

Performance Goals	Targets	Actual Performance
Increase the field strength of the National Health Service Corps through scholarships and loan repayment agreements. *HRSA Plan*	**Field** **Users** FY 02: 2,468 2.12M FY 01: 2,380 2.06M FY 00: 2,697 2.30M FY 99: 2,526 2.05M	FY 02: FY 01: 12/01 FY 00: 2,376 FY 99: 2,526 FY 98: 2,439 2.0M
Increase the percent of NHSC clinicians retained in service to the underserved. *HRSA Plan*	FY 02: 76% FY 01: 75% FY 00: 74% FY 99: 72%	FY 02: FY 01: FY 00: 4/01 FY 99: 70.1% FY 98: 70.9%
Increase the number of people receiving HIV primary care services under Early Intervention Services programs. *HRSA Plan*	FY 02: 117,000 clients FY 01: 117,000 FY 00: 110.000 FY 99: 90,433	FY 02: FY 01: FY 00: (1/02) FY 99: 108,945 FY 98: 96,451
Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) in Title I and II programs to a level that approximates inclusion of new clients. *HRSA Plan*	**HIV Emergency Relief Grants** FY 02: 3.05 million visits FY 01: 3.05 FY 00: 2.92 FY 99: 2.88 **HIV Care Grants to States** FY 02: 1.45 million visits FY 01: 1.45 FY 00: 1.53 FY 99: 1.22	FY 02: FY 01: FY 00: 1/02 FY 99: 2.73 million visits FY 98: 2.79 FY 97: 2.77 FY 96 : 2.67 FY 02: FY 01: FY 00: 1/02 FY 99: 1.23 million visits FY 98: 1.45 FY 97: 1.07

Performance Goals	Targets	Actual Performance
Reduce the percentage of enrolled women who receive late or no prenatal care. *HRSA Plan*	FY 02: 9.75% FY 01: 10.75%	FY 02: FY 01: FY 00: 5/01 FY 99: 11.1% FY 98: 17.2%
Increase annual access to dental services for the American Indian and Alaskan Native population. *IHS Plan*	FY 02: 1% > FY 01 FY 01: 29% FY 00: 27% FY 99: 21%	FY 02: FY 01: FY 00: 25.1% FY 99: 25.1% FY 98: 24.5% FY 97: 22.0%
Increase the number of children served by Title V, Maternal and Child Health Block Grant. *HRSA Plan*	FY 02: 24.5 million FY 01: 24	FY 02: FY 01: FY 00: 01/02 FY 99: 2.30 million FY 98: 21.6 FY 97: 20.2
Increase the percentage of Head Start children who receive necessary medical treatment. *ACF Plan*	FY 02: 94% FY 01: 92% FY 00: 90% FY 99: 88%	FY 02: FY 01: FY 00: 88% FY 99: 87% FY 98: 88%
Increase the number of health care providers trained to meet the health needs of people with developmental disabilities. *ACF Plan*	FY 02: 5,200 FY 01: 5,000 FY 00: 4,825 FY 99: 4,000	FY 02: FY 01: FY 00: 1/02 FY 99: 4,100 FY 98: 3,733
Develop and operate collaborative models of health care services in rural areas which will serve underserved populations. *HRSA Plan*	**Persons Served Per Year** FY 02: 764,000 FY 01: 764,000 FY 00: 764,000 FY 99: 680,000 FY 98: 616,000	FY 02: FY 01: FY 00: 760,000 FY 99: 681,000 FY 98: 630,000

Performance Goals	Targets	Actual Performance
Increase access for minorities and persons with disabilities to nondiscriminatory services in managed care settings (managed care plans' compliance with Title VI, Section 504 and the Americans with Disabilities Act). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 89 FY 01: 87	FY 02: FY 01: FY 00: 85 (baseline)
Increase access to HHS services for limited English proficient (LEP) persons (compliance with Title VI by recipients of Federal financial assistance). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 423 FY 01: 413	FY 02: FY 01: FY 00: 403 (baseline)
Health Outcomes		
Decrease proportion of Health Center users who are hospitalized for potentially avoidable conditions. *HRSA Plan* Health Centers serve a population that is: 65% minority, 86% low income, 41% uninsured	FY 02: 12.5/1000 FY 01: 13 FY 00: 13.5 FY 99: 14	FY 02: FY 01: FY 00: 4/03 FY 99: 4/02 FY 98: 4/01 FY 97: 14.7/1000 **Norm:** 18.9/1000

Performance Goals	Targets	Actual Performance
Increase proportion of Health Center women receiving age-appropriate screening for cervical and breast cancer. *HRSA Plan*	**Up-to-date Pap Tests** FY 02: 95% FY 01: 94% FY 00: 92% FY 99: 90% **Up-to-date Mammograms** FY 02: 75% FY 01: 70% FY 00: 67.5% FY 99: 65% **Up-to-date Clinical Breast** FY 02: 86% FY 01: 85.5% FY 00: 84% FY 99: 82.5%	FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 88.5% FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 62.5% FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 80.5%
Ensure women receive screening for cervical and breast cancer in Family Planning clinics. *HRSA Plan* These clinics serve a population that is approximately 40% minority and nearly two-thirds have incomes below 100% of the poverty level and 89% have incomes below 200% of poverty level.	**Pap tests** FY 02: 3 million **Breast Exams** FY 02: 3 million	**Pap tests** FY 02: FY 01: FY 00: 11/01 FY 99: 2.970 million FY 98: 2.937 FY 97: 3.130 **Breast Exams** FY 02: FY 01: FY 00: 11/01 FY 99: 2.812 million FY 98: 2.774 FY 97: 2.961
Increase percent of Health Center users with diabetes with up-to-date testing of glycohemoglobin – % adults with diabetes tested at recommend intervals. *HRSA Plan*	FY 02: 90% FY 01: 90% FY 00: 80% FY 99: 60%	FY 02: FY 01: FY 00: 3/01 FY 99: 60% FY 98: 43% **Norm**: 20%

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicare beneficiaries aged 65 and older who receive a mammogram every two years. *HCFA Plan*	FY 01: Switched to new data source (see below) FY 00: 60% FY 99: 59% FY 02: 52% FY 01: 51% FY 00: N/A	FY 01: N/A FY 00: Summer 2002 FY 99: Summer 2001 FY 98: 63.8% FY 94: 55% (NHIS) 01-02: 8/03 00-01: 8/02 99-00: 8/01 (Interim) 98-99: 49% 97-98: 45% (MCBS)
Increase the percentage of Medicare beneficiaries age 65 years and older who receive vaccinations. Increase rate of annual influenza (flu) vaccination. (NHIS) Increase annual influenza (flu) and lifetime pneumococcal vaccinations. (MCBS) -- Flu/Pneumococcal *HCFA Plan*	FY 01: Switched to new data source. (see below) FY 00: 60% FY 99: 59% FY 02: 73%/65% FY 01: 72%/63% FY 00: Not Applicable	FY 00: Summer 2002 FY 99: Summer 2001 FY 98: 64% FY 97: 63% FY 95: 58% FY 94: 55% (NHIS) FY 02: 12/03 FY 01: 12/02 FY 00: 12/01 (Interim) FY 99: 69.1%/61.2% (interim) FY 98: 68.5%/56.1% FY 97: 67.1%/50.9% FY 96: 65%/44.1% FY 95: 61%/34.6% FY 94: 59%/24.6%

Performance Goals	Targets	Actual Performance
The rate of vaccination among persons >65 years will be increased for influenza and pneumococcal pneumonia. *CDC Plan*	**Influenza** FY 02: 74% FY 01: 72% FY 00: 70% FY 99: 60% **Pneumococcal Pneumonia** FY 02: 66% FY 01: 63% FY 00: 60% FY 99: 54%	 FY 02: FY 01: FY 00: 09/02 FY 99: 09/01 FY 98: 63% FY 97: 63% FY 95: 58% FY 02: FY 01: FY 00: 09/02 FY 99: 90/01 FY 98: 46% FY 97: 42% FY 95: 34%
Increase proportion of Health Center adults with hypertension who report their blood pressure is under control. *HRSA Plan*	FY 02: 96% FY 01: 96% FY 00: 93% FY 99: 92%	FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 90%
Continue to assure that priority is given to furnishing family planning services to persons from low-income* families. *HRSA Plan* *Incomes at or below 200 percent of the Federal poverty level	**Low Income Users** / **Total Users** FY 02: 90% / 4.792 milion FY 01: / 4.792 FY 00: / 5.25 FY 99: / 5.00	 FY 02: FY 01: FY 00: 11/01 FY 99: 90% 4.442 FY 98: 89% 4.408 FY 97: 90% 4.477 FY 96: 90% 4.562
Decrease the percentage of low birth weight babies born to Healthy Start clients. HRSA *Plan*	FY 02: 11% FY 01: 11.4%	FY 02: FY 01: FY 00: 5/01 FY 99: 11.58% FY 98: 12.06%

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicaid two-year old children who are fully immunized. (To be achieved in 3 phases for State groupings.)		
– Group 1 States (Set State-specific methodology and baseline: 1999-2000; first report: 2001)	FY 02: Second Report FY 01: First Report FY 00: Set State-specific methodology and baseline FY 99: Not Applicable	FY 02: FY 01: FY 00: 13 Group I States developed State-specific methodology, targets and measured baselines. 3 States will complete these efforts in FY 2001 FY 99: Identified Group I States. Began developing State-specific methodology and baselines
– Group 2 States (Set State-specific methodology and baseline: 2000-2001; first report: 2002)	FY 02: First Report FY 01: Set baseline FY 00: Begin State-specific methodology and baseline activities	FY 02: FY 01: FY 00: Identified Group II States. Began developing State-specific methodology and baselines
– Group 3 States (Set State-specific methodology and baseline: 2001-2002; first report: 2003)	FY 02: Set baseline FY 01: Begin State-specific methodology and baseline activities FY 00: N/A	FY 02: FY 01: FY 00: N/A FY 99: N/A
HCFA Plan		

Performance Goals	Targets	Actual Performance
Achieve or sustain the following immunization coverage of at least 90% among children 19- to 35-months of age for each vaccine: *CDC Plan* 1. 4 doses of Diphtheria-Tetanus-Pertussis containing vaccine 2. 3 doses of *Haemophilus influenzae* type b vaccine 3. 1 dose of Measles-Mumps-Rubella vaccine* 4. 3 doses of Hepatitis B vaccine 5. 3 doses of Polio vaccine 6. 1 dose of Varicella vaccine* 7. 4 doses of Pneumococcal Conjugate vaccine* **Performance targets for newly recommended vaccines will begin 5 years after the ACIP recommendation. The varicella measure will begin in 2001, even though coverage is being reported earlier. The pneumococcal conjugate measure will begin in 2006, even though coverage will be reported earlier.	FY 02: 90% FY 01: 90% FY 00: 90% FY 99: 90%	FY 02: FY 01: 8/02 FY 00: Provisional data. Final 08/01 1. 83% 2. 94% 3. 91% 4. 90% 5. 90% 6. 63%* FY 99: 1. 83% 2. 94% 3. 92% 4. 88% 5. 90% 6. 58%* FY 98: 1. 84% 2. 93% 3. 92% 4. 87% 5. 91% 6. 43%*

See also:

Objective 3.6, Improve the Health Status of American Indians and Alaskan Natives

HHS 3.4: Protect and Improve the Health and Satisfaction of Beneficiaries in Medicare and Medicaid

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicare beneficiaries age 65 years and older who receive vaccinations.		
Increase rate of annual influenza (flu) vaccination. (NHIS)	FY 01: Switched to new data source. (see below) FY 00: 60% FY 99: 59%	FY 00: Summer 2002 FY 99: Summer 2001 FY 98: 64% FY 97: 63% FY 95: 58% FY 94: 55% (NHIS)
Increase annual influenza (flu) and lifetime pneumococcal vaccinations. (MCBS) -- Flu/Pneumococcal	FY 02: 73%/65% FY 01: 72%/63% FY 00: Not Applicable	FY 02: 12/03 FY 01: 12/02 FY 00: 12/01 (Interim) FY 99: 69.1%/61.2% (interim*) FY 98: 68.5%/56.1%* FY 97: 67.1%/50.9%* FY 96: 65%/44.1% FY 95: 61%/34.6% FY 94: 59%/24.6% * includes community dwelling beneficiaries only
HCFA Plan		

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicaid two-year old children who are fully immunized. (To be achieved in 3 phases for State groupings.)		
– Group 1 States (Set State-specific methodology and baseline: 1999-2000; first report: 2001)	FY 02: Second Report FY 01: First Report FY 00: Set State-specific methodology and baseline FY 99: Not Applicable	FY 02: FY 01: FY 00: 13 Group I States developed State-specific methodology, targets and measured baselines. 3 States will complete these efforts in FY 2001 FY 99: Identified Group I States. Began developing State-specific methodology and baselines
– Group 2 States (Set State-specific methodology and baseline: 2000-2001; first report: 2002)	FY 02: First Report FY 01: Set baseline FY 00: Begin State-specific methodology and baseline activities	FY 02: FY 01: FY 00: Identified Group II States. Began developing State-specific methodology and baselines
– Group 3 States (Set State-specific methodology and baseline: 2001-2002; first report: 2003) *HCFA Plan*	FY 02: Set baseline FY 01: Begin State-specific methodology and baseline activities FY 00: N/A	FY 02: FY 01: FY 00: N/A FY 99: N/A
Improve the rate of biennial diabetic eye exams. *HCFA Plan*	FY 02: 69.5% FY 01: 69.0% FY 00: New in 2001	00-02: 12/02 99-01: 12/01 98-00: 3/01 (Interim) 97-99: 68.5%

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicare Beneficiaries Age 65 and over who receive a mammogram every two years. *HCFA Plan*	FY 01: Switched to new data source (see below) FY 00: 60% FY 99: 59% FY 02: 52% FY 01: 51% FY 00: N/A	FY 01: N/A FY 00: Summer 2002 FY 99: Summer 2001 FY 98: 63.8% FY 94: 55% (NHIS) 01-02: 8/03 00-01: 8/02 99-00: 8/01 (Interim) 98-99: 49% 97-98: 45% (MCBS)
Decrease one-year mortality among Medicare beneficiaries hospitalized for heart attack. *HCFA Plan*	FY 02: 27.4% FY 01: 27.4% FY 00: 27.4% FY 99: New in FY 00	01-02: 6/04 00-01: 6/03 99-00: 6/02 98-99: 6/01 (Interim) 97-98: 31.7% 96-97: 31.1% 95-96: 31.2%*(Baseline) (*revised from 31.4)
Increase access for minorities and persons with disabilities to nondiscriminatory services in managed care settings (managed care plans' compliance with Title VI, Section 504 and the Americans with Disabilities Act). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 89 FY 01: 87	FY 02: FY 01: FY 00: 85 (baseline)
Increase access to HHS services for limited English proficient (LEP) persons (compliance with Title VI by recipients of Federal financial assistance). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 423 FY 01: 413	FY 02: FY 01: FY 00: 403 (baseline)

See also:

- Objective 4.2, Increase Consumer and Patient use of Health Care Quality Information

- Objective 4.3, improve Consumer and Patient Protection

HHS 3.5: Enhance the Fiscal Integrity of HCFA Programs and Purchase the Best Value Health Care for Beneficiaries

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Reduce the error rate for all Medicare fee-for-service payments. *HCFA Plan*	FY 02: 5.0% FY 01: 6.0% FY 00: 7.0% FY 99: 9.0%	FY 02: FY 01: FY 00: 6.8% FY 99: 7.97% FY 98: 7.1% FY 97: 11.0% FY 96: 14.0%
Decrease improper payment rate for home health services. *HCFA Plan*	FY 01: Goal discontinued FY 00: 10% FY 99: 35%	FY 01: FY 00: CY 2001 FY 99: 19% 1995-1996: 40% **(Baseline)**
Increase the number of volunteers trained by AoA grantees under the Senior Medicare Patrol Projects to educate beneficiaries to protect their health care benefits. *AoA Plan*	FY 02: 100% FY 01: 100% FY 00: 125% FY 99: NA	FY 02: 2/03 FY 01: 2/02 FY 00: 187% FY 99: 13,700
Increase the number of substantiated complaints generated through AoA's Senior Medicare Patrol activities. *AoA Plan*	FY 02: 75% FY 01: 60% FY 00: 200 FY 99: NA	FY 02: 2/03 FY 01: 2/02 FY 00: 1241 FY 99: 133

Performance Goals	Targets	Actual Performance
Increase Medicare Secondary Payer (MSP) dollar recoveries and/or decrease recovery time via the Medicare Credit Balance Report (HCFA-838). *HCFA Plan*	FY 02: Develop improved processes and controls to be utilized by contractors to ensure consistency and timely recoveries. FY 01: Gather information on 1) provider credit balance identification, submission and resolution processes; and 2) contractor monitoring and resolution of credit balances reported by providers. FY 00: New in FY 01	FY 02: FY 01: FY 00: N/A

HHS 3.6: Improve the Health Status of American Indians and Alaska Natives

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase the proportion of I/T/U clients with diagnosed diabetes that have improved their glycemic control. *IHS Plan*	**Ideal Glycemic Control** FY 02: 3-year average improved FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 25% **Good Glycemic Control** FY 99: 38%	 FY 02: FY 01: FY 00: 7/01 FY 97-99: 24% FY 99: 25% FY 99: 35 % FY 98: 35%
Increase the proportion of I/T/U clients with diagnosed diabetes and hypertension that have achieved diabetic blood pressure control standards. *IHS Plan*	**Ideal Hypertension Control** FY 02: 3-year average improved FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 41%	 FY 02: FY 01: FY 00: 7/01 FY 97-99: 37% FY 99: 36% FY 98: 38%
Increase the proportion of the American Indian and Alaskan Native female population over 40 years of age who receive screening mammography. *IHS Plan*	FY 02: 2% over FY 01 FY 01: 3% over FY 00 FY 00: 3% over FY 99 FY 99: establish baseline	FY 02: FY 01: FY 00: 14.7% past two years; provisional FY 99: baseline not adequate
Increase the proportion of American Indian and Alaskan Native (AI/AN) women who receive Pap screening. *IHS Plan*	**Pap Screening** FY 02: 2% over FY 01 FY 01: 3% over FY 00 FY 00: 3% over FY 99 FY 99: establish baseline **Cervical Cancer** FY 99: determine incidence	 FY 02: FY 01: FY 00:11.9% past year 17.9% past 3 years provisional data FY 99: baseline not adequate FY 99: 8-10/100,000 based on 40% of AI/AN

Performance Goals	Targets	Actual Performance
Increase the proportion of American Indian and Alaskan Native children receiving a minimum of four Well Child Visits by 27 months of age and expand coverage. *IHS Plan*	FY 02: 2% over FY 01 FY 01: 2% over FY 00 FY 00: 2% over FY 99 FY 99: establish baseline	FY 02: FY 01: FY 00: 47.7% (9.2% over FY 99) provisional FY 99: 38.5%
Increase the number of public health nursing services (primary and secondary treatment and preventive services) provided to infants and elders. *IHS Plan*	**Total Visits** FY 02: 2% > FY 01 FY 01: 3% > FY 00 FY 00: 7% > FY 97 or 363,033 **Home Visits** FY 02: 2% > FY 01 FY 01: 3% > FY 00 FY 00: 7% > FY 97 or127,846	FY:02: FY 01: FY 00: 371,548 (+9.5%) * FY 99: 336,134 FY 97: 339,283 FY 02: FY 01: FY 00: 127,873 (+7%) * FY 99: 111,836 FY 97: 119,482 *provisional data
Increase the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth. *IHS Plan*	**6-8 Years** FY 02: 1% over FY 00 FY 01: 3% over FY 00 FY 00: 3% over FY 99 FY 99: 50% (36.1% based on recalculated FY 91 baseline) **14-15 Years** FY 02: 1% over FY 01 FY 01: 3% over FY 00 FY 00: 3% over FY 99 FY 99: 59% (58% based on recalculated FY 91 baseline)	FY 02: FY 01: FY 00: 44.1% (+ 4.5%) * FY 99: 39.6% FY 91: 40.1% corrected baseline FY 02: FY 01: FY 00: 49.1% (-15.9%) * FY 99: 65.0% FY 91: 66.5% corrected baseline *Provisional data
Increase the proportion of American Indian and Alaskan Native children who have completed all recommended immunizations by the age two. *IHS Plan*	FY 02: 1% over FY 01 FY 01: 1% over FY 00 FY 00: 2% over FY 99 FY 99: 91%	FY 01: FY 00: 86% 12/12 Areas (-3%) FY 99: 89% 12/12 Areas 87% 11/12 Areas FY 98: 88% 11/12 Areas

Performance Goals	Targets	Actual Performance
Increase overall pneumococcal and influenza vaccination levels among diabetics and adults aged 65 years and older. *IHS Plan*	**Influenza** FY 02: 1% over FY 01 FY 01: 1% over FY 00 FY 00: 65% **Pneumococcal** FY 02: 1% over FY 01 FY 01: secure electronic baseline FY 00: 65%	FY 02: FY 01: FY 00:30.7% (new baseline from automated process) FY 98: 63% (baseline from diabetes audit) FY 02: FY 01: FY00: data source inadequate FY 98: 63% (baseline from diabetes audit)
Maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-interventioncomparison sites, as part of an overall assessment of the ongoing childhood obesity prevention project's effectiveness. *IHS Plan*	FY 02: continue implementation and access community acceptance FY 01: implement program and monitor pilots and comparisons sites FY 00: develop five pilot sites FY 99: develop approach and baselines	FY 01: FY 00: pilot sites established FY 99: accomplished
Increase the number of home-delivered meals provided to elderly Native Americans. (Numbers in thousands) *AoA Plan*	FY 02: 1,850 FY 01: 1,795 FY 00: 1,632 FY 99: 1,456	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 1,698 FY 98: 1,624 FY 97: 1,525 FY 96: 1,400
Increase the number of congregate meals provided to elderly Native Americans. (Numbers in thousands) *AoA Plan*	FY 02: 1,650 FY 01: 1,583 FY 00: 1,439 FY 99: 1,322	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 1,327 FY 98: 1,354 FY 97: 1,386 FY 96: 1,313
Maintain the number of in-home services provided to elderly Native Americans. (Numbers in thousands) *AoA Plan*	FY 02: 953 FY 01: 953 FY 00: 866 FY 99: 742	FY 02: 2/04 FY 01: 2/03 FY 00: 2/02 FY 99: 944 FY 98: 1,032 FY 97: 882 FY 96: 507

Performance Goals	Targets	Actual Performance
CDC will support American Indian and Alaskan Native organizations to address health priorities, gaps in prevention, and service delivery interventions for their proposed communities. *CDC Plan*	FY 02: 5 organizations FY 01: 5 organizations	FY 02: FY 01:08/01 FY 99: 0

See also:

- Objective 3.2, Eliminate Disparities in Health Access and Outcomes
- Objective 3.3, Increase the Availability of Primary Health Care Services for Underserved Populations
- Objective 4.1, Enhance the Appropriate Use of Effective Health Services

HHS 3.7: Increase the Availability and Effectiveness of Services for the Treatment and Management of HIV/AIDS

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) in Title I and II programs to a level that approximates inclusion of new clients. *HRSA Plan*	**HIV Emergency Relief Grants** FY 02: 3.05 million FY 01: 3.05 FY 00: 2.92 FY 99: 2.88 **HIV Care Grants to States** FY 02: 1.45 million visits FY 01: 1.45 FY 00: 1.53 FY 99: 1.22	 FY 02: FY 01: FY 00: 1/02 FY 99: 2.73 million FY 98: 2.79 FY 97: 2.77 FY 96 : 2.67 FY 02: FY 01: FY 00: FY 99: 1.23 million visits FY 98: 1.45 FY 97: 1.07
Increase the number of AIDS Drug Assistance Programs (ADAP) clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year. *HRSA Plan*	FY 02: 72,000 clients FY 01: 72,000 FY 00: 71,000	FY 02: FY 01:(11/01) FY 00: 65,387 FY 99: 64,500 FY 98: 55,000
Increase the number of people receiving HIV primary care services under Early Intervention Services programs. *HRSA Plan*	FY 02: 117,000 clients FY 01: 117,000 FY 00: 110,000 FY 99: 90,433	FY 02: FY 01: FY 00: (1/02) FY 99: 108,945 FY 98: 105,398 FY 97: 96,451

Performance Goals	Targets	Actual Performance
Increase number of female clients with HIV/AIDS provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission of HIV. *HRSA Plan*	FY 02: 21,884 females FY 01: 21,884 FY 00: 14,470 FY 99: 13,900	FY 02: FY 01: FY 00: (1/02) FY 99: 18,948 FY 98: 12,690 FY 97: 9,469
Decrease by 5 percent annually, the number of newly reported AIDS cases in children as a result of perinatal transmission. *HRSA Plan*	FY 02: 141 cases FY 01: 151 FY 00: 161 FY 99: 214	FY 02: FY 01: FY 00: 1/02 FY 99: 171 cases FY 98: 235 FY 97: 310 FY 96: 502
Increase proportion of AIDS Education Training Centers training interventions provided to minority health care providers. *HRSA Plan*	FY 02: 41% FY 01: 40%	FY 02: FY 01: 11/02 FY 98: 37%
Increase the number of persons with HIV/AIDS for whom a portion of their unreimbursed oral health costs were reimbursed. *HRSA Plan*	FY 02: 29,800 persons FY 01: 29,800 FY 00: 46,000 FY 99: 66,000	FY 02: FY 01: FY 00: 29,000 FY 99: 46,000
Among persons with HIV/AIDS attributed to heterosexual behavior, increase the proportion of persons diagnosed with HIV prior to disease progression to AIDS. *CDC Plan*	FY 02: 83% FY 01: 82%	FY 02: FY 01: FY 00: FY 99:81% in areas with HIV reporting
Among persons with HIV/AIDS attributed to injecting drug use, increase the proportion of persons diagnosed with HIV prior to disease progression to AIDS. *CDC Plan*	FY 02: 77% FY 01: 76%	FY 02: FY 01: FY 00: FY 99:75% in areas with HIV reporting FY 98:73% in areas with HIV reporting
Among persons with HIV/AIDS attributed to male to male sexual contact, increase the proportion of persons diagnosed with HIV prior to disease progression to AIDS. *CDC Plan*	FY 02: 75% FY 01: 74%	FY 02: FY 01: FY 00: FY 99: 73% in areas with HIV reporting FY 98: 74% in areas with HIV reporting

Performance Goals	Targets	Actual Performance
Expand the number of States that are able to measure access to care; adherence to treatment; and impact of antiretroviral therapy (ART) for HIV/AIDS on long-term survival. *CDC Plan*	FY 02-01: Continue to expand the numbers of States that collect data and can measure care and treatment outcomes.	**Access to Care** FY 02: FY 01: 6 FY 00: 5 FY 99: 4 **Adherence to Treatment** FY 02: FY 01: 16 FY 00: 15 FY 99: 12 **Impact of ART** FY 02: FY 01: 11 FY 00: 11 FY 99: 11

See also:

- Objective 1.4, Reduce Alcohol Abuse and Prevent Under Age Drinking
- Objective 1.5, Reduce the Abuse and Illicit Use of Drugs
- Objective 1.6, Reduce Unsafe Sexual Behaviors
- Objective 4.1, Enhance the Appropriate Use of Effective Health Services
- Objective 6.1, Advance the Scientific Understanding of Normal and Abnormal Biological Functions and Behaviors
- Objective 6.2, Improve Our Understanding of How to Prevent, Diagnose, and Treat Disease and Disability

HHS 3.8: Increase the Availability and Effectiveness of Mental Health Care Services

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
In the Community Mental Health Services Block Grant, States will pilot performance indicators. *SAMHSA Plan*.	FY 02:Maintain FY 01:Maintain FY 00:16 States 32 indicators FY 99:16 States 32 indicators	FY 02: FY 01: FY 00:16 States 32 indicators FY 99:16 States 32 indicators FY 98: 5 States 28 indicators
For children receiving services through the Children's Outcomes: Comprehensive Community Mental Health Services for Children and Their Families, *SAMHSA Plan*		
Increase the percent of children attending school 75% or more of the time after 12 months.	FY 02: Maintain 18% FY 01: 18% increase FY 00: Maintain 10% FY 99: 10% increase FY 98: 5% increase	FY 02: FY 01: FY 00: 82.0% (+17%) FY 99: 88.9% (+27%) FY 98: 78.8% (+12%) FY 97: 70% (at 6 months)
Increase the percent of children with law enforcement contacts at entry who have no law enforcement contacts after 12 months.	FY 02: Maintain 43% FY 01: 43% FY 00: Maintain 57% FY 99: 57% FY 98: 52%	FY 02: FY 01: FY 00: 44% FY 99: 43% FY 98: 54.8% FY 97: 47% (at 6 months)
Increase stability of living arrangements by decreasing the percent of children having more than one living arrangement after 12 months in services.	FY 02: Maintain 65% FY 01: 65% decrease FY 00: 25% decrease FY 99: 20% decrease FY 98: 10% decrease	FY 02: FY 01: FY 00: 26% (-65.8%) FY 99: 27% (-64.5%) FY 98: 23.7% (-68%) FY 97: 76% (at 6 months)

Performance Goals	Targets	Actual Performance
Increase the percentage of Head Start children who receive necessary treatment for emotional or behavioral problems after being identified as needing such treatment. *ACF Plan*	FY 02: 85% FY 01: 83% FY 00: 81% FY 99: 81%	FY 02: FY 01: FY 00: 77% FY 99: 75% FY 98: 75%
Increase the number of complaints of abuse that are addressed under the Protection and Advocacy for Individuals with Mental Illness program. *SAMHSA Plan*	FY 02: 19,300 FY 01: 11,100 FY 00: 9,650 FY 99: 9,000	FY 02: FY 01: FY 00: 3/01 FY 99: 8,147 FY 98: 8,687 FY 97: 8,360
For the Knowledge Exchange Network for information about mental health treatment and services, *SAMHSA Plan*		
Increase usefulness of KEN information.	FY 02: 10% increase FY 01: 10% increase FY 00: Establish Baseline	FY 02: FY 01: FY 00: 69%
Increase information requests [(800) number].	FY 02: 10% increase FY 01: 10% increase FY 00: 10% increase FY 99: 10% increase FY 98: 10% increase FY 97: 10% increase	FY 02: FY 01: FY 00: 52,252 (-2%) FY 99: 52,303 (+89%) FY 98: 27,642 (+3%) FY 97: 26,603 (+158%) FY 96: 10,324
Increase publications distributed.	FY 02: 10% increase FY 01: 10% increase FY 00: 10% increase FY 99: 10% increase FY 98: 10% increase FY 97: 10% increase	FY 02: FY 01: FY 00: 549,955 (+87%) FY 99: 293,572 (+109%) FY 98: 139,912 (+30%) FY 97: 107,087 (+98%) FY 96: 53,932
Increase web site contacts.	FY 02: 10% increase FY 01: 10% increase FY 00: 10% increase FY 99: 10% increase FY 98: 10% increase FY 97: 10% increase	FY 02: FY 01: FY 00: 706,919 (+94%) FY 99: 363,973 (+119%) FY 98: 179,690 (+127%) FY 97: 79,093 (+612%) FY 96: 11,108

Performance Goals	Targets	Actual Performance
Increase the number of visits for health-related care (primary medical, dental, **mental health,** substance abuse, rehabilitative and home health) in Title I and II programs to a level that approximates inclusion of new clients. *HRSA Plan*	**HIV Emergency Relief Grants** FY 02: 3.05 million FY 01: 3.05 FY 00: 2.92 FY 99: 2.88 **HIV Care Grants to States** FY 02: 1.45M visits FY 01: 1.57M FY 00: 1.53M FY 99: 1.22M	FY 02: FY 01: FY 00: 1/02 FY 99: 2.73 FY 98: 2.79 FY 97: 2.77 FY 96 : 2.67 FY 02: FY 01: FY 00: 1/02 FY 99: 1.23M FY 98: 1.45M FY 97: 1.07M
Increase the proportion of people 18 and over reporting depression in the past 12 months who are receiving treatment. *OPHS Plan*	FY 02: 29% FY 01: 26%	FY 02: FY 01: FY 00: 12/01 FY 99: DNC FY 98: DNC FY 97: 23%
Decrease the annual rate of suicide. *OPHS Plan*	FY02: 9.5 FY 01: 10 FY 00: 10.5	FY 02: FY 01: FY 00: 12/01 FY 99: 12/01 FY 98: 10.8 FY 96: 11.7
Decrease proportion of injurious suicide attempts among youth ages 14-17. *OPHS Plan*	FY 02: 1.4 FY 01: 1.6 FY 00: 1.8 FY 99: 2.0	FY 02: FY 01: FY 00:DNC FY 99: 2.6% FY 98: DNC FY 97: 2.6% FY 95: 2.8%
Increase percentage of IHS, Tribal and Urban programs that have implemented a suicide surveillance system to monitor the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions) which assures those at risk receive services, and that appropriate population-based prevention interventions are implemented. *IHS Plan*	FY 02: 10% > FY 01 FY 01: 50%	FY 02: FY 01: FY 00: baseline 3/01 FY 98: 25% est.

See also:

- Objective 1.2, Reduce the Incidence and Impact of Injuries and Violence in American Society
- Objective 1.4, Reduce Alcohol Abuse and Prevent Under Age Drinking
- Objective 1.5, Reduce the Abuse and Illicit Use of Drugs

HHS 3.9: Increase the Availability and Effectiveness of Health Services for Children with Special Health Care Needs

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Increase the number of children served by Title V, Maternal and Child Health Block Grant. *HRSA Plan*	FY 02: 24.5 million FY 01: 24	FY 02: FY 01: FY 00: 01/02 FY 99: 01/01 FY 98: 04/00 FY 97: 20.2 million
Increase the percent of Children with special needs in the State program with a source of insurance for primary and specialty care. *HRSA Plan*	FY 02: 91% FY 01: 90%	FY 02: FY 01: 1/02 FY 00: 1/01
Increase the number of health care providers trained to meet the health needs of people with developmental disabilities. *ACF Plan*	FY 02: 5,200 FY 01: 5,000 FY 00: 4,825 FY 99: 4,000	FY 02: FY 01: FY 00: 1/02 FY 99: 4,100 FY 98: 3,733

HHS Goal 4: IMPROVE THE QUALITY OF HEALTH CARE AND HUMAN SERVICES

Improving quality of life and health in the United States also involves improving the quality of human services and health care that persons receive. The focus of this goal and supporting objectives is on the implementation of a variety of strategies to improve service quality. In this respect, several of the objectives parallel the goals in the Department's health care quality initiative. (Other elements of the initiative are included elsewhere in the strategic plan.) On the human services side, quality improvement focuses on the generation of knowledge that can be translated into the improvement of human services.

While many Americans receive quality health care, there is disturbing evidence that quality is a problem in a number of areas. The Institute of Medicine of the National Academy of Sciences estimates that as many as 98,000 persons die each year from medical errors (To Err is Human: Building a Safer Health System. National Academy Press. Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, editors. 2000). Under-use of services is an ongoing challenge. For example, one study found that 30 percent of women age 52 to 69 in surveyed managed care plans had not received a mammogram in the previous two years. On the other hand, some services are used unnecessarily. One study indicated that half of all patients diagnosed with a cold and two-thirds of the patients diagnosed with acute bronchitis received antibiotics which offer little or no benefit for these conditions. Screening tests are sometimes misread. One study found that anywhere from 10 to 30 percent of Pap smear test results were incorrectly classified as normal. Finally, improving health care quality must involve consumers and purchasers of health care who are knowledgeable about quality choices. Yet when considering and selecting their health care options, the majority of Americans do not use quality-related information comparing the quality of health care plans, doctors, or hospitals to make their choices.

With respect to the quality of human services, the Department has been engaged in the development of a research strategy to better understand the transformations in human services programs. This strategy identifies the requisite knowledge base, data, performance measures, and program evaluations and research needs for national leadership. The movement toward devolution of responsibility for human services to State and local organizations and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 offer tremendous opportunities and unprecedented challenges in the redefinition and implementation of services to families. Documenting, understanding, interpreting, and facilitating the exchange of information and experiences among States is essential for encouraging sound decisions that promote the well-being of families and children.

SUMMARY PERFORMANCE REPORT
HHS Strategic Goal 4

These are selected performance stories from the performance plans of the HHS operating and staff components that support key areas related to the achievement of this strategic goal. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan.

APPROPRIATE USE OF EFFECTIVE HEALTH CARE SERVICES

Vaccinations for Senior Citizens. CDC plays a critical role in developing immunization policy by providing technical and scientific support to groups that recommend immunization policy in the United States and globally. Data indicate that the incidence of deaths related to influenza and pneumoccoccal disease can be reduced by ensuring persons aged 65 and older receive appropriate vaccinations. CDC supports immunization programs to increase community participation, education, and partnerships through public information campaigns, education and training for providers, assistance to communities on building coalitions, and partnerships with community-based organizations, national minority organizations, volunteer groups, vaccine companies, professional organizations and Federal agencies. CDC has demonstrated an increase in the percentage of persons 65 years of age or older receiving vaccine against influenza (from 33 percent in 1989 to 64 percent in 1998). Similarly, the coverage rate for pneumococcal vaccine increased from 15 percent to 46 percent over the same period.

  CDC has demonstrated an increase in the percentage of persons 65 years of age or older receiving vaccine against influenza (from 33 percent in 1989 to 64 percent in 1998). Similarly, the coverage rate for pneumococcal vaccine increased from 15 percent to 46 percent over the same period. CDC will report data on its FY 1999 targets of 60 percent and 54 percent, respectively, in September of 2001.

  Although performance data on HCFA's goal to increase the rate of influenza vaccination to 60 percent will not be available until 2002, NHIS trend data indicates that vaccination rates in this population have risen from 55 percent in FY 1994 to 64 percent in FY 1998. In FY 2001, HCFA will begin using data from the Medicare Current Beneficiary Survey, which will support separate targets for rates of influenza and pneumococcal vaccinations for nursing home residents as well as beneficiaries in the community. Adult immunizations are being examined by the Peer Review Organizations as part of HCFA's quality improvement efforts.

  IHS established a FY 2000 baseline of 30.7 percent of all American Indians and Alaskan Natives over 65 vaccinated against influenza by extracting this data from its electronic medical records, and has set targets for a one percent increase in both FY 2001 and FY 2002. Pneumococcal immunization, which is only recommended once every five years, is more difficult to ascertain from IHS electronic medical records, and IHS was not able to develop a baseline. In FY 2001, IHS will pilot and validate methods using influenza vaccination, and

based on the outcome of these studies, will begin measuring pneumococcal vaccination rates to establish a baseline in FY 2001.

Heart Attacks. Through its Peer Review Organizations, HCFA is influencing providers to employ known successful interventions for properly treating heart attacks and preventing second heart attacks. As an indicator of hospital performance in employing these interventions, HCFA set a goal for its Peer Review Organizations to decrease 1 year mortality among Medicare beneficiaries hospitalized for heart attack. During the baseline years of 1995 - 1996, 31.2 percent of Medicare beneficiaries hospitalized for heart attack died within a year. HCFA seeks to reduce that rate to 27.4 percent by FY 2002. Data through FY 1998 show a relatively constant 1-year mortality rate, which may represent the gradual phase-in of the national program, increasing median age of the Medicare population which increases risk of mortality, and changes in the rate of concomitant diseases or severity of illness.

Mammograms. Encouraging breast cancer screening for women age 65 and over, including regular mammograms, is critical to reducing breast cancer deaths. HCFA's Peer Review Organizations have been directed to monitor and improve the percentage of female Medicare beneficiaries age 65 and older who receive a mammogram as an indicator of the quality of preventive care. In FY 1998 the National Health Interview Survey (NHIS) indicated that 63.8 percent of women age 65 or over received a mammogram, a considerable increase from the baseline of 55 percent in 1994. Data indicating HCFA's progress in meeting its FY 2000 target of 60 percent will be available in Summer of 2000. Beginning in FY 2001, HCFA will use Medicare claims data for this measure rather than self-reported NHIS data. Baseline reports show mammography rates of 45 percent in FY 1998 and 49 percent in FY 1999. HCFA has revised its targets accordingly. In FY 2001, it has set a target to increase mammography rates to 51 percent.

Hospitalization for Potentially Avoidable Conditions. Hospitalizations for potentially avoidable conditions, also known as ambulatory care sensitive conditions (ACSC) is widely recognized as a measure of access to appropriate primary care. Low rates indicate access to appropriate ambulatory services and is a measure of high quality of care delivered at HRSA's Community Health Centers. An ongoing evaluation comparing ACSC hospitalizations among Health Center users and non-users showed a rate of 18.9 ACSC per 1000 hospitalizations for non-users compared to 14.7 per 1000 hospitalizations for Health Center users in FY 1997. HRSA has set targets of 14, 13.5 and 13 per 1000 hospitalizations for FY 1999, 2000 and 2001. HRSA will have results from a follow-up ACSC study in April 2001.

CHRONIC DISEASES

Cardiovascular Disease. Cardiovascular disease (CVD) is the Nation's number one killer among men and women of all racial and ethnic groups, and associated annual costs exceed $286 billion. CDC is implementing a crosscutting approach to heart disease and stroke prevention by building State-specific capacity for cardiovascular health promotion, beginning with those States with the greatest heart disease and stroke burden. In FY 1999, CDC funded 11 States to develop core capacity to address cardiovascular disease and its risk factors, and all States met the required five of seven core prevention capacities. In FY 2000, CDC funded 25 States and anticipates reporting on their achievements in June 2001. In addition, CDC

funds four States at the comprehensive level to develop and disseminate key policy and environmental interventions. A primary focus of policy and environmental interventions is reducing leading risk factors for cardiovascular diseases - lack of regular physical activity, poor nutrition, tobacco use, high blood pressure, and high cholesterol.

Diabetes. The goal of CDC's diabetes control program is to eliminate preventable diabetes-related morbidity and disability while improving the overall quality and length of life for all persons with diabetes. CDC accomplishes this goal through collaborative program management with the National Institutes of Health (NIH) and the Health Resources and Services Administration. One example of this collaboration is the development, coordination and implementation of the National Diabetes Education Program and the Health Status and Performance Improvement Collaborative in Community Health Centers. In FY 1999, 70 percent of CDC-funded programs adopted patient care guidelines for improving the quality of health care received by persons with diabetes. CDC set a goal of 100 percent compliance in FY 2000 and beyond. In addition to the patient care guidelines, CDC has also set a goal for its funded States to increase the percentage of diabetics who receive an annual eye exam from 67.3 to 72 percent, and for annual foot exams to be increased from 57.8 percent to 62 percent.

Diabetes and American Indians and Alaskan Natives (AI/AN). The IHS plan includes four goals that target improvements in diabetic care that have a strong evidence-based association with a reduction in diabetic morbidity and mortality. IHS met its FY 1999 targets for three of these goals. In FY 1998, 22 percent of diagnosed diabetes patients had improved their glycemic control, and in FY 1999 this increased to 25 percent, meeting IHS' targeted three percent increase. Screening of diagnosed diabetes patients for dyslipidemia increased from 29 percent in FY 1998 to 46 percent in FY 1999, exceeding the targeted three percent increase. Screening for microalbuminuria to assess early diabetic nephropathy increased from 33 percent in FY 1998 to 36 percent in FY 1999, meeting IHS' target.

However, IHS had targeted a three percent increase in the proportion of patients with diagnosed diabetes who achieved diabetic blood pressure control, while the rate actually decreased from 38 percent in FY 1998 to 35 percent in FY 1999. In response, the IHS National Diabetes Program is encouraging programs to use the new diabetes funding to enhance their clinical care programs, including better blood pressure screening and more aggressive treatment as well as increased funds to the pharmacy budget to purchase newer, more effective antihypertensive agents.

Diabetes Care in Community Health Centers. Monitoring performance in chronic disease management serves as a marker for the quality of care delivered at HRSA's Community Health Centers and ultimately measure their ability to eliminate health disparities within the population served. Patients at Health Centers have rates of diabetes that far exceed national prevalence rates for comparable racial/ethnic and socioeconomic groups. Yet, Health Center diabetics are three times as likely to have their glycohemoglobin tests performed at regular intervals than the national norm. HRSA's Community Health Centers have established two goals relating to diabetes care. They met their FY 1999 target of testing glycohemoglobin levels in 60 percent of adults with diabetes at recommended intervals, up from the baseline of 43 percent in FY 1998. The targets will increase to 80 percent in FY 2000 and 90 percent in 2001. HRSA established a new goal for FY 2001 for increasing the percent of users with

diabetes who have had an annual dilated eye exam with an ambitious target of 90 percent. Baseline testing indicated a rate of 49 percent in FY 1989 and 57 percent in FY 1994..

Diabetes and Medicare Beneficiaries. HCFA includes a performance goal starting in FY 2001 to improve the rate of biennial diabetic retinal eye exams for Medicare beneficiaries. Baseline data from 1997-1999 indicate 68.5 percent performance rate, and targets of 69 percent and 69.5 percent have been established for FY 2001 and 2002 respectively. This area is a quality improvement project for HCFA's Peer Review Organizations.

Arthritis. By the year 2020, an estimated 60 million people will be affected and over 11 million will have some disability because of arthritis. CDC is working with the Department and other partners to implement the *National Arthritis Action Plan: A Public Health Strategy* (NAAP). The goal of CDC's arthritis program is to improve the quality of life among persons affected by arthritis by decreasing pain and disability, and improving physical, psychosocial and work function. In FY 2000, twenty-nine States were funded to develop basic public health components to address arthritis. Eight States were funded at a core level to enhance monitoring activities and partnerships, educate the public about arthritis, and develop and implement pilot programs to decrease the impact of arthritis in select populations.

Breast and Cervical Cancer Prevention. CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is a cross departmental program (NCI, IHS, FDA) that provides cancer screening for under-served women, particularly low-income women, older women, and members of racial/ethnic minorities. The program has diagnosed over 6,543 breast cancers, and cervical cancer has been prevented in as many as 31,000 women through the detection and treatment of precancerous lesions. In 1999, excluding breast cancers diagnosed on an initial screen in the NBCCEDP, at least 70 percent of women aged 40 and older were diagnosed at the localized stage. In 1999, excluding invasive cervical cancers diagnosed on an initial screen in the NBCCEDP, the age adjusted rate of invasive cervical cancer in women aged 20 and older was 19 per 100,000 Pap tests provided.

HRSA's Community Health Centers have established FY 1999 goals for up-to-date Pap tests (90 percent of women), mammograms (65 percent of women), and clinical breast exams (82.5 percent of women). Data is expected to be available in June 2001.

Cancer Registries. Through the National Program of Cancer Registries (NPCR), CDC funds States and territories to enhance existing cancer registries. NPCR-funded central registries to complement existing registries, such as the National Cancer Institute's (NCI) Surveillance, Epidemiology, and End Results (SEER) program, which monitors trends in incidence, treatment, survival time, and extent of disease. In FY 1999, CDC set a goal to increase the percent of States funded by CDC's NPCR that have at least 95 percent of unduplicated, expected malignant cases of reportable cancer occurring in state resident in a diagnosis year reported to the state cancer registry to 30 percent. The 1999 data (cancer cases diagnosed in 1997) indicated that 60 percent of NPCR-funded States were reporting their data were at least 95 percent complete within 24 months of the close of the diagnosis year.

Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is the foundation upon which many successful State and health agency programs are built and is becoming recognized throughout the health care and disease prevention communities as an important and powerful

tool in the development, implementation, and evaluation of health care programs. BRFSS data is collected on a wide range of health risk areas, to include areas such as health care access, asthma, diabetes, exercise, tobacco use, weight control, women's health, sexual behavior, oral health, hypertension, cholesterol awareness, colorectal cancer, immunizations, alcohol consumption, cardiovascular disease, arthritis, and skin cancer. Although BRFSS has always been designed to produce State-level estimates, data has been used in research studies and combined across States. For example, these cross-state analyses have been performed to estimate the extent of alcohol and tobacco use among pregnant women. To increase the validity of BRFSS data, CDC has developed a goal that will increase the number of States that complete 4,000 telephone interviews per year. (At present, the sample size between States ranges from approximately 1,700 to approximately 7,500.) The larger sample size will permit better identification of geographic and demographic variations in health risk behaviors. This information can then be used to more effectively target public health programs to appropriate geographic and demographic groups.

ORGAN DONATIONS AND BONE MARROW TRANSPLANTS

Organ Transplants. The number of organ transplants has increased by 65 percent in the 10-year period between 1989 and 1999. However, the number of transplant candidates has continued to rise at a substantially faster rate than the number of donors, while the number of medically-suitable potential donors has not increased because of improved trauma care and increased seat belt and helmet use. In 1998 HRSA's Organ and Tissue Donation program established a network of public and private partnerships which set an ambitious goal to increase the number of organ donors by 20 percent over two years. Performance showed a 6 percent increase in 1998 and a 0.8 percent increase in 1999, which did not meet the target. The first nine months of 2000 have shown a 5 percent increase in organ transplants. A more prudent goal of increasing transplants by 5 percent per year has now been established. A national effort is underway to increase consent to donation by encouraging individual declaration of intent and discussion of the declaration with family members; ensuring that family members are asked about donation; and learning more about what works to increase donation. An additional FY 1999 goal of increasing the number of minority organ donors by 20 percent has also not been met, with the number of donors decreasing from 1998 to 1999. This goal has also been changed to a 5 per cent increase per year. More effective methods for reaching the minority communities are being developed through the organ donation grant program.

Bone Marrow Registry. HRSA's Bone Marrow Registry Program has increased the number of unrelated bone marrow donors in the national registry to 4.15 million donors in FY 2000, and the program has facilitated over 11,000 transplants (over 1,500 in CY 2000). The number of donors registered has increased by more than 8 percent over each of the last three years, exceeding annual targets of a 7.5 percent increase. However, because of increased costs of typing new potential donors, increased emphasis on retaining registered potential donors, and increased emphasis on increasing the actual number of patients brought to transplant, the goal for increasing the numbers on the bone marrow registry has been changed to 5 percent for FY 2001 and FY 2002. The program also has a goal of increasing the number of unrelated minority bone marrow donors in the registry by 10 percent per year. In FY 2000, the number of new donors increased from .92 million to 1.05 million, exceeding the target.

PROTECTION FOR PATIENTS, CONSUMERS, AND PERSONS WITH DISABILITIES

National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank. HRSA's National Practitioner Data Bank (NPDB) tracks all significant adverse professional actions against physicians and dentists as well as malpractice settlements and judgments against all licensed health care professionals, and can be queried by licensing, privileging and credentialing authorities prior to granting licensure or extending clinical privileges. As of December 31, 2000, the NPDB contained 264,066 reports on 164,320 practitioners. During FY 2000 the NPDB processed 3,258,918 queries. Queriers received over 400,000 matched responses containing malpractice payment, adverse action or exclusion report information, and over 2.8 million responses that the named practitioner had a clean record in the database. Based on previous user surveys conducted by the OIG, an estimated 11,050 licensure, credentialing, or membership decisions were affected by these match responses in FY 2000. The number of queries represents a small increase over FY 1999, and did not meet the target of 4 million queries. The target was set in anticipation of regulations which have not been implemented, and the lower performance may also reflect consolidation in the managed care industry. The Healthcare Integrity and Protection Data Base (HIPDB) augments information available in the NPDP and contains licensure and clinical privileging information for practitioners other than physicians and dentists, as well as providers and suppliers. The HIPDB opened for reporting in November 1999 and for queries in March 2000. As of December 2000 it contained 83,855 reports. It responded to almost 675,000 queries in the 7 months it was open for querying in FY 2000, with 81,833 responses containing reports on listed practitioners. Ambitious FY 2001 targets of 4.3 million queries for the NPDB and 1.8 million queries for the HIPDB are set in anticipation of adoption of regulations.

Protection and Advocacy for Individuals with Mental Illness (PAIMI). In FY 1999, SAMHSA's PAIMI program investigated 8,147 abuse complaints in public and private residential care or treatment facilities, short of its FY 1999 target of 9,000. State P&A programs are authorized to investigate incidents of abuse (including fatalities) involving individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe the incidents occurred. However, not all incidents of abuse in public and private residential facilities are reported to P&A systems. In FY 1999, the the General Accounting Office and the HHS Office of Inspector General found that incidents of abuse in these facilities – especially those involving the inappropriate or unauthorized use of seclusion and restraint by facility staff – frequently resulted in deaths that were not documented or reported to the appropriate State agency. Furthermore, the majority of States do not have a central reporting system for residential facilities to report abuse and fatality incidents so State P&A systems are unable to provide accurate estimates of them. The Children's Health Act 2000 required reporting of this information; SAMHSA expects more reliable data for this goal to be available in FY 2002, and has set its FY 2002 target accordingly.

Nursing-Home Care. While HHS focuses significant attention on avoiding institutional care, the Department is fully committed to protecting the rights of nursing home residents and enhancing their care. Both the reduced use of physical restraints on nursing home patients and the lowered prevalence of pressure ulcers in nursing homes are widely accepted as indicators of quality of care. HCFA has reported the achievement of its FY 1999 goal to reduce the

prevalence of the use of physical restraints among all nursing homes from 17.2 percent in 1996 to 14 percent in 1999. With reported prevalence of under 12 percent in 1999, HCFA has adopted a more rigorous target of 10 percent for FY 2000 and FY 2001. Interim data for FY 2000 show a reduction to 9.8 percent. HCFA has reported baseline data for 9.8 percent prevalence of pressure ulcers in nursing homes, and has established targets of 9.6 percent and 9.5 percent for FY 2001 and FY 2002 respectively. AoA has incorporated these goals for reduction in physical restraints and pressure ulcers into its plan as indicators of the responsiveness of the Ombudsman Program to the most serious complaints raised on behalf of nursing home residents.

Long-term Care Ombudsman Program. Major goals of the Administration on Aging's (AoA) Long-term Care Ombudsman Program are to enable residents of long-term care facilities and their families to be informed "long-term care consumers" and to facilitate the resolution of problems regarding care and conditions in long-term care facilities. Over the past several years AoA has maintained a 70 percent or greater resolution/partial resolution rate for complaints involving nursing homes which will be maintained. Performance for FY 1999 was 74.3 percent; exceeding the target of 71.48 percent. To provide some perspective, in FY 1998, ombudsmen nationwide opened 136,424 cases and closed 121,686 cases involving 201,053 individual complaints. Data for FY 2000 will be available in November, 2001.

Discrimination in Access to HHS Programs. The Office for Civil Rights (OCR) enforces nondiscrimination in access to HHS services by resolving discrimination complaints, conducting reviews and investigations, providing technical assistance to recipients of HHS funding who must comply with civil rights requirements, establishing joint projects with other agencies and stake-holders, and conducting other outreach activities. Through these various methods, OCR uses a flexible approach to increasing compliance with civil rights requirements and therefore increasing individuals' access to HHS services and programs.

For the first time, OCR has combined FY 2000 data for the different types of activities into a single measure for each priority area. OCR tracks its outputs in each of those types of activities listed above, including the number of corrective actions or "no violation" findings when a review or investigation results in the recipient making changes to policies or practices, or when OCR determines the recipient made no violation. The outputs are now combined into a single measure for a priority area to reflect OCR's total effort in that area for improving compliance and access. Examples are as follows:

- *Increasing the number of managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act, while increasing their awareness and understanding of civil rights requirements:* OCR had 85 corrective actions, no violation findings, reviews, outreach, consultations/technical assistance and joint projects in this priority area in FY 2000. OCR previously had three different indicators in this area, measuring 53 outputs with a combined target of 69 activities. However, it had not counted OCR's technical assistance and joint project activities, which comprise a growing part of its efforts.

- *Increasing the number of HHS providers and grantees found to be in compliance with Title VI in reviews/ investigations related to limited-English proficiency, while increasing*

knowledge and understanding of limited-English proficiency policy guidance: OCR had 403 corrective actions, no violation findings, reviews, outreach, consultations/technical assistance and joint projects in this priority area in FY 2000. OCR previously had five different indicators in this area measuring the 403 outputs with a combined target of 487 activities. Over half the activities (245) were outreach, consultations/technical assistance and joint projects.

- *Increasing the number of state and local TANF agencies and service providers found to be in compliance with Title VI, Section 504 and ADA while increasing knowledge and understanding of civil rights requirements in the administration of TANF:* OCR had 242 corrective actions, no violation findings, reviews, outreach, consultations/technical assistance and joint projects in this priority area in FY 2000. OCR previously had five different indicators in this area measuring the 242 outputs with a combined target of 122 activities.

- *Increasing the number of state agencies and local adoption agencies found to be in compliance with the nondiscrimination provision so the Small Business Job Protection Act, while increasing knowledge and understanding of adoption and foster care nondiscrimination requirements:* OCR had 40 corrective actions, no violation findings, reviews, outreach, consultations/technical assistance and joint projects in this priority area in FY 2000. OCR previously had two different indicators in this area, measuring eight outputs with a combined target of 37 activities. However, it had not counted OCR's technical assistance, outreach and joint project activities, which comprise the bulk of its efforts in this area.

Protection Against Fraud, Waste, and Abuse. OIG conducts independent and objective audits, evaluations, and investigations, which are reported to Department officials, the Administration, the Congress, and the public. OIG examines Return On Investment (ROI) as a measure of its effectiveness and includes both expected recoveries (including fines, penalties, restitution, forfeitures, and final audit disallowances) and savings (including funds not expended as a result of OIG recommendations and funds put to better use) in its calculations. The actual FY 2000 total expected recoveries and savings per OIG dollar invested was $104, $29 more than the FY 2000 target of $75 per dollar invested. Although the financial implications of its work are important, OIG recognizes the importance of its qualitative impact on HHS programs and reported data on these impacts for the first time in FY 2000. These include legislative, regulatory, policy and practice changes that are made subsequent to an OIG recommendation for such changes. Overall, 106 instances of qualitative impact were documented. Both qualitative and quantitative outcomes in any given year generally are the result of OIG's audits, evaluations and investigations from previous years.

IMPROVE THE QUALITY AND EFFECTIVENESS OF HUMAN SERVICES PRACTICE

Dissemination of AHRQ Research. AHRQ pursues the dissemination of research primarily through partnerships established for that purpose. AHRQ established a performance goal to form 5 dissemination partnerships in FY 1999, and exceeded that target by forming 30 public-private and public-public partnerships in FY 1999. AHRQ's achievements in research

dissemination are also reflected in its goals to promote the translation of research into practice. For example, in FY 1999, AHRQ found that 21 purchasers and/or businesses used AHRQ research findings to make decisions. In FY 2000, AHRQ partnered with over 30 diverse public and private organizations, including Web-based groups, to disseminate evidence-based information. Further, the widespread use of AHRQ findings is providing purchasers with valuable information for making health care decisions. For example, in FY 2000 more than 90 million Americans use AHRQ'S Consumer Assessment of Health Plans (CAHPS) to help them decide which health plan best meets their health care needs. CAHPS is now used by more than 20 States. The Health Care Financing Administration has begun using CAHPS to survey Medicare managed care enrollees, and the US Office of Personnel Management used CAHPS to report consumer assessments of health plans available to Federal workers and retirees for its FY 2000 open season. In FY 2001, AHRQ projects that its evidence-based practice centers will produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality.

HHS 4.1: Enhance the Appropriate Use of Effective Health Services

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Heart Attack		
Decrease one-year mortality among Medicare beneficiaries hospitalized for heart attack. *HCFA Plan*	FY 02: 27.4% FY 01: 27.4% FY 00: 27.4% FY 99: New in FY 00	01-02: 6/04 00-01: 6/03 99-00: 6/02 98-99: 6/01 (Interim) 97-98: 31.7% 96-97: 31.1% 95-96: 31.2%* (Baseline) (*revised from 31.4)
Collaborate with NIH and American Indian and Alaska Native sites in developing and implementing culturally sensitive, community-directed pilot cardiovascular disease prevention programs. *IHS Plan*	FY 02: 3 sites implementing interventions FY 01: 3 sites with intervention plan	FY 02: FY 01:
The number of States with 5 of the 7 core cardiovascular disease prevention capacities as delineated in "Preventing Death and Disability from Cardiovascular Diseases: A State Based Plan for Action" and in CDC Program Announcement, "CDC Cardiovascular Health Programs," will be increased. *CDC Plan*	FY 02: 15 States FY 01: 15 FY 00: 11 FY 99: 8	FY 02: FY 01: FY 01: FY 00: FY 99: 11States FY 98: 7 States
Breast and Cervical Cancer		
Excluding breast cancers diagnosed on and initial screen in the NBCCEDP, at least 73% of women aged 40 and older will be diagnosed at localized stage. *CDC Plan*	FY 02: 73% FY 01: 73% FY 00: 72% FY 99: 71%	FY 02: FY 01: FY 00: 4/01 FY 99: 70% FY 98: 70% FY 95: 70%

Performance Goals	Targets	Actual Performance
Excluding invasive cervical cancers diagnosed on an initial screen in the NBCCEDP, the age adjusted rate of invasive cervical cancer in women aged 20 and older is not more that 22 per 100,000 Pap tests provided. *CDC Plan*	FY 02-FY 99: No more than 22/100,000	FY 01: FY 00: 4/01 FY 99: 19/100,000 FY 98: 23/100,000 FY 95: 26/100,000
Increase the percentage of Medicare Beneficiaries Age 65 and over who receive a mammogram every two years. *HCFA Plan*	FY 01: Switched to new data source (see below) FY 00: 60% FY 99: 59% FY 02: 52% FY 01: 51% FY 00: N/A	FY 01: N/A FY 00: Summer 2002 FY 99: Summer 2001 FY 98: 63.8% FY 94: 55% (NHIS) 01-02: 8/03 00-01: 8/02 99-00: 8/01 (Interim) 98-99: 49% 97-98: 45% (MCBS)
Increase proportion of Health Center women receiving age-appropriate screening for cervical and breast cancer. *HRSA Plan*	**Up-to-date Pap Tests** FY 02: 95% FY 01: 94% FY 00: 92% FY 99: 90% **Up-to-date Mammograms** FY 02: 75% FY 01: 70% FY 00: 67.5% FY 99: 65% **Up-to-date Clinical Breast** FY 02: 86% FY 01: 85.5% FY 00: 84% FY 99: 82.5%	FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 88.5% FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 62.5% FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 80.5%

Performance Goals	Targets	Actual Performance
Ensure women receive screening for cervical and breast cancer in Family Planning clinics. *HRSA Plan* These clinics serve a population that is approximately 40% minority and nearly two-thirds have incomes below 100% of the poverty level and 89% have incomes below 200% of poverty level.	**Pap tests** FY 02: 3 Million **Breast Exams** FY 02: 3 Million	**Pap tests** FY 02: FY 01: FY 00: 11/01 FY 99: 2.970 million FY 98: 2.937 FY 97: 3.130 **Breast Exams** FY 02: FY 01: FY 00: 11/01 FY 99: 2.812 million FY 98: 2.774 FY 97: 2.961
Increase the proportion of the American Indian and Alaskan Native female population over 40 years of age who receive mammography screening . *IHS Plan*	FY 02: 2% over FY 01 FY 01: 3% over FY 00 FY 00: 3% over FY 99 FY 99: establish baseline	FY 02: FY 01: FY 00:14.73% past two years; provisional FY 99: baseline not adequate
Increase the proportion of American Indian and Alaskan Native (AI/AN) women who receive Pap screening. *IHS Plan*	**Pap Screening** FY 02: 2% over FY 01 FY 01: 3% over FY 00 FY 00: 3% over FY 99 FY 99: establish baseline **Cervical Cancer** FY 99: determine incidence	FY 02: FY 01: FY 00:11.9% past year 17.9% past 3 years provisional data FY 99: baseline not adequate FY 99: 8-10/100,000 based on 40% of AN/AN
Diabetes		
Percentage of CDC-funded State diabetes control programs that will adopt, promote, and implement patient care guidelines for improving the quality of care received by persons with diabetes. *CDC Plan*	FY 02: 100% FY 01: 100%. FY 00: 100%	FY 02: FY 01: FY 00: 6/01 FY 99: 70% FY 98: 60%

Performance Goals	Targets	Actual Performance
For all States that receive CDC funding for comprehensive diabetes control programs, increase the percentage of diabetics who receive an annual eye exam and annual foot exam. *CDC Plan*	FY 02: 72% Eye 62% Foot FY 01: 72% Eye 62% Foot FY 00: 72% Eye 62% Foot	FY 02: FY 01: FY 00: FY 99: 67.3% Eye 57.8% Foot FY 98: 64.7% Eye 56.5% Foot FY 96: 62.0% Eye 52.0% Foot
Increase the proportion of I/T/U clients with diagnosed diabetes that have improved their glycemic control. *IHS Plan*	**Ideal Glycemic Control** FY 02: 3-year average improved FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 25% **Good Glycemic Control** FY 99: 38%	 FY 02: FY 01: FY 00: 7/01 FY 97-99: 24% FY 99: 25% FY 99: 35 % FY 98: 35%
Increase the proportion of I/T/U clients with diagnosed diabetes and hypertension that have achieved diabetic blood pressure control standards. *IHS Plan*	**Ideal Hypertension Control** FY 02: 3-year average improved FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 41%	 FY 02: FY 01: FY 00: 7/01 FY 97-99: 37% FY 99: 36% FY 98: 38%
Increase percent of Health Center users with diabetes with up-to-date testing of glycohemoglobin – % adults with diabetes tested at recommend intervals. *HRSA Plan*	FY 02: 90% FY 01: 90% FY 00: 80% FY 99: 60%	FY 02: FY 01: FY 00: 3/01 FY 99: 60% FY 98: 43% Norm: 20%
Avoidable Hospitalizations		
Decrease proportion of Health Center users who are hospitalized for potentially avoidable conditions. *HRSA Plan*	FY 02: 12.5/1000 FY 01: 13 FY 00: 13.5 FY 99: 14	FY 02: FY 01: FY 00: 4/03 FY 99: 4/02 FY 98: 4/01 FY 97: 14.7/1000 Norm: 18.9/1000

Performance Goals	Targets	Actual Performance
Prenatal Care		
Reduce the percentage of enrolled women who receive late or no prenatal care. *HRSA Plan*	FY 02: 9.75% FY 01: 10.75%	FY 02: FY 01: FY 00: 5/01 FY 99: 11.1% FY 98: 17.2%
Newborn Screening		
Increase the number of disorders covered in the Newborn Screening Quality Assurance Program. *CDC Plan*	FY 02: 35 disorders FY 01: 15 disorders	FY 02: FY 01: FY 00: 15
Increase the percentage of newborns who have been screened for hearing impairment before hospital discharge. *HRSA Plan*	FY 02: 85% FY 01: 75%	FY 02: FY 01: FY 00: 46% est.
Depression		
Increase the proportion of people 18 and over reporting depression in the past 12 months who are receiving treatment. *OPHS Plan*	FY 02: 34% FY 01: 32%	FY 02: FY 01: FY 00:12/01 FY 99: DNC FY 98: DNC FY 97: 23%
Hypertension		
Increase proportion of Health Center adults with hypertension who report their blood pressure is under control. *HRSA Plan*	FY 02: 96% FY 01: 96% FY 00: 93% FY 99: 92%	FY 02: FY 01: FY 00: 4/02 FY 99: 6/01 FY 95: 90%
Emergency Medical Services		
Conduct needs assessments in areas considered in highest need. (Developmental) *HRSA Plan*	FY 02: TBD FY 01: TBD	FY 02: FY 01:
Increase the number of States that have implemented Statewide pediatric protocols for medical direction. *HRSA Plan*	FY 02: 15 Statewide FY 01: 15 Statewide FY 00: 20* FY 99: 18 * *Statewide and Partial	FY 02: FY 01: FY 00: 12 Statewide FY 99: 25* FY 98: 16*

Performance Goals	Targets	Actual Performance
Immunization		
Increase the percentage of Medicare beneficiaries age 65 years and older who receive vaccinations.		
Increase rate of annual influenza (flu) vaccination. (NHIS)	FY 01: Switched to new data source. (see below) FY 00: 60% FY 99: 59%	FY 00: Summer 2002 FY 99: Summer 2001 FY 98: 64% FY 97: 63% FY 95: 58% FY 94: 55% (NHIS)
Increase annual influenza (flu) and lifetime pneumococcal vaccinations. (MCBS)		
-- Flu/Pneumococcal *HCFA Plan*	FY 02: 73%/65% FY 01: 72%/63% FY 00: Not Applicable	FY 02: 12/03 FY 01: 12/02 FY 00: 12/01 (Interim) FY 99: 69.1%/61.2% (interim*) FY 98: 68.5%/56.1%* FY 97: 67.1%/50.9%* FY 96: 65%/44.1% FY 95: 61%/34.6% FY 94: 59%/24.6% * includes community dwelling beneficiaries only
The rate of vaccination among persons >65 years will be increase for influenza and pneumococcal pneumonia. *CDC Plan*	**Influenza** FY 02: 74% FY 01: 72% FY 00: 70% FY 99: 60% **Pneumococcal Pneumonia** FY 02: 66% FY 01: 63% FY 00: 60% FY 99: 54%	FY 02: FY 01: FY 00: 09/02 FY 99: 09/01 FY 98: 63% FY 97: 63% FY 95: 58% FY 02: FY 01: FY 00: 09/02 FY 99: 90/01 FY 98: 46% FY 97: 42% FY 95: 34%

Performance Goals	Targets	Actual Performance
Increase overall pneumococcal and influenza vaccination levels among diabetics and adults aged 65 years and older. *IHS Plan*	**Influenza** FY 02: 1% over FY 01 FY 01: 1% over FY 00 FY 00: 65% **Pneumococcal** FY 02: 1% over FY 01 FY 01: secure electronic baseline FY 00: 65%	FY 02: FY 01: FY 00:30.7% (new baseline from automated process) FY 98: 63% (baseline from diabetes audit) FY 02: FY 01: FY00: data source inadequate FY 98: 63% (baseline from diabetes audit)
Achieve or sustain the following immunization coverage of at least 90% among children 19- to 35-months of age for each vaccine: 1. 4 doses of Diphtheria-Tetanus-Pertussis containing vaccine 2. 3 doses of *Haemophilus influenzae* type b vaccine 3. 1 dose of Measles-Mumps-Rubella vaccine* 4. 3 doses of Hepatitis B vaccine 5. 3 doses of Polio vaccine 6. 1 dose of Varicella vaccine* 7. 4 doses of Pneumococcal Conjugate vaccine* **Performance targets for newly recommended vaccines will begin 5 years after the ACIP recommendation. The varicella measure will begin in 2001, even though coverage is being reported earlier. The pneumococcal conjugate measure will begin in 2006, even though coverage will be reported earlier. *CDC Plan*	FY 02: 90% FY 01: 90% FY 00: 90% FY 99: 90%	FY 02: FY 01: 8/02 FY 00: Provisional data. Final 08/01 1. 83% 2. 94% 3. 91% 4. 90% 5. 90% 6. 63%* FY 99: 1. 83% 2. 94% 3. 92% 4. 88% 5. 90% 6. 58%* FY 98: 1. 84% 2. 93% 3. 92% 4. 87% 5. 91% 6. 43%*

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicaid two-year old children who are fully immunized. (To be achieved in 3 phases for State groupings.)		
– Group 1 States (Set State-specific methodology and baseline: 1999-2000; first report: 2001)	FY 02: Second Report FY 01: First Report FY 00: Set State-specific methodology and baseline FY 99: Not Applicable	FY 02: FY 01: FY 00: 13 Group I States developed State-specific methodology, targets and measured baselines. 3 States will complete these efforts in FY 2001 FY 99: Identified Group I States. Began developing State-specific methodology and baselines
– Group 2 States (Set State-specific methodology and baseline: 2000-2001; first report: 2002)	FY 02: First Report FY 01: Set baseline FY 00:Begin State-specific methodology and baseline activities	FY 02: FY 01: FY 00: Identified Group II States. Began developing State-specific methodology and baselines
– Group 3 States (Set State-specific methodology and baseline: 2001-2002; first report: 2003) *HCFA Plan*	FY 02: Set baseline FY 01: Begin State-specific methodology and baseline activities FY 00: N/A	FY 02: FY 01: FY 00: N/A FY 99: N/A
Increase the proportion of American Indian and Alaskan Native children who have completed all recommended immunizations by the age two. *IHS Plan*	FY 02: 1% over FY 01 FY 01: 1% over FY 00 FY 00: 2% over FY 99 FY 99: 91%	FY 02: FY 01: FY 00: 86% 12/12 Areas FY 99: 89% 12/12 Areas 87% 11/12 Areas FY 98: 88% 11/12 Areas

Performance Goals	Targets	Actual Performance
Organ Donations/Bone Marrow Registry		
Increase by 5% per year the number of organ donors nationally. *HRSA Plan*	FY 02: 6,728 FY 01: 6,408 FY 00: 6.589 FY 99: 5,990	FY 02: 5/03 FY 01: 5/02 FY 00: 5/01 FY 99: 5,849 FY 98: 5,801
Increase by 5% the number of unrelated bone marrow donors (national registry of potential donors) over previous year totals. *HRSA Plan*	FY 02: 4.45M donors FY 01: 4.24M FY 00: 4.04M FY 99: 2.84M	FY 02: 10/02 FY 01: 10/01 FY 00: 4.15M donors FY 99: 3.76M FY 98: 3.36M FY 96: 2.58 M
Dissemination of Protocols/Guidelines		
Based on established criteria, continue to publish the *Morbidity and Mortality Weekly Reports (MMWR)* series of publications including Reports and Recommendations, Surveillance Summaries, and the Annual Summary to communicate major public health events to the media, public policy makers and health professionals through multiple media channels - print, television, radio, interactive World Wide Web. *CDC Plan*	FY 02: 86 issues FY 01: 86 issues FY 00: 81 issues FY 99: 77 issues	FY 02: FY 01: FY 00: 81 issues FY 99: 77 issues published. Also available on CDC Internet site.

See also:

- Objective 1.7, Reduce the Incidence and Impact of Infectious Diseases
- Objective 3.3, Increase the Availability of Primary Health Care Services for Underserved Populations
- Objective 3.4.Protect and Improve the Health and Satisfaction of Beneficiaries in Medicare and Medicaid
- Objective 3.6, Improve the Health Status of American Indians and Alaskan Natives
- Objective 3.7, Improve the Management and Effectiveness of Services for the Treatment and management of HIV/AIDS

HHS 4.2: Increase Consumer and Patient Use of Health Care Quality Information

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance. *HCFA Plan*	FY 02: TBD FY 01: Exceed national enrollment growth rates collectively in areas under HCFA outreach and enrollment grant; Increase enrollment by 4 percentage points in States where FY 2000 target was not met FY 00: Increase enrollment by 4 percentage points nationally FY 99: Establish target	FY 02: FY 01: FY 00: Goal met, 5,499,349 dual eligible beneficiaries, a 4.4% enrollment increase FY 99: Goal met, target established *5,270,000 dual eligible beneficiaries. FY 98: 5,167,000 dual eligible beneficiaries (baseline) *FY 98 & 99 data approximated based on trend of 2% increase per year

Performance Goals	Targets	Actual Performance
For the Knowledge Exchange Network for information about mental health treatment and services: *SAMHSA Plan*		
Increase usefulness of KEN information.	FY 02: 10% increase FY 01: 10% increase FY 00: Establish Baseline	FY 02: FY 01: FY 00: 69%
Increase information requests [(800) number].	FY 02: 10% increase FY 01: 10% increase FY 00: 10% increase FY 99: 10% increase FY 98: 10% increase FY 97: 10% increase	FY 02: FY 01: FY 00: 52,252 (-2%) FY 99: 52,303 (+89%) FY 98: 27,642 (+3%) FY 97: 26,603 (+158%) FY 96: 10,324
Increase publications distributed.	FY 02: 10% increase FY 01: 10% increase FY 00: 10% increase FY 99: 10% increase FY 98: 10% increase FY 97: 10% increase	FY 02: FY 01: FY 00: 549,955 (+87%) FY 99: 293,572 (+109%) FY 98: 139,912 (+30%) FY 97: 107,087 (+98%) FY 96: 53,932
Increase web site contacts.	FY 02: 10% increase FY 01: 10% increase FY 00: 10% increase FY 99: 10% increase FY 98: 10% increase FY 97: 10% increase	FY 02: FY 01: FY 00: 706,919 (+94%) FY 99: 363,973 (+119%) FY 98: 179,690 (+127%) FY 97: 79,093 (+612%) FY 96: 11,108
Improve American Indian and Alaskan Native consumer satisfaction with the acceptability and accessibility of health care as measured by IHS consumer satisfaction survey. *IHS Plan*	FY 02:secure baseline FY 01: secure OMB clearance FY 00: OMB clearance and establish baseline FY 99: develop instrument and protocol	FY 02: FY 01: FY 00: submitted but clearance not completed FY 99: Completed

Performance Goals	Targets	Actual Performance
Increase access to HHS services for limited English proficient (LEP) persons (compliance with Title VI by recipients of Federal financial assistance). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 423 FY 01: 413	FY 02: FY 01: FY 00: 403 (baseline)

See also:

- Objective 5.2, Improve the Safety of Food, Drugs, Medical Devices, and Biological Projects

HHS 4.3: Improve Consumer and Patient Protection

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Decrease then sustain the reduced prevalence of the use of physical restraints in nursing homes. *HCFA Plan, AoA Plan*	FY 02: 10% FY 01: 10% FY 00: 10% FY 99: 14%	FY 02: FY 01: FY 00: 9.8% (Interim) FY 99: 11.9% FY 96: 17.2% (baseline)
Reduce the prevalence of pressure ulcers (bed sores) among patients in nursing homes. *HCFA Plan, AoA Plan*	FY 02: 9.5% FY 01: 9.6 % FY 00: Establish baseline/targets FY 99: New in 2000	FY 02: FY 01: FY 00: 9.8% (baseline) FY 99: N/A
For the Administration on Aging's Ombudsman program, maintain the resolution/partial resolution rate for complaints involving nursing homes. *AoA Plan*	FY 02: 70% FY 01: 70% FY 00: 70% FY 99: 71.48%	FY 02: FY 01: FY 00: 11/01 FY 99: 74.3% FY 98: 70.6% FY 97: 72.1% FY 96: 74%

Performance Goals	Targets	Actual Performance
Sustain improved laboratory testing accuracy. – Percentages from laboratories enrolled in proficiency testing (PT) with no failures. – Laboratories properly enrolled and participating in PT. *HCFA Plan*	CY 02: 90% CY 01: 90% CY 00: 90% CY 99: 90% CY 02: 95% CY 01: 95% CY 00: 95% CY 99: 95%	CY 02: CY 01: CY 00: 91.7% CY 99: 91.3% CY 98: 88.1% CY 97: 88.6% CY 96: 87.4% CY 95: 69.4% CY 02: CY 01: CY 00: 96.4% CY 99: 95.4% CY 98: 94.8% CY 97: 94.4% CY 96: 93.2% CY 95: 89.6%
Maintain 100% accreditation of all IHS hospitals and outpatient clinics. *IHS Plan*	FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100%	FY 02: FY 01: FY 00: 100% FY 99: 100% FY 98: 100%
Increase the number of complaints of abuse that are addressed under the Protection and Advocacy for Individuals with Mental Illness program. *SAMHSA Plan*	FY 02: 19,300 FY 01: 11,100 FY 00: 9,650 FY 99: 9,000	FY 02: FY 01: FY 00: 3/01 FY 99: 8,147 FY 98: 8,687 FY 97: 8,360
Increase access for minorities and persons with disabilities to nondiscriminatory services in managed care settings (managed care plans' compliance with Title VI, Section 504 and the Americans with Disabilities Act). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 89 FY 01: 87	FY 02: FY 01: FY 00: 85 (baseline)

Performance Goals	Targets	Actual Performance
Increase access to HHS services for limited English proficient (LEP) persons (compliance with Title VI by recipients of Federal financial assistance). Measure: Increased number of corrective actions, no violation findings, reviews, outreach activities, consultations/technical assistance and partnerships. *OCR Plan*	FY 02: 423 FY 01: 413	FY 02: FY 01: FY 00: 403 (baseline)
Increase number of collaborative activities (workshops, publications and other resource materials produced) that assist institutions to (1) promote integrity in the health science research enterprise, and (2) develop administrative processes that effectively respond to allegations of scientific misconduct. *OPHS Plan*	FY 02: 4 workshops and 2 resources FY 01: 4 workshops and 2 resources FY 00: 4 workshops and 2 resources	FY 02: FY 01: FY 00: 5 workshops 1 resource FY 99: 6 workshops 1 resource
Increase percent of institutional policies for responding to allegations of scientific misconduct that have been reviewed for compliance with the Federal regulation 42 CFR Part 50, Subpart A. *OPHS Plan*	FY 02: 45% FY 01: 40% FY 00: 40%	FY 02: FY 01: FY 00: 37% FY 99: 35%

HHS 4.4: Develop Knowledge That Improves the Quality and Effectiveness of Human Services Practice

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Establish future research agenda based on users' needs. *AHRQ Plan.*	Accomplish the following based on consultation with various groups:	
	FY 02: Agency research agenda covering strategic goal areas for FY 2002 priorities is documented based on consultations with various groups.	FY 02:
	FY 01: Agency research agenda covering strategic goal areas for FY 2001 priorities (patient safety and informatics) is documented.	FY 01:
	FY 00: Agency research agenda covering the 3 strategic research goals and the new FY 2000 closing the gap initiatives are documented.	FY 00:Completed
	FY 99: Agency research agenda covering the 3 strategic research goals is developed and documented.	FY 99: Completed

Performance Goals	Targets	Actual Performance
Evaluate the impact AHRQ sponsored products in advancing methods to measure and improve health care. *AHRQ Plan*	FY 02: • Evaluate private sector use of at least 5 AHRQ findings. • Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. FY 01: • Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. FY 00: • Use of evidence reports and technology assessments to create quality improvement tools in at least 10 organizations. • Consumer Assessment of Health Plan Study (CAHPS) has assisted the Health Care Financing Administration in informing Medicare beneficiaries about their health care choices. • FY 99 • Develop and initiate evaluation studies on the quality and usefulness of the evidence reports and technology assessments produced by the Evidence-based Practice Centers • Results of the evaluation of the CAHPS will be used to improve the usability and usefulness of the tool. Findings are expected to show whether information increases consumer confidence when choices.	FY 02: FY 01: FY 00: 16 examples listed Completed. FY 99: Final report received in 06/00

See also:

- Objective 6.5 Strengthen and Diversity the Base of Well-Qualified Health Researchers

HHS Goal 5: IMPROVE THE NATION'S PUBLIC HEALTH SYSTEMS

In addition to behavior, access, and quality, the vitality of the public health system in the United States is essential to ensuring and improving the health of Americans. Therefore, Goal 5 is concerned with making sure the infrastructure of the public health system is sound.

Weaknesses in the public health infrastructure have been documented since the 1988 report from the Institute of Medicine, The Future of Public Health (National Academy of Sciences, IOM, Committee for the Study of the Future of Public Health; Division of Health Care Services, 1988). Most recently (February 1999), a General Accounting Office study reported that over half of state public health laboratories do not conduct tests for surveillance of hepatitis C and penicillin-resistant *S. pneumoniae*. According to the study, just over half of the state public health laboratories have access to advanced molecular technology. The study reported that public health directors believe that there are not enough laboratory staff who can perform tests and that there are insufficient numbers of epidemiology staff who can analyze data and translate surveillance information into disease prevention and control activities. The laboratories at the Centers for Disease Control and Prevention and the Food and Drug Administration are overcrowded. Other data indicate that State and local public health staff have limited access to technology. For example, only 48 percent of local health department directors have continuous high speed Internet access.

SUMMARY PERFORMANCE REPORT
HHS Strategic Goal 5

These are selected performance stories from the performance plans of the HHS operating and staff components that support key areas related to the achievement of this strategic goal. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan.

SAFETY AND EFFECTIVENESS OF FOOD, DRUGS, AND MEDICAL PRODUCTS

Preventive Control Systems–HAACP. FDA ensures the safety of the food supply through the implementation of food safety standards at all points along the food production chain. Preventive control systems such as the HACCP (Hazard Analysis Critical Control Point) allow manufacturers and food preparers to identify points in the process where safety problems can occur and establish measures to prevent them. In FY 1999, FDA set a target to ensure that 50 percent of the domestic seafood industry had functioning HACCP systems. Although fewer than 50 percent of these processors met all the criteria for operating a functioning HACCP system, only 4 percent of the firms inspected warranted regulatory action due to problems that raise significant public health concerns. In evaluating the public health outcomes of HACCP implementation in this industry, FDA has met the intent of using HACCP as a strategy to prevent microbial contamination of seafood produced in the United States.

Surveillance of Foodborne Illness. Improving the ability of public health agencies to monitor foodborne illness is a key component of the Food Safety Initiative. CDC has made substantial progress in improving food safety through collaborations with Federal, State, and local government partners and with public and private sector partners. CDC led the development and implementation of impressive foodborne disease surveillance systems. These data will help in effectively targeting resources and improving prevention methods. For example, the PulseNet laboratory DNA fingerprinting network (in 48 public health laboratories) provides early detection of foodborne disease outbreaks within and between States. CDC met its goal of expanding the number of labs using PulseNet to 40 and anticipates that 45 laboratories will be participating in FY 2001.

Premarket Review–Timeliness. FDA has consistently met or exceeded its goals for premarket review established by the Prescription Drug User Fee Act. For example, FDA met its FY 1999 target to review and complete first action on 90 percent of standard original New Drug Application submissions on time (within 12 months of receipt), and expects to meet its FY 2000 target of 90 percent. Completion of on-time reviews will allow FDA to bring a greater number of new products to market each year. In 2000, FDA approved several new drugs, including: FocalSeal-L Surgical Sealant was approved as a surgical sealant for use in lungs to seal air leaks following removal of cancerous lung tumors; and the drug Kaletra, which is one of a class of AIDS drugs called protease inhibitors for use by adults and by HIV infected infants and children who are older than six months.

Premarket Review–Conformance. FDA has established performance goals for conformance with FDA requirements as indicators of the agency's success in ensuring the quality and accuracy of mammograms. FDA has consistency met its goal for ensuring that 97 percent of mammography facilities met with inspection standards, with less than 3 percent of facilities with serious inspection problems. Performance data indicate that FDA achieved a conformance rate of 97 percent in FY 1997, FY 1998, FY 1999, and 2000. This was the third consecutive year of achieving this high standard. Inspection data continue to show facilities' compliance with the national standards and in the quality of x-ray images.

Postmarket Surveillance--Adverse Event Reporting. To ensure the safety of drugs that are already on the market, FDA implemented an adverse event reporting system. FDA evaluates spontaneous reporting data from the Adverse Event Reporting System (AERS) to identify any serious, rare, or unexpected adverse events or an increased incidence of events. Based on its evaluation, FDA may decide to disseminate risk information, such as Dear Healthcare Professional letters, and may initiate regulatory action. The AERS has been operational for nearly three years. In CY 1999, over 275,000 Individual Safety Reports (ISRs) were received for entry into the AERS of which over 82,000 (30 percent) represented serious and unexpected events. In CY 2000, 261,000 ISRs were received for entry into AERS. In November 1998, FDA published an *Advanced Notice of Proposed Rulemaking for Electronic Reporting of Postmarketing Adverse Drug Reactions* that would require manufacturers of marketed human drugs to submit ISRs to the agency electronically. In response, FDA set a FY 1999 goal to implement AERS for the electronic receipt and review of voluntary and mandatory Adverse Drug Event (ADE) reports. In FY 1999, FDA conducted a pilot program for electronic submission of ISRs involving manufacturers with approved products. In addition, FDA developed and piloted an AERS data retrieval system to provide reviewers with quick access to the AERS data and reduce their reliance on hard copy reports. In FY 2000, the pilot program to increase participation in electronic expedited reporting is ongoing. Regulation requiring that adverse event reports be coded using standardized international terminology (i.e., Medical Dictionary for Regulatory Activities (MedRA)), is on target to be released this year.

PUBLIC HEALTH SYSTEMS AND SURVEILLANCE

Public Health Infrastructure. In November 2000, Congress passed the landmark, bipartisan ***Frist-Kennedy Public Health Improvement Act***, mandating immediate actions to remedy deficiencies in public health systems and infrastructure. CDC's strategy to improve public health is built on these recommendations and encompasses five approaches – a combination of ***broad-based*** efforts to build core public health capacities and ***targeted*** programs to address areas of special need. Through these strategies – and in concert with our external public health partners – CDC is committed to improving public health at all levels.

- **Strengthening public health practice** by strengthening the major components of the **public health infrastructure** that undergirds public health: the public health workforce;

public health departments and laboratories; and public health's information, communications, and knowledge management systems;

- **Stimulating extramural *prevention* research** to discover how the latest *biomedical* research can be applied in our local communities and to supply those who work on the front lines of public health with evidence of "what works";
- **Eliminating racial and ethnic health disparities** to close serious gaps in health status by developing targeted public health interventions and testing their effectiveness in racial and ethnic minority communities where they will have the greatest impact; and
- Building the **National Electronic Disease Surveillance System** to effectively integrate disease detection and monitoring and ensure rapid reporting and followup;
- **Building cross-cutting capacities and expertise at CDC** to support key components of all categorical prevention programs.

BIOTERRORISM

- **Countering Bioterrorism.** In response to the growing threat of biological terrorism, CDC has focused on strengthening the public health capacity at the Federal, State and local level to respond to a terrorist event. In FY 2000, CDC funded 11 States or localities in Preparedness & Response planning activities, expanded epidemiology and surveillance capacity to 55 health departments (exceeding a target of 40 health departments), and increased the number of laboratories participating in the National Laboratory Response Network (NLRN) to 43. In FY 2001, CDC's target is for 80 laboratories to participate in the NLRN. In addition, CDC will maintain the National Pharmaceutical Stockpile for biological or chemical agents, including the ability to medically treat 1 million civilians from biological agents of anthrax, plague, and tularemia and/or medically treat 10,000 civilians from chemical attack using nerve or blistering agents.

- **National Pharmaceutical Stockpile (NPS) Program.** In response to the need for medication, antidotes, and medical supplies during or after a bioterrorism act, the Department has made a commitment to develop and maintain a National Pharmaceutical Stockpile Program. CDC's NPS Program maintains a physical stockpile of adequate medical and response supplies that are strategically located near population centers or at air cargo transport hubs. This approach facilitates deployment in the event of a bioterrorism incident or other public health emergency in 12 hours. During FY 2000 the physical stockpile has become fully operational and ready for deployment, hence achieving CDC targets. In FY 2001 and FY 2002, CDC will focus its efforts on the maintenance of the NPS.

- **Metropolitan Medical Response System.** OPHS manages and coordinates the Federal health, medical and health related social service response and recovery to major emergencies, Federally declared disasters and terrorist acts. As such, OPHS directs the Metropolitan Medical Response System (MMRS) development program, which provides a mechanism to forge a local integrated response which links multiple local, State and Federal agencies as well as private health care institutions that will serve as the initial responders to any weapon of mass destruction (WMD) event. MMRS that address the health consequences of the release of a weapon of mass destruction (WMD) were initiated in 20 additional areas in 2000, bringing the total to 72, meeting the FY 2000 target. In FY 1999, twenty new MMRS development

contracts were initiated in cities. During FY 2000, 25 contract modifications were made to add funding for bioterrorism capabilities to the systems begun during FY 1999, bringing the total number to the target of 47.

HHS 5.1: Improve the Capacity of the Public Health System to Identify and Respond to Threats to the Health of the Nation's Population

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
The Emerging Infections Program (EIP), a network of regional population-based programs, will be established to conduct active surveillance, engage in applied epidemiologic and laboratory research and pilot and evaluate prevention and intervention measures. *CDC Plan*	FY 01: 9 EIP sites. FY 00: 9 EIP sites. FY 99: 8 EIP sites	FY 01: FY 00: 9 EIP sites. FY 99: 7 EIP sites.
At least 85% of total required data from all programs funded by the Preventive Health and Health Services Block grant will be reported to CDC annually. *CDC Plan*	FY 02: At least 85% FY 01: At least 85% FY 00: At least 85% FY 99: At least 80%	FY 02: FY 01: FY 00: 3/01 FY 99: 82% FY 95: 77%
Ensure safe and healthful working conditions by developing a system for surveillance for major occupational illnesses, injuries, exposures, and health hazards. *CDC Plan*	FY 00: Finalize surveillance strategic plan and begin implementing the recommendations FY 99: Undertake a comprehensive surveillance planning process with NIOSH partners at the State and Federal levels to establish surveillance priorities and define roles for agencies.	FY 00: Achieved. "Tracking Occupational Injuries, Illnesses, and Hazards: The NIOSH Surveillance Strategic Plan" published FY 99: Planning process completed; draft surveillance strategic plan developed.

Performance Goals	Targets	Actual Performance
By 2002, a national network will exist that will provide all States with better access to data on disabilities for their use in analyzing the needs of people with disabling conditions as measured by the number of States using the Behavioral Risk Factor Surveillance Survey (BRFSS) Disability Module. *CDC Plan*	FY 02: 20 States FY 01: 14 FY 00: 14 FY 99: 15	FY 02: FY 01: FY 00: 16 FY 99: 16 FY 97: 0
Implement the MedSun (Medical Device Surveillance Network) System. *FDA Plan*	FY 02: Recruit 75 to 100 new facilities FY 01: Recruit 75 to 100 hospitals to report adverse events associated with medical devices. FY 00: Develop MedSun System based on approximately 75 to 90 user facilities. FY 99: N/A	FY 02 FY 01: FY 00: Implement Phase II Pilot with 25 hospitals FY 99: Pilot completed FY 98: Recruited 24 pilot facilities.

Performance Goals	Targets	Actual Performance
Streamline the Adverse Event Reporting System (AERS). *FDA Plan*	FY 02: Issue final rules on adverse drug event reporting and electronic submissions	FY02:
	FY 01: Issue Proposed Rule on adverse event reporting requirements. Issue Guidance on electronic submission of adverse event reports. Grant waivers to companies wishing to submit adverse event reports electronically. Continue AERS development. Roll out of AERS data mart to medical officer in new drug review divisions module.	FY 01:
	FY 00: Develop next generation of the AERS to enhance functionality.	FY 00: Development and roll-out of AERS 2.0 was completed. Pilot program to increase participation in electronic expedited reporting is ongoing. Regulation requiring that adverse event reports be precoded using the Medical Dictionary for Regulatory Activities (MedRA) is on target for release for public comment this FY.
	FY 99: Implement AERS for the electronic receipt and review of voluntary and mandatory ADE reports.	FY 99: The AERS was successfully implemented and has been operational for nearly three years.

Performance Goals	Targets	Actual Performance
Develop environmental health surveillance system, and complete community environmental assessments in 90% AI/AN communities. *IHS Plan*	FY 02: 10% over FY 01 FY 01: 15% of communities assessed FY 00: develop surveillance protocol and plan	FY 02: FY 01: FY 00: protocol and plan partially completed FY 99: no reliable baseline
Bioterrorism		
Increase the number of state and major city health departments with expanded epidemiology and surveillance capacity to investigate and mitigate health threats by bioterrorism. *CDC Plan*	FY 02: 55 health departments FY 01: 55 FY 00: 40 FY 99: 40	FY 02: FY 01: FY 00: 55 FY 99: 34 FY 98: 0
The number of laboratories participating in the National Laboratory Response Network to provide rapid and/or reference support for biologic agents. *CDC Plan*	FY 02: 80 laboratories FY 01: 80 FY 00: 43	FY 02: FY 01: FY 00: 43 FY 99: 43
Increase capacity of state and major city laboratories to provide or access rapid testing or potential bioterrorism agents. *CDC Plan*	FY 02: 50-55 laboratories FY 01: 50-55 FY 00: 40 FY 99: 2	FY 02: FY 01: FY 00: 43 FY 99: 43 FY 98: 0
The number of laboratories qualified to provide surge capacity for analysis of chemical agents. *CDC Plan*	FY 02: 5 laboratories FY 01: 5 FY 00: 4	FY 02: FY 01: FY 00: 5 FY 99: 4
Rapidly measure, in blood and urine, toxic substances likely to be used in chemical terrorism. *CDC Plan*	FY 02: 160 substances FY 01: 120 FY 00: 100 FY 99: 50	FY 02 : FY 01: FY 00: 90 FY 99: 50 FY 98: 0
The number of States and major metropolitan areas with health sector dedicated communications systems to facilitate or expedite detection and response to terrorist events will be increased. *CDC Plan*	**States/Metropolitan Areas** FY 02: 54 FY 01: 54 FY 00: 40	FY 02: FY 01: FY 00: 40 FY 99: 36 FY 98: 0

Maintain a national pharmaceutical "stockpile" for deployment to respond to terrorist use of potential biological or chemical agents, including the ability to medically treat 1 million civilians from biological agents of anthrax, plague and tularemia and/or to medically treat 10,000 civilians from chemical attack using nerve or blistering agents. *CDC Plan*	FY 02: Maintain operational and ready status for deployment. FY 01: Stockpile is operational and ready for deployment. FY 00: Maintain a national pharmaceutical "stockpile" for deployment to respond to terrorist use of potential biological or chemical agents, including the ability to medically treat 1 million civilians from biological agents of anthrax, plague and tularemia and/or to medically treat 10,000 civilians from chemical attack using nerve or blistering agents FY 99: Create a national pharmaceutical "stockpile" available for deployment to respond to terrorist use of potential biological or chemical agents, including the ability to protect 1-4 million civilians from anthrax attacks.	FY 02: FY 01: FY 00: Stockpile now capable of treating 6.64 million for biological agents including anthrax, plague and tularemia, and 16,000 for exposure to chemical weapons such as nerve or blistering agents. FY 99: Created stockpile FY 98: no plan
Increase number of Metropolitan Medical Response Systems with bioterrorism capabilities. *OPHS Plan*	FY 02: 97 FY 01: 72 FY 00: 47	FY 02: FY 01: FY 00: 47 FY 99: 27 FY 98: 0

See also:

- Objective 1.8, Reduce the Impact of Environmental Factors on Human Health

HHS 5.2: Improve the Safety of Food, Drugs, Medical Devices, and Biological Products

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Food Safety		
Increase the percentage of high-risk domestic food establishments inspected once every year. *FDA Plan*	FY 02: 90% once every year FY 01: 90-100% once every year FY 00: 90-100% once every one to two years	FY 02: FY 01: FY 00: 91%
Maintain biennial inspection coverage by inspecting 50% of registered animal drug and feed establishments. *FDA Plan*	FY 02: 50% FY 01: 46% FY 00: 27% FY 99: 27%	FY 02 FY 01: FY 00: 39% FY 99: 25%
Assure 100% compliance with the Bovine Spongiform Encephalopathy (BSE) feed regulation through inspections and compliance actions.`*FDA Plan*	FY 02: 100% FY 01: N/A FY 00: N/A FY 99: Ensure compliance with good manufacturing practices including the newly implemented BSE regulation through a variety of methods.	FY 02: FY 01: FY 00: N/A FY 99: 7200 inspections to date. Computer base training module for BSE inspections developed.
Complete first action on 65% of food and color additive petitions within 360 days of receipt. *FDA Plan*	FY 02: 65% FY 01: 50% FY 00: 40% FY 99: 30%	FY 02: FY 01: FY 00: 10/01 FY 99: 77%
Respond to 95% of notifications for dietary supplements containing "new dietary ingredients" within 75 days. *FDA Plan*	FY 02: 95% FY 01: 90% FY 00: 90% FY 99: N/A	FY 02: FY 01: FY 00: 100% FY 99: 100% FY 98: 100%

Performance Goals	Targets	Actual Performance
The proportion of reported foodborne outbreak investigations in which the causative organism or toxin is identified. *CDC Plan*	FY 02: 57 % FY 01: 55% FY 00: 50% FY 99: 45%	FY 02: FY 01: FY 00: 04/01 FY 99: 45% FY 98: 40%
The proportion of reported foodborne outbreaks in which the food that caused the outbreak is identified. *CDC Plan*	FY 02: 57% FY 01: 55% FY 00: > 50% FY 99: 50%	FY 02: FY 01: FY 00: 4/01 FY 99: 48% FY 98: 40%
Expand the number of public health labs capable of accessing PulseNet to build subtyping capacity and rapid exchange of foodborne illness data for early identification of and response to outbreaks within and between States. *CDC Plan* Overall Target: 56 public health departments (number of pathogens that are added may increase as new emerging pathogens are identified.	FY 02: 45 Labs for *E.coli* 0157:H7 and *Salmonella Typhimurium;* 30 labs for *Listeria monocytogenes*; 15 labs for *Shigella sonnei.* FY 01: 45 labs for *E.coli* 0157:H7 and *Salmonella Typhimurium*, 30 labs for *Listeria monocytogenes*, FY 00: 40 labs for E.coli 0157:H7 and *Salmonella Typhimurium* and 20 labs for *Listeria monocytogenes*. FY 99: Enhanced surveillance and control in 29 State labs for *E.coli* 0157:H7 and expanded to include Salmonella and Listeria in 7 State labs.	FY 02: FY 01: 4/01 FY 00: Expanded capacity to 40 labs for *E.coli* 0157:H7 and *Salmonella Typhimurium*, and **u20** labs for *Listeria monocytogenes*, and 7 labs for *Shigella sonnei*. FY 99: Enhanced surveillance and control in 29 state labs for *E.coli* 0157:H7 and expanded to include Salmonella and Listeria in 7 state labs. FY 97: 0 States

Performance Goals	Targets	Actual Performance
Enhance FoodNet, a foodborne diseases active surveillance network, by increasing the number of pathogens and syndromes under active surveillance to identify trends in foodborne illness. *CDC Plan* Overall Target: on-going. Dependant on identification of new pathogens and syndromes.	**Pathogens/Syndromes** FY 02: 11 FY 01: 11 FY 00: 10 FY 99: 8 pathogens.	 FY 02: FY 01: 4/01 FY 00: 10 FY 99: 8 FY 97: 7 pathogens
Drugs, Biological Products, and Medical Device Safety		
The rate of central-line associated bloodstream infections in adult intensive care unit patients will be reduced as measured through the National Nosocomial Infections Surveillance (NNIS) System. *CDC Plan*	FY 02: 3.80 FY 01: 3.86 FY 00: 4.4 FY 99: 5.2 Overall target 3.80	FY 02: FY 01: FY 00: 3.92 FY 99: 4.4 FY 98: 5.3
Inspect registered human drug manufacturers, repackers, relabelers and medical gas repackers. *FDA Plan*	FY 02: 20% FY 01: 20% FY 00: 22% FY 99: 22%	FY 02: FY 01: FY 00: 22% FY 99: 26% FY 98: 24% FY 97: 26%
Ensure that at least 97% of mammography facilities meet inspection standards, with less than 3% of facilities with Level 1 (serious) inspection problems in FY 2002. *FDA Plan*	FY 02: 97% FY 01: 97% FY 00: 97% FY 99: 97%	FY 02: FY 01: FY 00: 97% FY 99: 97% FY 98: 97% FY 97: 97% FY 96: 95%
Maintain inspection coverage for Class II and Class III domestic medical device manufacturers at 25% in FY 2002. *FDA Plan*	FY 02: 22% FY 01: 22% FY 00: 22% FY 99: 26%	FY 02: FY 01: FY 00: 18% FY 99: 30% FY 98: 33% FY 97: 40%

Performance Goals	Targets	Actual Performance
Make available to consumers and health professionals more easily-understandable information on choosing and taking prescription and Over the Counter (OTC) drugs to prevent and reduce their misuse, take more of an activist role in how consumers use these drugs, and improve drug risk management, analysis, and communication procedures. *FDA Plan*	FY 02: Give consumers and health professions more easily understandable OTC drug information. FY 01: Give consumers and health professionals more easily understandable OTC drug information. FY 00: Make new drug approval information increasingly available via the Internet. Develop partnerships with national organizations to disseminate educational information to consumers	FY 02: FY 01: FY 00: OTC label education campaigns were targeted to grassroots consumers and key health professional organizations.
Meet the biennial inspection statutory requirement by inspecting 50 percent of registered blood banks, source plasma operations and biologics manufacturing establishments. *FDA Plan*	FY 02: 50% FY 01: 50% FY00: 50% FY 99: 43%	FY 02: FY 01: FY 00: 57% FY 99: 64% FY 98: 46% FY 97: 46%

See also:

- Objective 4.2 Increase Consumer and Patient Use of Health Care Quality Information

HHS Goal 6: STRENGTHEN THE NATION'S HEALTH SCIENCE RESEARCH ENTERPRISE AND ENHANCE ITS PRODUCTIVITY

The "health research" goal recognizes the prominence of health research in HHS and its importance in furthering the overall mission of improving the Nation's health. Many strategies under other goals and objectives are also research based, so there is overlap among the goals and objectives. The objectives under Goal 6 deal with creating knowledge that ultimately is useful in addressing health challenges. In this respect, the objectives address the need to maintain and improve the research infrastructure that produces scientific advances.

SUMMARY PERFORMANCE REPORT
HHS Strategic Goal 6

These are selected performance stories from the performance plans of the HHS operating and staff components that support key areas related to the achievement of this strategic goal. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan.

PREVENTION, DIAGNOSIS, AND TREATMENT OF DISEASE AND DISABILITY

Normal and Abnormal Biological Functions and Behavior. Understanding how disease, genetic alterations, and environmental factors affect the function of molecules, cells, tissues, organs and organisms and their consequences for human health are critical to improving our understanding of disease and developing methods for preventing, diagnosing and treating it. The nonlinear nature of basic research poses unique challenges for measuring research outcomes. In FY 2000 the NIH GPRA Assessment Working Group, composed of experts in the field of biomedical research, addressed the question of how NIH research added to the body of knowledge about normal and abnormal biological functions and behavior, and concluded that NIH had substantially exceeded its goals in this area. The research evaluated by the group resulted in significant new understandings of biological and behavioral processes, yielded answers to long-standing, important biological and behavioral questions, and had the potential for translation into new or improved technologies, diagnostics, treatments, and preventive strategies. The outcomes cited spanned a spectrum from genomics and molecular biology to studies of human populations and health care delivery, and included basic research that contributed to all areas of clinical medicine and behavior.

Biomedical Research in Prevention, Diagnosis and Treatment. NIH funded applied research has yielded significant advances in the prevention, diagnosis and treatment of disease and disability. Outcome goals for each of these areas were assessed by the GPRA Assessment Working Group which concluded that in FY 2000 goals were substantially exceeded in each area. In prevention, the Working Group cited as noteworthy research in prevention of transmission of HIV and other infectious diseases; prevention of alcohol, drug abuse and other abusive behaviors; prevention of Alzheimers' disease, obesity, diabetes, cardiovascular disease and cancer; and prevention of diseases and disabilities acquired during pregnancy and childhood. In diagnosis, the Working Group cited the development of new or improved methods for diagnosing disease and disability. In treatment, the group cited advances which ranged from novel gene- or cell-based techniques to alternative or low-technology approaches that were simple and cost-effective. The new or potential treatments were often more effective, had fewer side effects, and relieved pain and suffering, with the potential to reduce costs and improve the quality of treatment.

Public Health Research in Prevention, Diagnosis and Treatment. CDC prevention research has led to significant improvement in the prevention, diagnosis, and treatment of

diseases of public health interest. CDC uses a reliable, proven, flexible four-step process that adapts to the wide variety of problems that are subjects of CDC programs: infectious diseases, environmental and occupational health, injuries, and chronic diseases. This public health approach consists of detecting and defining a problem through surveillance, determining the causes, developing and testing potential strategies for handling the problem, and implementing nationwide prevention programs. The approach is supported by science, and is reflected in CDC's programs, as well as its evaluation of programs. Prevention effectiveness has been institutionalized as a public health science at CDC. Since 1992, CDC has substantially increased its ability to scientifically assess the prevention effectiveness of its programs and strategies. More than ever, CDC is able to prove that prevention is a sound and solid investment.

Human Genome Project. The Human Genome Project was started in 1990 and has, from its beginning, enjoyed significant success. A major goal of the Human Genome Project is to sequence, or read, each of the approximately three billion bases in the human genetic instruction book. Determining the complete genetic blueprint of humans will greatly accelerate the identification of the genes embedded in this genetic code that underlie many human diseases, including complex diseases that represent the greatest health burden to the U.S. population. Identifying those genes is the first step to a more profound understanding of the biological basis of disease and this, in turn, will lead to new, more effective, and inexpensive ways to diagnose, treat and prevent disease. Towards this end, a series of momentous scientific achievements were accomplished in FY 2000. In December 1999 the complete sequence of chromosome 22 was published in *Nature*, and in May 2000 the complete sequence of chromosome 21 was published in *Nature.* The genome sequence of the most complex model organism to date, the fruit fly, *Drosophila melanogaster*, was published in March 2000 in *Science*. Capping a remarkable year, the international consortium intends to publish its results of the working draft of the human genome in early 2001. This "working draft" represents 90 percent coverage of the human genome with at least 99 percent accuracy. This combined data set of maps and sequence has already accelerated the identification of over a hundred genes that are associated with disease and will serve as a valuable resource for the genetics community.

AIDS Vaccine Development. A safe and effective AIDS vaccine is a global public health imperative. AIDS is now the fourth leading cause of death and is the leading cause of disease burden in the developing world. An estimated 36 million people worldwide are living with AIDS. In sub-Sarahan Africa, the worst affected area, there are countries where more than 20 percent of adults are infected. Programmatically, perhaps the most important event in FY 2000 regarding the development of HIV vaccines was the formation of a new international HIV Vaccine Trials Network (HVTN). The HVTN will provide a comprehensive, clinically based network to develop and test preventive HIV vaccines. In addition to the units based in the United States, participating sites will be located in sub-Saharan Africa, Asia, Latin America and the Caribbean. The Network provides a coordinated, global framework in which to conduct clinical HIV vaccine research and thus will strengthen and expand NIH's HIV vaccine studies both domestically and in countries devastated by the AIDS pandemic. In FY 2000, NIH launched four novel public-private partnerships to accelerate the development of promising HIV/AIDS vaccines for use around the world. The new partnerships, called HIV Vaccine Design and Development Teams (HVDDTs), tap the different skills and talents of

private industry and academic research centers, and provide incentive to move strong HIV/AIDS vaccine candidates out of the laboratory and into human testing.

HEALTH CARE QUALITY, FINANCING, COST AND COST EFFECTIVENESS

AHRQ Research Agenda. Consistent with the principal of the Agency for Healthcare Research and Quality (AHRQ) that its research should begin and end with its customers, AHRQ met its FY 1999 performance goal to develop an Agency research agenda reflecting consultations with its customers. AHRQ received input from: 1) responses to mailings to over 100 stakeholders and customers; 2) responses to its *Federal Register* notice: "Request for Planning Ideas;" 3) over 20 "expert" and user group meetings; and 4) consultations with peer review study section members and the National Advisory Council. In FY 2000, AHRQ's ability to sustain a high level of performance is evidenced by how its research has been used to provide better health care and the impact it has had on the delivery of health care services. For example, in FY 2000 AHRQ: 1) established 19 primary care practice-based research networks; 2) documented over 38,961,574 hits on the National Guideline Clearinghouse (NGC) Web site; and 3) saw continued growth in the number of health plans (now over 400) using Consumer Assessment Health Plan (CAHPS), a survey and reporting program that helps employees choose among survey health plans.

Relevance of Findings of AHRQ Research. In FY 1999, findings from at least 10 AHRQ research activities were published in major peer reviewed professional publications. AHRQ documented over 50 citations of research sponsored by the Agency. Conservatively, there were 3,146 newspaper, trade press, and magazine articles citing the agency. Most importantly, AHRQ documented thirteen cases of research findings being implemented in the health care system. In FY 2000, there were 250 publications in outstanding peer-reviewed publications of AHRQ-sponsored and funded research, as well as 32 examples of featured coverage in major media. Further, AHRQ-sponsored research findings have been featured in coverage by an extensive number of major media representatives, such as CNN, Fox News, Washington Post, Boston Globe and USA Today.

Dissemination of AHRQ Research. AHRQ pursues the dissemination of research primarily through partnerships established for that purpose. AHRQ established a performance goal to form 5 dissemination partnerships in FY 1999, and exceeded that target by forming 30 public-private and public-public partnerships in FY 1999. AHRQ's achievements in research dissemination are also reflected in its goals to promote the translation of research into practice. For example, in FY 1999, AHRQ found that 21 purchasers and/or businesses used AHRQ research findings to make decisions. In FY 2000, AHRQ partnered with over 30 diverse public and private organizations, including Web-based groups, to disseminate evidence-based information. Further, the widespread use of AHRQ findings is providing purchasers with valuable information for making health care decisions. For example, in FY 2000 more than 90 million Americans use AHRQ'S Consumer Assessment of Health Plans (CAHPS) to help them decide which health plan best meets their health care needs. CAHPS is now used by more than 20 States. The Health Care Financing Administration has begun using CAHPS to survey Medicare managed care enrollees, and the US Office of Personnel

Management used CAHPS to report consumer assessments of health plans available to Federal workers and retirees for its FY 2000 open season. In FY 2001, AHRQ projects that its evidence-based practice centers will produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality.

Disparities in Health Care Research. AHRQ plans to continue to address racial disparities by funding projects which identify effective strategies for eliminating disparities in health care, particularly for racial and ethnic minorities. In FY 2000 AHRQ funded over 30 projects on health disparities. In collaboration partnership with the National Institutes of Health, AHRQ funded the Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED) initiative, which is a major new research initiative that will improve knowledge of the factors underlying ethnic and racial inequities in health care.

RESEARCH CAPACITY

Pre-and Post-Doctoral Trainees. In FY 1999, AHRQ supported 167 pre-and post-doctoral trainees, exceeding its FY 1999 goal of supporting 150 such trainees. AHRQ will strengthen its investment in future years by increasing the number of pre- and post-doctoral trainees it supports. In FY 2000, AHRQ funds supported 218 scholars, a 25 percent increase over FY 1999. The Agency also launched two career development programs (the Independent Scientist Award and the Mentored Clinical Scientist Development) that supported an additional 16 scholars. AHRQ plans to continue to address racial disparities by funding projects in FY 2001 to address eliminating disparities in health care, particularly for racial and ethnic minorities. AHRQ plans to support at least fifteen minority investigators through individual and center grants in FY 2001.

Research Training and Career Development Outreach. NIH is committed to training an supporting a research community that reflects the Nation's social diversity. Accordingly, NIH supports a number of training programs specifically designed to provide support to minority graduate and postdoctoral students and to recruit them into research at all career levels. NIH also supports programs designed to enhance the retention of women in biomedical research careers and provide support for individuals with disabilities. All of these efforts address in part the disparities in morbidity and mortality across racial/ethnic and other demographic groups. While progress remains slow, NIH continues to attract women, minorities and individuals with disability into health-related research.

Research Training and Career Development Support. Through its Research Training and Career Development Program, NIH supports a critical aspect of scientific research: the development of a talent base capable of producing advances in science. To evaluate its success in attracting, developing and retaining a diverse group of scientists, NIH has established several performance goals to assess the agency's success in attracting qualified applicants. In FY 2000, NIH substantially met its goal to maintain an application flow consistent with success rates close to historical levels of 40 percent for fellowships and career awards for basic scientists and 60 percent for research training grants and entry level career

awards. These awards remain popular with the pool of potential applicants and the quality of applications remains stable.

Facilities (NIH). NIH supports construction of facilities on the NIH campus, as well as grants to fund facility improvements at institutions outside of NIH. For FY 2000, NIH set goals to evaluate the progress of intramural construction projects. The goal to improve the operating conditions and environment of intramural facilities and the availability and reliability of NIH utility distribution systems to support Intramural Research Program was substantially met with 93 percent of intended FY 2000 repairs completed and 100 percent of site utilities completed. Construction of the Dale and Betty Bumpers Vaccine Research Center was completed as scheduled, and the Louis Stokes Laboratories building construction was 90 percent completed. Additional buildings are under initial stages of construction or in planning. For evaluating the progress of facility improvements outside of facility improvements at institutions outside of NIH (extramural), NIH has set targets for required approval of construction designs with 25 percent of construction designs approved one year after the grant was awarded, 50 percent approved within two years and 100 percent within three years. For FY 2000, the first and third year targets were substantially met and the second year target was significantly exceeded.

DISSEMINATION OF HEALTH RESEARCH RESULTS

Technology Transfer. The broad purpose of NIH's technology transfer activities is to promote the efficient transfer of new technology forthcoming from NIH research to the private sector, to facilitate and enhance the development of new drugs, other projects, and methods of treatment that benefit human health. Beyond the promise to advance public health, technology transfer contributes to global competitiveness of the Nation's businesses and ultimately to the U.S.'s economic prosperity. At present, NIH has one of the most active technology transfer programs in government. Through these activities, NIH has forged partnerships with industry, and other external research organizations that have enhanced and augmented the capacity of NIH to conduct laboratory and clinical research. In FY 2000 NIH determined that currently used measures have proved to be unsatisfactory in gauging the success of technology transfer program performance. To a large extent, the presence of "external influences" have made it difficult to separate the effects of NIH management from the influence of uncontrolled, outside factors. NIH has determined that the value and effect of NIH activities in technology transfer requires the development of new performance measures of the social and economic downstream effect of technologies developed through NIH scientists' efforts that are brought to market by licensees. Potential measures include dosages prescribed or used, reduction in mortality/morbidity, reduction in number of sick days used, and extension of life.

Dissemination of Public Health Information. CDC communicates public health news about disease outbreaks and trends in health and health behavior through the *Morbidity and Mortality Weekly Report*. CDC met its FY 2000 target to publish 81 issues of the *MMWR*, and expects to increase that number to 86 issues in FY 2001. In addition to its work with the *MMWR*, CDC is actively working to increase the number of States with a plan for a

comprehensive information network. In FY 1999, CDC targeted 18 States to participate in planning and attained the cooperation of 33 States. In FY 2001 CDC will work with an additional 9 States to implement communications networks.

The nearly explosive growth in use of Internet access to information led to a reduction in the use of the CDC Voice/FAX Information Service (VIS). While the VIS numbers are lower than the previous year, the numbers were still significant – average monthly calls received were over 46,000 and over 14,000 requests for documents to be faxed. Internet visitors for FY 2000 increased over 88 percent over that for FY 1999; accesses to information for FY 2000 increased by 82 percent over FY 1999 as well. Long-term projections indicate a reduced use of both audio and written information in favor of the Internet; therefore, starting in FY 2001,CDC merged these two goals into a single goal to continually enhance CDC's Information Technology infrastructure so that the public access to CDC information resources using the Internet, voice, and fax increases 25 percent per year.

PROTECTING HUMAN SUBJECTS IN RESEARCH/RESEARCH INTEGRITY

Educational Program in Responsible Conduct. The Online Resource for Instruction in the Responsible Conduct of Research, developed with support from OPHS' Office of Research Integrity (ORI), became available on November 1, 2000. This site provides individuals and institutions with the tools and resources to refine existing programs or develop new programs to foster the responsible conduct of research. The website is located at [http://rcr.ucsd.edu]. In addition, ORI has contracted for a self-instruction booklet that covers the pertinent subjects.

Oversight of Misconduct Cases. In FY 2000, the OPHS Office of Research Integrity (ORI) exceeded the target rate set for completing oversight of scientific misconduct cases within eight months of receiving final decision from institution, which was 70 percent. Of 26 cases closed by ORI during FY 2000, 85 percent were closed within 8 months of receiving the institutional documentation and final decision. The average ORI processing time for such cases was 6.2 months (the median time was 4 months). Twenty-six of the 30 cases open at the beginning of the fiscal year were closed by the end of the year. Of the oversight cases opened prior to 1999, only three remain open. Six of the 27 closed cases resulted in misconduct findings and the imposition of administrative actions. In another case, a settlement resulted in the imposition of administrative actions but no finding of misconduct.

Policy Reviews. The OPHS Office of Research Integrity (ORI) has now reviewed the policy of 37 percent of the institutions that have an assurance on file with it. The expected 40 percent goal was not reached because of the effort required to switch the assurance program to electronic administration and the growing number of assurances in the database. The analysis of institutional policies on research misconduct describes the range of approaches institutions have taken to the 18 issues generally covered in such policies. The study will be developed into a web-based module to help institutions create or revise their policies.

Compliance Oversight Activities. In FY 2000, the Division of Compliance Oversight (DCO) of the OPHS Office for Human Research Protections (OHRP) conducted four compliance oversight site visits (Duke University Healthcare System, Charles R. Drew University of Medicine and Science/King Drew Medical Center, University of Wisconsin-Madison, and University of Texas Medical Branch at Galveston). Additionally, OHRP opened 91 new compliance oversight cases and closed 60 cases in FY 2000. The number of open cases has been reduced from its peak of 182 in July 2000 to 144 as of January 2001. Approximately 30 additional cases have undergone extensive evaluation and are approaching closure.

National Human Research Protections Advisory Committee. The National Human Research Protections Advisory Committee held its first meeting in December 2000. This newly established committee will provide expert advice and recommendations to senior departmental officials on a broad range of issues and topics pertaining to or associated with the protection of human research subjects.

HHS 6.1: Advance the Scientific Understanding of Normal and Abnormal Biological Functions and Behaviors

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Add to the body of knowledge about normal and abnormal biological functions and behaviors. *NIH Plan*	*Annual Target* Progress in advancing scientific understanding in key fields bearing on our knowledge of biological functions and behavior in their normal and abnormal states	FY 02: FY 01: FY 00: Substantially exceeded FY 99: Substantially exceeded
Develop new or improved instruments and technologies for use in research and medicine. *NIH Plan*	Annual Target Progress in developing new instrumentation or technologies that enhance capabilities for investigating biological functions and diagnosing and treating diseases and disorders	FY 02: FY 01: FY 00: Substantially exceeded FY 99: Substantially exceeded

Performance Goals	Targets	Actual Performance
Develop critical genomic resources, including the DNA sequences of the human genome and of the genomes of important model organisms and disease-causing microorganisms. *NIH Plan*	FY 02 1. Finish 2/3 of the human genome. NIH grantees will be responsible for half of this target (1/3 of total). 2. Complete working draft of the mouse genome. 3. Obtain full-length clones and sequence data for 20,000 mammalian cDNAs. 4. Establish a mechanism to facilitate access to resources, services, and technologies needed to investigate gene function. 5. Develop technologies that assess, display, and query human genome sequence data to facilitate investigation of how the immune system responds during different disease conditions. 6. Initiate pathogen genome sequencing projects for additional NIH priority areas.	FY 02:
	FY 01 1. Worldwide effort completes "full shotgun" of human genome sequence. 2. Finish 1/3 of human genome. 3. Identify 750,000 single nucleotide polymorphisms (SNPs) 4. Complete sequencing of 5 additional bacterial pathogens and 5 chromosomes of protozoan parasites. 5. Initiate sequencing projects for at least 6 additional genomes (bacterial, fungal, parasitic). 6. Complete sequencing of genome of P.falciparum.	FY 01 (2/02)
	FY 00 1. Worldwide effort completes working draft of human genome. US contributes 2/3 of sequence, NIH contributes 85% of US total. 2. Finish sequence of at least one human chromosome. 2. Complete sequence of Drosophila melanogaster.	FY 00: Met Exceeded Met
	FY99 1. US annual production of 90 million base pairs 2. Worldwide annual production of 220 million base pairs. 3. Total sequence complete worldwide 400 million base pairs. 4. Complete sequence of C. elegans genome.	FY 99: Exceeded Exceeded Met Met

Performance Goals	Targets	Actual Performance
Develop an AIDS vaccine by 2007	FY 02-FY01	FY 02
	1.Progress in the design and development of new or improved vaccine strategies and delivery/production technologies.	FY 01
	2. Progress in characterization, standardization, and utilization of animal models for evaluating candidate vaccines.	
	3. Progress in collaborating with scientists in developing companies and with industry.	
	4. Progress in completion of ongoing trials and initiation of additional domestic and/or international trials of new or improved concepts and designs, including the progression of promising candidates to larger trials testing vaccine candidates.	
	FY 00	FY 00:
	1.Progress in the design and development of new or improved vaccine strategies and delivery/production technologies.	Met
	2. Progress in characterization, standardization, and utilization of animal models for evaluating candidate vaccines.	Met
	3. Progress in collaborating with scientists in developing companies and with industry.	Met
	4. Progress in completion of ongoing trials and initiation of additional domestic and/or international trials of new or improved concepts and designs, including the progression of promising candidates to larger trials testing vaccine candidates.	Met
	FY 99	FY 99:
	1. Increases in the research portfolio supporting innovative vaccine discovery.	Met
	2. Increased interactions between academic investigators and industry, to enhance opportunities for vaccine discovery and product development.	Met
	3. Progress in completion of ongoing trials of new vaccine concepts and designs.	Met

HHS 6.2: Improve Our Understanding of How to Prevent, Diagnose, and Treat Disease and Disability

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Develop new or improved approaches for preventing or delaying the onset or progression of disease and disability. *NIH Plan*	Annual Target Progress in developing (or facilitating the private sector's development of) new or improved approaches for preventing or delaying the onset of diseases and disabilities–and which reflect NIH responsiveness to emerging health needs, scientific opportunities, and new technologies	FY 02: FY 01: FY 00: Substantially exceeded FY 99: Successfully met
Develop new or improved methods for diagnosing disease and disability. *NIH Plan*	Annual Target Progress in developing (or facilitating the private sector's development of) new or improved diagnostic methods that are more accurate, less invasive, and/or more cost effective–and which reflect NIH responsiveness to emerging health needs, scientific opportunities, and new technologies	FY 02: FY 01: FY 00: Substantially exceeded FY 99: Substantially exceeded

Performance Goals	Targets	Actual Performance
Develop new or improved approaches for treating disease and disability. *NIH Plan*	Annual Target Progress in developing (or facilitating the private sector's development of) new or improved treatments that expand therapy options; improve the length and quality of life; and/or are more cost effective– and which reflect NIH responsiveness to emerging health needs, scientific opportunities, and new technologies	FY 02: FY 01: FY 00: Substantially exceeded FY 99: Substantially exceeded
Develop new or improved instruments and technologies for use in research and medicine. *NIH Plan*	Annual Target Progress in developing new instrumentation or technologies that enhance capabilities for investigating biological functions and diagnosing and treating diseases and disorders.	FY 02: FY 01: FY 00: Substantially exceeded FY 99: Substantially exceeded
Reduce morbidity and mortality attributable to behavioral risk factors by building nationwide programs in chronic disease prevention and health promotion and intervening in selected diseases and risk factors. Measure: Reduce the percentage of teenagers (in grades 9-12) who smoke by conducting an educational campaign, providing funding and technical assistance to State programs, and working with non-governmental entities. *CDC Plan*	FY 03: 32.3% FY 01: 34.2% FY 99: 36.4 %	FY 03: FY 01: 7/01 FY 99: 34.8% FY 97: 36.4 % FY 95: 34.8 % FY 93: 30.5 % FY 91: 27.5 %

Performance Goals	Targets	Actual Performance
Develop and strengthen epidemiologic and laboratory methods for detecting, controlling, and preventing infectious diseases. Measure: Extramural awards will be provided to conduct enhanced research investigations to assist in development and improvement of diagnostic tests for use in areas such as antimicrobial resistance, sexually transmitted diseases, malaria, Lyme disease, healthcare-associated infections, and blood safety. *CDC Plan*	FY 02: n/a FY 01: 45 awards FY 00: 22 awards FY 99: 22 awards	FY 01: FY 00: 04/01 FY 99: 22 awards FY 97: 17 awards
Strengthen domestic and global epidemiologic and laboratory capacity for surveillance and response to infectious disease. Measure: Establish a surveillance system to collect data on antimalarial drug resistance in sub-Saharan African countries. *CDC Plan*	FY 02: n/a FY 01: 54 Countries FY 00: 25 Overall target 54 countries	FY 01: FY 00: 54 FY 99: 0
Increase the toxic substances that can be measured by CDC's environmental health laboratory so state-of-the-art laboratory methods can be employed to prevent avoidable environmental disease. *CDC Plan*	FY 02:12 new substances FY 01:12 FY 00: 8 FY 99: 8	FY 02: FY 01: FY 00: 8 FY 99: 9 FY 97: 200

Performance Goals	Targets	Actual Performance
Increase early detection of breast and cervical cancer by building nationwide programs in breast and cervical cancer prevention.		
Measure: Excluding breast cancers diagnosed on and initial screen in the NBCCEDP, at least 73% of women aged 40 and older will be diagnosed at localized stage.	FY 02: 73% FY 01: 73% FY 00: 72% FY 99: 71%	FY 02: FY 01: FY 00: 4/01 FY 99: 70% FY 98: 70% FY 95: 70%
Measure: Excluding invasive cervical cancers diagnosed on an initial screen in the NBCCEDP, the age adjusted rate of invasive cervical cancer in women aged 20 and older is not more that 22 per 100,000 Pap tests provided. *CDC Plan*	FY 02-FY 99: No more than 22/100,000	FY 02: FY 01: FY 00: 4/01 FY 99: 9/100,000 FY 98: 23/100,000 FY 95: 26/100,000

Performance Goals	Targets	Actual Performance
Develop with other organizations, gene chip and gene array technology.		
– Support at least two multi-disciplined DNA and RNA-based microarray technologies.	FY 02: Support microarray technologies	FY 02:
– Develop "risk chip" technology to screen large numbers of people for biomarkers simultaneously.	FY 01: Develop technology	FY 01:
– Conduct molecular epidemiology studies to identify biomarkers of the most frequently occurring cancers in highly susceptible subpopulations.	FY 00: Conduct studies	FY 00: Established and validated conventional genotyping methods for 28 gene targets and polymorphisms; 686 colonoscopy individuals were genotyped for all common NAT2 alleles; analysis ongoing on completed case-control colorectal cancer study.
– Complete biochemical and epidemiology studies to define the basis of susceptibility of humans to the toxicity of regulated compounds. *FDA Plan*	FY 99: Complete studies	FY 99: Biochemical studies on pancreatic and colorectal cancer were completed and epidemiology studies on cancer are in the enrollment phase. FY 98: Conducted case control molecular epidemiology studies to assess breast and prostate cancer in African-American women/men.

See also:

- Objective 4.1, Enhance the Appropriate Use of Effective Health Services
- Objective 4.4, Develop Knowledge that Improves the Quality and Effectiveness of Human Services Practice

HHS 6.3: Enhance Our Understanding of How to Improve the Quality, Effectiveness, Utilization, Financing, and Cost-Effectiveness of Health Services

These are selected performance goals from the performance plans of the HHS operating and staff components that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Establish future research agenda based on users' needs. *AHRQ Plan.*	Accomplish the following based on consultation with various groups:	
	FY 02: Agency research agenda covering strategic goal areas for FY 2002 priorities is documented based on consultations with various groups.	FY 02:
	FY 01: Agency research agenda covering strategic goal areas for FY 2001 priorities (patient safety and informatics) is documented.	FY 01:
	FY 00: Agency research agenda covering the 3 strategic research goals and the new FY 2000 closing the gap initiatives are documented.	FY 00: Completed
	FY 99: Agency research agenda covering the 3 strategic research goals is developed and documented.	FY 99: Completed

Performance Goals	Targets	Actual Performance
Make significant contributions to the effective functioning of the U.S. health care system through the creation of new knowledge. *AHRQ Plan.*	FY 02: Funding of a minimum of 100 projects; 30% of these projects address priority populations.	FY 02
	FY 01: Funding a minimum of 60 projects to improve health care quality, safety and efficiency.	FY 01:
	FY 00: Funding a minimum of 10 projects that address gaps in knowledge about the priority problems faced by Medicare and Medicaid.	FY 00: 43 projects funded
	Funding of a minimum of 10 projects to address eliminating disparities in health care, particularly those for racial and ethnic minorities.	More than 30 projects funded
	FY 99: Funding of a minimum of 21 projects in consumers use of information on quality; strengthening value-based purchasing; measuring national health care quality; vulnerable populations; and translating research into practice.	FY 99: 56 projects funded
	FY 99: Funding of a minimum of 17 projects in outcomes for the elderly and chronically ill; clinical preventive services; and children's health.	FY 99: 51 projects funded

HHS 6.4: Accelerate Private-Sector Development of New Drugs, Biologic Therapies, and Medical Technology

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Review and act on 90% of standard original New Drug Application (NDA), Product License Application (PLA) and Biologic License Application (BLA) submissions within 10 months of receipt; and review and act on 90% of priority original NDA/PLA/BLA submissions within 6 months of receipt. *FDA Plan*	**Standard Applications within 12 months** FY 02: N/A FY 01: 90% FY 00: 90% FY 99: 90% **Standard Applications within 10 months** FY 02: 90% FY 01: 70% FY 00: 50% FY 99: 30% **Priority Applications within 6 months** FY 02: 90% FY 01: 90% FY 00: 90% FY 99: 90%	FY 02: FY 01: FY 00: 01/02 FY 99: 100% Drugs & Biologics FY 98: 100% FY 97: 100% FY 96: 100% FY 02: FY 01: FY 00: 09/01 FY 99: 66% Drugs FY 99: 80% Biologics FY 02: FY 01: FY 00: 07/01 FY 99: 100% Drugs & Biologics FY 98: 100% FY 97: 100%

Performance Goals	Targets	Actual Performance
Maintain the percentage of Premarket Approval Application (PMA) first actions completed on time (within 180 days). *FDA Plan*	FY 02: 90% FY 01: 90% FY 00: 85% FY 99: 65%	FY 02: FY 01: FY 00: 96% FY 99: 74% FY 98: 79% FY 97: 65% FY 96: 51%
Review and act on 80% of NADAs/Abbreviated New Animal Drug Applications (ANADAs) within 180 days of receipt. *FDA Plan*	FY 02: 80% FY 01: 80% FY 00: 73% FY 99: N/A	FY 02: FY 01: FY 00: 75% FY 99: 73%
Protect human research subjects participation in drug studies and assess the quality of data from these studies by conducting approximately 700 onsite inspections and data audits annually. *FDA Plan*	FY 02: 780 FY 01: N/A FY 00: N/A FY 99: N/A **Note**: The number of inspections completed each year is dependent on the number of applications received, has averaged approximately 100-120 per year.	FY 02: 01/03 FY 01: FY 00: 679 inspections completed FY 99: 683 inspections completed.

Performance Goals	Targets	Actual Performance
Develop a system to identify and measure the health outcomes of technologies licensed by the NIH. *NIH Plan*	FY 02: Develop two case studies to test the proposed methodology; finalize the approach; and apply it to 10% of all exclusively licensed technologies which are a part of commercially available products. FY 01: Establish a working group and obtain recommendations on potential outcome measures and sources for obtaining reliable data for those measurements on therapeutic drugs, vaccines and devices.	FY 02: FY 01:
Extramural awards will be provided to conduct enhanced research investigations to assist in development and improvement of diagnostic tests for use in areas such as antimicrobial resistance, sexually transmitted diseases, malaria, Lyme disease, healthcare-associated infections, and blood safety. *CDC Plan*	FY 02: n/a FY 01: 45 FY 00: 22 FY 99: 22	FY 01: FY 00: 04/01 FY 99: 22 awards FY 97: 17 awards

HHS 6.5: Strengthen and Diversify the Base of Well-Qualified Health Researchers

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Strengthen the scope and nature of extramural public health research programs. Measure: CDC will increase the number of young investigator and public health research training opportunities. *CDC Plan*	FY 01: n/a FY 00: 5% increase in career development awards funded by PRI.	FY 00: Continued funding 2 career development awards FY 99: Two extramural projects and one "infrastructure" project funded to support expanded training activities
The annual number of health services providers participating in distance learning activities will be increased. *CDC Plan*	FY 02: 125,000 FY 01: 120,000 FY 00: 115,000 FY 99: 105,000	FY 02: FY 01: FY 00: FY 99: 135,000 FY 97: 100,000
Public health microbiology fellows will be trained and available for employment in local, state, and Federal public health laboratories. *CDC Plan*	FY 02: 125 fellows trained FY 01: 100 FY 00: 70 FY 99: 40	FY 02: FY 01: FY 00: 73 FY 99: 40 FY 97: 13

Performance Goals	Targets	Actual Performance
As a measure of an acceptable supply of well-trained medical researchers, maintain historical application success rates for:		
– fellowships (F32).	FY 02: 40% FY 01: 40% FY 00: 40% FY 99: 40%	FY 02: FY 01: FY 00: 48% FY 99: 44%
– research training grants (T32).	FY 02: 60% FY 01: 60% FY 00: 60% FY 99: 60%	FY 02: FY 01: FY 00: 67% FY 99: 64%
– career awards for basic scientists(K01).	FY 02: 40% FY 01: 40% FY 00: 60% FY 99: 60%	FY 02: FY 01: FY 00: 36% FY 99: 37%
– entry-level career awards (K08). *NIH Plan*	FY 02: 50% FY 01: 50% FY 00: 60% FY 99: 60%	FY 02: FY 01: FY 00: 50% FY 99: 52%
To increase the pool of clinical researchers who can conduct patient-oriented research, increase awards in:		
– Mentored (K23) and Mid-Career Investigator (K24), Patient-Oriented Research Awards. *NIH Plan*	FY 02: 80 FY 01: 80 FY 00: 80 FY 99: 80	FY 02: FY 01: FY 00:189 (K23) 75 (K24) FY 99: 85 (K23) 81 (K24)

Performance Goals	Targets	Actual Performance
Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio. *AHRQ Plan*	FY 02: • Produce a minimum of 18 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality by improving practice • Fund at least 10 projects in tool and data development FY 01: • Support a minimum of 165 pre-and post-doctoral trainees. • Support a minimum of 15 minority investigators through individual and center grants. FY 00: Support a five percent increase, at a minimum, in number of pre- and post-doctoral trainees. FY 99: Support a minimum of 150 pre-and post-doctoral trainees.	FY 02: FY 01: FY 00: 25% increase FY 99: 167 trainees

HHS 6.6: Improve the Communication and Application of Health Research Results

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Based on established criteria, continue to publish the *Morbidity and Mortality Weekly Reports (MMWR)* series of publications including Reports and Recommendations, Surveillance Summaries, and the Annual Summary to communicate major public health events to the media, public policy makers and health professionals through multiple media channels - print, television, radio, interactive World Wide Web. *CDC Plan*	FY 02: 86 issues FY 01: 86 issues FY 00: 81 issues FY 99: 77 issues	FY 02: FY 01: FY 00: 81 issues FY 99: 77 issues published. Also, available on CDC web site

Performance Goals	Targets	Actual Performance
Make data more readily accessible to decision makers and researchers by releasing statistics in new formats to speed the release of data on high-priority topics. *CDC Plan*	FY 02: Maintain formats FY 01: Release two reports in such format. FY 00: Release one report.	FY 02: FY 01: FY 00: NCHS has released Variations in Teenage Birth Rates, 1991-1198: National and State Trends; expects to release *America's Children: Key National Indicators of Well-being* in July, and the *2000 Adolescent Health Chartbook* in the fall FY 99: *1999 Health and Aging Chart book* - projected publication - September 1999. FY 98: *Teenage Births in the United States: National and State Trends 1990-96* was published.
Research findings will be disseminated by investigators receiving PRI funds. *CDC Plan*	FY 01: Implement dissemination tracking system. FY 00: Establish dissemination goals for PRI-funded projects and methods for collection of data, including the number of published peer-reviewed studies and the number of products developed and distributed to consumers.	FY 01: FY 00:Developed initial design and plan for implementing a website. Dissemination goals for PRI funded projects: 80% of awards will have submitted results for publication within 1 year of study completion. FY 99: Developed initial design and plan for a website.

Performance Goals	Targets	Actual Performance
Maximize dissemination of information, tools, and products developed from research results for use in practice settings. *AHRQ Plan*	FY 02: • Number of State and local governments trained and or receiving technical assistance through User Liaison Program (ULP). • Form at least 20 partnerships to disseminate and implement research findings with public and private-sector organizations. FY 01: • Formation of a minimum of 10 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations. • Evidence-based practice centers (EPCs) will produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality. FY 00: At least 10 purchasers/businesses use AHRQ findings to make decisions. FY 99: At least 5 purchasers/ businesses use AHRQ findings to make decisions.	FY 02: FY 01: FY 00: AHRQ partnered with more than 30 diverse public and private organizations to disseminate evidence-based information. FY 99: Over 30 partnerships used to disseminate materials.

Performance Goals	Targets	Actual Performance
Continually enhance CDC's information technology infrastructure so that the public access to CDC information resources using the Internet, voice, and fax grows by 25 percent per year. *CDC Plan*	FY 02: +25 % FY 01: +25%	FY 02: FY 01: FY 00: Average monthly visitors to CDC's website was 2.8M with an average of 7 accesses of information content per visit. Average monthly calls to the CDC VIS was 46,000 and 14,000 requests for documents to be faxed to the callers.

HHS 6.7: Strengthen Mechanisms for Ensuring the Protection of Human Subjects in Research and the Integrity of the Research Process

These are selected performance goals from the performance plans of the HHS operating and staff divisions that support the achievement of this strategic objective. For in-depth performance information, program strategies that support the goal, and data verification and validation, please refer to the originating plan noted in italics at the end of each goal.

Performance Goals	Targets	Actual Performance
Sustain the number of collaborative activities (workshops, publications and other resource materials produced) that assist institutions to (1) promote integrity in the health science research enterprise, and (2) develop administrative processes that effectively respond to allegations of scientific misconduct. *OPHS Plan*	FY 02: 4 workshops and 2 resources FY 01: 4 workshops and 2 resources FY 00: 4 workshops and 2 resources	FY 02: FY 01: FY 00: 5 workshops 1 resource FY 99: 6 workshops 1 resource
Increase percent of institutional policies for responding to allegations of scientific misconduct that have been reviewed for compliance with the Federal regulation 42 CFR Part 50, Subpart A. *OPHS Plan*	FY 02: 45% FY 01: 40% FY 00: 40%	FY 02: FY 01: FY 00: 37% FY 99: 35%
Increase rate of completing oversight of scientific misconduct cases within eight months of receiving final decision from institution. *OPHS Plan*	FY 02: 80% FY 01: 75% FY 00: 70%	FY 02: FY 01: FY 00: 81% completed in 8 months FY 99: 79% completed in 1 year
Increase number of compliance oversight site-visits to evaluate allegations of non-compliance with the Federal regulations at 45 CFR Part 46.*OPHS Plan*	FY 02: 10 FY 01: 6	FY 02: FY 01: FY 00: 4