SECTION I:
Overview of Key Programs and Services Performance

HHS' Mission and Strategic Goals

Healthy and productive individuals, families, and communities are the very foundation of the nation's security and prosperity. Through its leadership, the Department of Health and Human Services (HHS) impacts virtually all Americans and people around the world, whether through direct services, the benefits of advances in science, or information that helps them to live better and to make healthy choices.

HHS' Mission

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

In a society that is diverse in culture, language, and ethnicity, HHS also manages an array of programs that aim to close the gaps and eliminate disparities in health status and access to health services and that increase opportunities for disadvantaged individuals to work and lead productive lives.

HHS accomplishes its mission by focusing on six strategic goals that reflect department-wide priorities:

- **Goal 1:** Reduce the major threats to the health and productivity of all Americans.
- **Goal 2:** Improve the economic and social well-being of individuals, families, and communities in the United States.
- **Goal 3:** Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.
- **Goal 4:** Improve the quality of health care and human services.
- **Goal 5**: Improve the nation's public health systems.
- **Goal 6:** Strengthen the nation's health science research enterprise and enhance its productivity.

More than 300 HHS programs are working toward accomplishing these goals that cut across individual HHS components and programs. For example, HHS works directly and with its partners to:

- conduct and sponsor medical and social science research to improve Americans' health and well being;
- guard against the outbreak of infectious diseases through immunization services and the elimination of environmental health hazards near peoples' homes and work places;
- assure the safety of food and drugs;
- provide health insurance for elderly and disabled Americans, for low-income people, and for children;

- provide financial assistance and employment support/services for low-income families;
- facilitate child support enforcement;
- improve maternal and infant health;
- improve preschool development and learning readiness;
- prevent child abuse and domestic violence;
- prevent and treat substance abuse;
- provide mental health services; and
- provide services for older Americans, including home-delivered meals.

HHS Partners: Working Together

The achievement of HHS's mission and goals, the success of HHS' programs, and the ability of HHS to meet the needs of clients are directly tied to the commitment, cooperation, and success generated by other federal agencies, states and local governments, tribes, community-based organizations, and other organizations.

HHS provides direct services for the underserved population of America, including American Indians and Alaska Natives. However, for many programs HHS' partners provide the direct services and have much more discretion in how the programs are implemented. In those cases, HHS contributes to accomplishing the programs and the strategic goals through funding, technical assistance, information dissemination, education and training, and research and demonstrations.

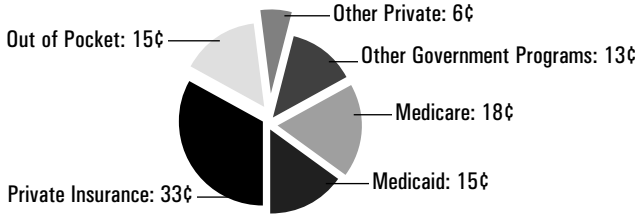
Often the needs of individuals and families go beyond individual HHS programs. Frequently programs are only focused on one particular need of a recipient because of the specific authority and funding for the program. However, to meet all the needs of a person, an integrated and comprehensive approach must be crafted with other HHS programs, other federal agencies, and HHS' partners. HHS therefore works internally and with its many, diverse partners to plan and deliver services in a coordinated way that maximizes resources and provides an integrated approach to clients' needs.

- HHS is the largest grant-making agency in the federal government — providing some $170 billion in public funds to states and other entities in fiscal year (FY) 1999.
- HHS funds more than 50,000 research investigators affiliated with about 2,000 university, hospital, and other research facilities.
- HHS helps fund and foster a nationwide network of more than

4,000 sites that provided needed primary and preventive care to nearly 12 million medically underserved patients last year.

- Another nationwide network HHS supports, the Aging Network, includes 57 state units on aging, 655 area agencies on aging, 225 tribal and native organizations representing 300 American Indian and Alaska Native tribal organizations, and two organizations serving Native Hawaiians, plus 27,000 service providers and adult care centers, and innumerable caregivers and volunteers.
- Nearly 40,000 providers of health care are certified to provide Medicare services and 21,700 employees of 54 Medicare contractors have primary responsibility for processing Medicare claims.
- Some 18,200 centers and 46,225 classrooms help to provide comprehensive development services with HHS support under the Head Start program for around 857,664 low-income preschool children, ages 3 to 5.

The Nation's Health Care Dollar, 1999



Source: HCFA/OACT
Note: 1999 is most current data available

HHS also collaborates and coordinates on common issues and challenges with other federal agencies, including:

- coordination with the Social Security Administration on the Medicare and Medicaid programs;
- coordination with the Departments of Agriculture, Education, and others for health insurance enrollment outreach, and the Department of Justice on health insurance integrity issues;
- coordination with the Office of National Drug Control Policy and Departments of Education, Justice, Treasury, Housing and Urban Development, and Transportation on drug control;
- collaboration between HHS and the Department of Labor to implement Welfare to Work programs; and
- cooperation with the Department of Education on the Head Start program.

In a recent example, working with the Departments of Education and Justice, HHS helped to expand the Safe Schools/Healthy Students Initiative to prevent school violence through a coordinated community-based partnership. In FY 2000, more than $41 million in new grants were awarded to 23 additional local education authorities, bringing the total number of grantees to 77. Urban, rural, suburban, and tribal school districts received support and plans were implemented to link community-based services and prevention activities

into a single, comprehensive community-wide approach to school safety, violence prevention and healthy child development.

HHS' Organization: Structured to Accomplish Our Mission

Because of the complexity and importance of the many issues involved in our mission, and consistent with the intention of congressional legislation, HHS is made up of components that administer the programs. Many of them are well-known to the average American. The Health Care Financing Administration manages health insurance programs. The Administration for Children and Families is responsible for temporary assistance to needy families, children's welfare, care and support, disabilities programs, and other services. The National Institutes of Health, Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry, Food and Drug Administration, Health Resources and Services Administration, Agency for Healthcare Research and Quality, Indian Health Service, and Substance Abuse and Mental Health Services Administration, are all devoted to public health. The Administration on Aging serves the elderly. All of these components and the Program Support Center, which provides centralized administrative support needs, are under the leadership of the Office of the Secretary of HHS. A more detailed discussion of the Office of the Secretary and each of the components is located in Appendix A of this report. The HHS organizational chart is located on the inside cover of the report.

HHS Performance on Key Programs and Services

HHS recognizes the challenge of managing more than 300 program activities, given the diversity of programs, target populations, and levels of government and the range of partners.

According to the January, 2001 General Accounting Office report on *Major Management Challenges and Program Risks*, "The Department of Health and Human Services . . . presents one of the more massive and complex management and program-related challenges in the federal government. The federal health and social programs it oversees tangibly affect the lives and well-being of virtually all Americans and encompass some of the most costly issues facing the nation . . ."

To help meet this challenge, HHS uses the HHS strategic plan to focus its efforts and has begun to use more than 900 annual performance goals and many more measures and targets under those goals as a means of directing annual efforts and determining the progress toward strategic goals. These annual performance goals and measures assess the processes, outputs, or outcomes and results of the programs.

In the discussion of the various programs that follow, it will be clear that for many HHS programs, the outcomes and results cannot be achieved without the cooperation and effort of other federal agencies and HHS' many partners. The results discussed here reflect the contributions and efforts of all of these partners.

This year HHS is continuing to work toward assessing the costs of HHS management of programs by associating a program's performance with its HHS net costs. Most of the programs discussed in this section were selected from the programs whose HHS net costs are in the $1 billion dollar range or more for FY 2000. The total sum of the net costs of the programs included here is equivalent to 97 percent of the total FY 2000 HHS net costs. HHS partners incur additional costs above these costs.

Health Statistics

	FY 1990	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999
National Health Expenditures (in billions)	$699	$994	$1.043	$1.092	N/A	N/A
Persons without Health Insurance (percent of people)	3.91%	15.4%	15.6%	16.1%	16.3%	15.5%
Days of Hospital Care (per 1,000 persons)	792	630	606	N/A	N/A	N/A

Source: U.S. Census Bureau 11/99
NA = Not available

These programs are well known to the American public. They include Medicare, Medicaid, State Children's Health Insurance Program, Temporary Assistance to Needy Families (welfare reform), Child Care, Child Welfare, Child Support Enforcement, and Head Start, as well as Substance Abuse Prevention and Treatment block grants, Infectious Diseases, and Biomedical and Medical Research. There are many intended purposes and facets of each of these programs; many are interrelated and contribute to several of the HHS strategic goals and objectives. In this report, they and their HHS net costs are discussed in the goal area that they primarily support.

These programs also complement and contribute to the efforts of programs in other HHS components that play an important part in accomplishing HHS' strategic goals, although these other programs do not have as high a dollar investment. The HHS strategic plan contains a useful explanation of how all of these programs interrelate.

A key purpose of GPRA is to improve the confidence of the American people in the capability of the federal government by systematically holding Federal agencies accountable for achieving program results.

The program performance information that follows is consistent with the Government Performance and Results Act of 1993 (GPRA) requirements and it supports and is aligned with the HHS strategic goals and related strategic objectives. The actual performance information in this report is current as of January 2001 and was extracted from available GPRA performance report information. The performance measures that were included are selected samples of many measures that exist and are usually one of many measures used to assess the program that they support.

This information is also consistent with GPRA programs discussed in the HHS FY 2002 Performance Plan and FY 2000 Report Summary and the HHS components' performance plans and performance reports. Performance information from other reliable sources was used as well. The source of the information is either cited or included in the listing of references in Appendix F.

HHS long ago resolved that performance data must be credible to be useful to decision-making. Overall, HHS has a large number of administrative and survey data systems to draw upon that provide high quality information. All parts of the Department have focused on the fundamentals of data verification and validation. However, program units have diverse functions and data needs; consequently, they vary

widely in how they collect, verify and validate timely performance data. HHS program units have also addressed other factors that affect data collection and quality. These include: reliance on achieving agreement by program partners, the timeliness of data, the resource-intensive nature of data collection, the diversity of data sources, and the suitability of data systems.

Since this is only the second year of GPRA performance reporting, indicators of program success are still evolving and issues of availability and reliability of performance data are still being addressed by many programs. It takes considerable time for partners to work together, develop shared priorities and goals, address weaknesses in data collection, and determine an optimum set of measures.

Some of the information in this FY 2000 report covers prior years because that is the most current information available at this time. The lag in reporting data occurs primarily in programs where HHS must rely on states and other outside entities for performance data. In addition, some data collections are not conducted annually. Therefore, assessment of HHS performance can best be determined by a comparison of annual trends from year to year, as more performance information becomes available.

For a more detailed discussion of data validation and verification and for more comprehensive GPRA program results, see the HHS GPRA Performance Plan and Report Summary and individual HHS component GPRA plans and reports that will appear online at **http://www.hhs.gov/budget/docgpra.htm**. The HHS strategic plan can be found at **http://aspe.hhs.gov/hhsplan/**. Additional discussion of the financial condition of programs is contained in individual HHS component financial reports that appear at their component's Web site or at **http://www.hhs.gov/of/reports/account/**.

The in-depth discussion that follows is organized under selected strategic goals that are achieved by the highest dollar programs. A brief discussion of the programs supporting the remaining strategic goals and other programs of interest are included at the end of this section.

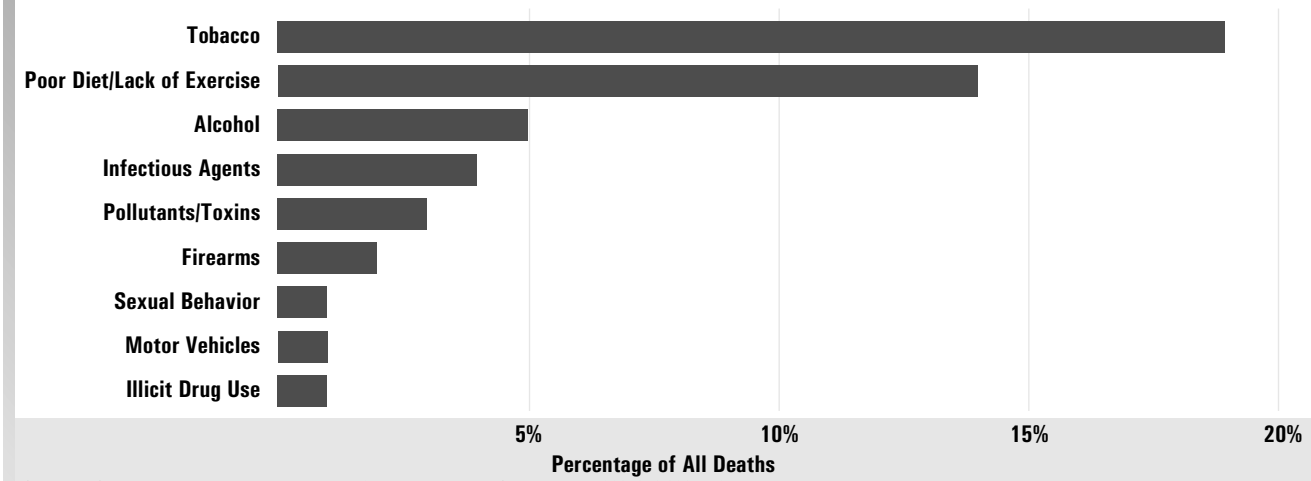
A bull's-eye denotes performance that met or exceeded the FY 2000 target.

Reduce the Major Threats to the Health and Productivity of All Americans

Medical research indicates that individuals who avoid such risky behaviors as smoking and engage in positive activities, such as exercise and sensible diets, are less likely to suffer prematurely from health and productivity problems.

HHS believes that a program of health risk reduction and the adoption of healthy behaviors can help more Americans to lead fuller, higher quality lives. Objectives associated with this goal are designed to promote healthy behavior, and to change the behaviors that increase the risks of premature death and disability.

Actual Causes of Death, United States, 1990



Source: McGinnis, J.M., Foege, W.H. Actual causes of death in the United States. JAMA 1993; 270:2207–12

We Assisted States and Local Governments in Reducing Tobacco Use, Especially Among Youth

Though 7 of every 10 deaths among Americans are due to chronic disease, the actual underlying causes of these deaths are often risk factors that could have been prevented. Tobacco use is the leading preventable cause of disability and death, killing more than 400,000 Americans each year at an annual cost of $50 billion in direct medical costs.

Every day, 3000 teenagers start smoking and 1 out of 3 of them will eventually die of smoking-related diseases. According to the National Household Survey of 1999, cigarette use among youths aged 12–17 years, was 15.9 percent in 1999; significantly lower than in 1997 (19.9 percent). Almost half (44.7) of persons aged 18 to 25 years reported past month use of some tobacco product in the 1999 survey.

Through the coordinated prevention, education, control, and research activities of the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Substance Abuse and Mental Health Services Administration (SAMHSA), HHS has led a national campaign to educate Americans about the health risks of tobacco. This effort included incorporating education initiatives in all departmental programs that target youth and promoting the adoption of tobacco education programs among health care providers.

Through SAMHSA's Substance Abuse Prevention and Treatment (SAPT) block grant, HHS funded tobacco control programs in all states to help educate young people about the dangers of tobacco use, to protect the public from secondhand smoke, to identify and eliminate disparities in tobacco use among population groups, and to reduce the use of smokeless tobacco. States and U.S. jurisdictions that received SAPT Block Grant funds are required, as a pre-condition of award, to enact and enforce laws making illegal the sale and distribution of tobacco products to individuals under the age of 18. The Synar Amendment established this requirement.

The Synar Amendment and its implementing regulation also require each state to conduct annual, random unannounced surveys of tobacco retailers to measure their compliance with state laws; and to meet negotiated retailer violation targets and a final goal of 20 percent or less retailer noncompliance. Failure to meet the requirements of the Synar Amendment and its implementing regulations subjects a state to a penalty of up to 40 percent of its SAPT Block Grant award, depending upon the year of noncompliance. Currently, states and U.S. jurisdictions are subject to this maximum rate.

SAMHSA has provided and continues to provide extensive technical assistance and guidance to assist the states and jurisdictions in developing comprehensive programs, which include strong tobacco control policies, ongoing law enforcement, community awareness and media advocacy strategies, and merchant education and training.

The continuing challenge is to assist states where needed with identifying retailers and developing retail outlet lists for monitoring.

Objective: Reduce Youth Tobacco Use

Increase the number of states whose retail sales violations for illegal tobacco sales to individuals under age 18 is at or below 20%

Actual Performance				Target
FY 1997	FY 1998	FY 1999	FY 2000	FY 2000
Baseline: 4 states	12 states	21 states	25 states	26 states

Also, the unannounced compliance checks of retailers that the FDA funded through the states and territories and which complemented SAMHSA's efforts, were halted after the Supreme Court ruled on March 21, 2000, that FDA did not have the authority to regulate tobacco. As a result, FDA terminated the program.

We Worked Cooperatively with Health Care Providers to Reduce the Incidence and Impact of Infectious Diseases

Although chronic diseases account for the majority of all United States deaths, infectious diseases remain the leading cause of death worldwide. Earlier predictions of the elimination of infectious disease did not take into account changes in demographics and human behaviors and the extraordinary ability of microbes to adapt, evolve, and develop resistance to drugs. Because of the advances and accessibility of modern transportation, epidemics can jump from city to city and from continent to continent within just hours.

HIV/AIDS, hepatitis C virus, West Nile virus, tuberculosis, and foodborne diseases, are just a few of the diseases that currently threaten the American population. CDC is responsible for battling those diseases through prevention, surveillance, technical assistance and funding to state and local health departments and networks. CDC's coordination with other HHS components, federal agencies, and international partners is also critical to responding to and eliminating these diseases.

One of these infectious diseases, HIV remains a deadly infection for which there is no vaccine or cure and for which there are limited treatments. Recent advances in highly effective antiretroviral medications allow people to live longer with HIV, but those advances have led some people to become complacent about practicing safe sex. As people live longer with infection, the potential for spreading infection increases.

Through December 1999, a total of 734,374 cases of AIDS among persons in the United States had been reported to CDC, and more than 430,441 of these persons have died. Although incidence has decreased substantially from the 150,000 cases per year in the late 1980s, CDC estimates that 40,000 people become infected with HIV every year. Researchers estimate that the discounted cost of lifetime treatment for a person with HIV now averages $155,000. This figure means that America faces an additional annualized cost of more than $6 billion each and every year.

In FY 2000, CDC addressed the HIV/AIDS epidemic by working with 100 experts to develop and publish a draft strategic plan to guide HIV prevention activities. CDC also played a key role in launching the LIFE Initiative (Leadership and Investment in Fighting an Epidemic) to assist the Ministries of Health in Africa and India to address the devastating impacts of HIV/AIDS. This initiative represents the first major commitment of United States resources to address the AIDS epidemic overseas.

In a collaborative effort with HRSA and SAMHSA, CDC provided technical assistance and training in seven demonstrations to prevent HIV and other health problems in correctional settings. The prevalence rate is much higher among inmates; the confirmed rate of AIDS among prisoners is five times the U.S. rate. CDC, HRSA, and SAMHSA aim to increase access to care and prevention services and transitional services between correctional settings and communities.

A key challenge to reducing HIV/AIDS is having reliable information on the incidence rate. CDC does not have those data because not all states have the required reporting in place to support an integrated surveillance system that includes both AIDS and HIV case reporting. More accurate data are needed to assess the spread of the disease and to determine how best to prevent it. As of FY 2000, only 34 of the 50 states monitor HIV incidence and prevalence.

Objective: Reduce AIDS Transmission

Decrease the number of AIDS cases related to injected drug use

Actual Performance			Target
FY 1997 15,700 cases Numbers represent diagnosed cases adjusted for reporting delay with risk redistributed	FY 1999 A total of 12,027 cases 23% reduction from FY 1997 (new data)	FY 2000 Data will be available in July 2001	FY 2000 Decrease by 10% from the 1997 base of 15,700 cases diagnosed to 14,130 Target was set before FY 1999 actuals were known

Improve the Economic and Social Well-Being of Individuals, Families, and Communities in the United States

With its partners, HHS supports strategies that create opportunities for individuals, families, and communities to be economically and socially productive. We stress interventions that are related to improving job skills, access to social services, family and community stability, and independent living. We further prioritize our efforts by targeting interventions toward low-income families, children, the elderly, persons with disabilities, and economically distressed communities.

Each person, regardless of age, gender, physical ability, or racial/ethnic background, should have the opportunity to lead an economically and socially productive life.

HHS' role in accomplishing this objective is to provide leadership, funding, and technical assistance to its partners (who are primarily states, tribes, and community-based organizations, in addition to other federal agencies), conduct research, promote best practices, and work to eliminate barriers to access of services and improvements. For many of the following programs, the states have the primary responsibility for the direction and accomplishment of the services and results.

Substantial progress has been made in the past several years in helping welfare recipients move to work, increasing child support payments, and providing child care and early learning services to low and moderate income families.

Poverty Statistics

	FY 1997	FY 1998	FY 1999
Poverty Rate for the United States	13.3%	12.7%	11.8%
Number of Poor People	35.6 million	34.5 million	32.3 million
Number of Poor Children Under Age 18	14.1 million	13.5 million	12.1 million

Source: U.S. Census Bureau 11/99

We Assisted State, Local, and Tribal Governments in Improving the Economic Independence of Low-Income Families

Welfare caseloads have fallen to their lowest level since 1968. As a percentage of the total population, the proportion of people on welfare has fallen to historic new lows; the percent is at 2.1 percent of the population as of June 2000, which is equal to the 1964 rate.

In 1996, a comprehensive welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act, building on work that many states had already done to reform welfare, dramatically changed the nation's welfare system into one that requires work in exchange for time-limited assistance. States, tribes, and territories receive block grants from the Administration for Children and Families under the Temporary Assistance to Needy Families (TANF) program to cover benefits, administrative expenses, and services.

The states, tribes, and territories have great flexibility to design and implement programs to move clients from welfare to work, including establishing eligibility requirements, benefit levels, and services provided, as long as they are consistent with the purposes of the program.

One purpose is to end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage. For most states, the two-parent work participation rate requirement in the law has always been the hardest to achieve. Since states are doing so well otherwise in meeting their targets for moving all types of families from welfare to work, ACF's emphasis has been to work with states to ensure that states were not liable for penalties under the law for rates that they did not meet, including the two-parent work participation rate.

Twenty-eight states of the 38 participating states, District of Columbia, and Guam met the FY 1999 two-parent work participation rate. The two-parent participation target rate increases to 90 percent for subsequent years. States have the option to move their two-parent cases into a separate state program and thus avoid the two-parent work participation requirements. Although some states have exercised this option, the statutory two-parent participation target of 90 percent remains a rigorous standard.

Objective: Increase Work Participation Rates

All states meet the Temporary Assistance to Needy Families program two-parent families work participation rates of 90%

Actual Performance			Target
FY 1998	FY 1999	FY 2000	FY 2000
66% of states	75% of states	Data will be available in December 2001	100% of states

In December, 2000, HHS awarded $200 million in bonuses to 28 states with the best records for FY 1999 (the most recent year for which data are available) in moving parents (one or both) on welfare into jobs and assuring their success in the workforce. According to reports filed by the 48 states

and the District of Columbia competing for the bonus, more than 1.2 million parents on welfare went to work in the period between October 1, 1998, and Sept. 30, 1999. Overall, 43 percent of welfare recipients entered the work force in 1999 compared with 39 percent in 1998. Retention rates were also high: of those who obtained jobs, 77 percent were still working in the next quarter. The states also reported a rise in the average increase in earnings of 22 percent from $2,114 in the first quarter of employment to $2,578 in the third quarter. States had reported an average increase of 24 percent in FY 1998.

The challenges for TANF will continue in four areas: reaching all families, moving families into work and promoting success at work, transforming the welfare office, and maintaining the investment. While the overall health of the economy could have a major effect on achieving the goal of increased employment, traditional business cycles have varying effects across geographic areas and sectors of the economy. Historically some groups are more vulnerable to unemployment, even during periods of economic recovery. ACF therefore continues to implement a wide range of projects to help the states produce the desired outcomes, such as training, technical assistance and sharing of best practices, and sponsoring research.

We Continued to Promote Access to Quality Child Care Services to Help Low-Income Working Parents and Their Children

To break the cycle of poverty and dependency, focusing on both the parents and the next generation is essential. Parents are more likely to succeed in employment and self-sufficiency if they have access to and confidence in their child care arrangements. According to new state-reported statistics for fiscal year 1999, 1.8 million, or about 12 percent of the estimated number of children in low-income working families are receiving federal child-care subsidies through the federal Child Care and Development Fund (CCDF) on an average monthly basis. This figure is a slight increase from the 1.5 million children served in 1998.

The quality of child care affects the health and safety of children, as well as their cognitive, emotional, and social development. The National Institute for Child Health and Human Development (NICHD) Study of early child care, *When Child Care Classrooms Meet Recommended Guidelines for Quality* (1998), shows that children attending centers meeting professional standards for quality score higher on school-readiness and language tests and have fewer behavioral problems than their peers in centers not meeting such standards.

ACF provides federal funds through CCDF to states, territories, and tribes and works with state administrators, professional groups, service providers, and others to promote quality child care. States are required to spend at least four percent of federal CDDF funds to improve the quality of child care and offer additional services to parents. States are continuing to expand the innovative ways to improve quality. In addition, funds are earmarked for resource and referral services and school-age care, infant and toddler care, and additional quality improvement activities. As an example, several states have already implemented, or are implementing, programs of tiered licensing based on the quality of care.

ACF has worked with states and territories for several years to develop appropriate and achievable program goals and measures for child care.

On the basis of the combined data of independent national organizations that have information about provider accreditation and certification, there were 8,658 accredited child care facilities nationwide in FY 2000 (reported as of November 2000). The FY 2000 number of accredited facilities will be used as the baseline for tracking future improvements. FY 2000 is also the baseline year for other child care measures that will have targets and will be reported on in future reports.

On August 30, 2000, HHS issued final regulations to implement High Performance Bonuses (HPB) under the TANF program. These regulations included a child care HPB to reward states in FY 2002 for effectively supporting working families with child care assistance.

The Social Services Block Grant program also provides funding to states for a broad array of services to help individuals achieve self-sufficiency. Due to the nature of the program, there are minimal reporting requirements. However, the program did fund wholly or in part, day care services for children of low-income families so parents can work or go to school. In FY 1998, the most recent year for which data are available, 2,399,827 children received day care services funded wholly or in part by SSBG funds.

The continuing challenge is to reach the estimated remaining 88 percent of the 15 million children eligible for child care subsidies under federal rules.

We Helped to Increase Parental Involvement and Financial Support of Noncustodial Parents in the Lives of Their Children

The most recent census data show that, in the spring of 1998, 14.0 million families with children had a parent living elsewhere. One quarter of children under the age of 21 who live in families and never married,

live in custodial parent families, 85 percent of which were headed by women and 15 percent headed by men. Of the 14.0 million custodial parent families, only 7.9 million (56 percent) of the custodial parents had awards or agreements for child support.

To ensure that parents support their children, ACF partners extensively with a range of federal, state, and local entities and provides funding and technical assistance for identifying assets of noncustodial parents who have not supported their children.

The Administration for Children and Families also promotes noncustodial parents' involvement in their children's lives. Since FY 1997, HHS has awarded $10 million in block grant funds annually to all 50 states, the District of Columbia, and U.S. territories to promote access and visitation programs that include such services as mediation, education and counseling, and guidelines. In March 2000, HHS approved ten state waivers for the Partners for Fragile Families Demonstration projects. Working at the community level with non-profit and faith-based partners to provide employment, health, and social services, these projects are testing new approaches to involving young fathers with their children and to helping mothers and fathers build stronger parenting partnerships.

As of April 2000, 51 states and territories submitted data requests from the Federal Case Registry, which locates absent parents across state lines, and which contained 13.5 million child support cases. When absent parents are found, ACF promotes state use of the IRS income tax refund intercept and administrative offsets for child support with the Department of the Treasury. As part of the total $17.9 billion collected for child support in FY 2000, a record $1.4 billion in delinquent child support was collected in calendar year 2000 using the tax refund and administrative offset. This is approximately $100 million more than the prior year. More than 1.42 million families benefited from these collections.

Objective: Increase Financial Support for Children

Increase the amount of child support collections

Actual Performance				Target
FY 1997 $13.38 billion	FY 1998 $14.367 billion	FY 1999 $15.8 billion	FY 2000 $17.9 billion	FY 2000 $20.8 billion

Also as of April 2000, all states and 146 agencies are reporting data to the National Directory of New Hires, another tool for identifying absent parents. During FY 2000 more than 690 million records were posted there that matched child support orders to employment records. In addition, to match delinquent parents with financial records, ACF is operating the new multistate financial institution data match system and is working with states to implement the in-state financial institution data match system. By the end of March 2000, 2.2 million matches were made.

The cost-effectiveness of the child support enforcement program is measured by the ratio of the total dollars collected per dollar of administrative expenditures by ACF and its partners. The objective is to increase the dollars collected per administrative dollar spent. In FY 1999, total administrative expenditures were up 15.9 percent to $4.0 billion. Compared with the total $15.8 billion collected, the cost-effectiveness ratio for that period is $3.92, which is a decrease of 2 percent over FY 1998. This decrease in cost-effectiveness is due to increased automated data processing expenditures.

Objective: Increase Child Support Enforcement Cost Effectiveness

Increase the cost-effectiveness of child support enforcement

Actual Performance					Target
FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2000
$3.93	$3.90	$4.00	$3.92	Data will be available in October 2001	$5.00

The continuing challenge for ACF and its partners is to locate absent parents and increase their parental responsibilities by involving them in raising their children. Some states have not fully implemented new collection tools which will help to increase collections in the future.

We Supported Local Communities in Improving the Healthy Development and Learning Readiness of Preschool Children

Head Start is a national program that provides comprehensive developmental education, health, mental health, nutrition, and social services for America's low-income, preschool children ages three to five and their families. The primary goal of Head Start is to promote the social competence and school readiness of low-income children. Head Start works to narrow the gap between disadvantaged children and all children in school readiness skills during the program year.

Approximately 1,525 community-based organizations develop unique and innovative programs. In 2000, there were 18,200 centers and 46,225 classrooms, in which 857,664 children were served.

Head Start children have been found to be ready for school, with the cognitive and social skills that indicate readiness to learn more in kindergarten. For example, on an assessment of word knowledge, the percentage of children scoring close to or above the national mean increased from only one in four when they started the program in the fall, to more than one in three in the spring — nearly a 40 percent increase. Baselines and targets were developed in FY 1999 for indicators of improved literacy, numeracy, and language skills. Actual performance will be available beginning in FY 2002, representing the 2000–2001 program year.

As with children who are enrolled in child care, Head Start children experience better outcomes when they have good classroom quality. Observed classroom quality is good on average, with no classrooms scoring below a minimal standard of quality. An element of that quality is the qualification of the teacher. For Head Start, that means classroom teachers who have a degree in early childhood education (ECE), a child development associate (CDA) credential, a state-awarded preschool certificate, a degree in a field related to ECE plus a state-awarded certificate or who are in CDA training and have been given a 180-day waiver, consistent with the provisions of Section 648A(a)(1) of the Head Start Act.

Objective: Provide Healthy Development and Learning Readiness for Preschool Children

Increase the number of classroom teachers with appropriate education for Head Start

Actual Performance			Target
FY 1998	FY 1999	FY 2000	FY 2000
95%	93%	94%	100%

The target for FY 2000 required in the legislation for qualified teaching staff was 100 percent; the actual achieved was 94 percent. This shortfall resulted from a combination of staff turnover or limited access to training and credentialing opportunities in certain areas of the country, or both. In partnership with institutions of higher education, Head Start is working to ensure that a majority of teachers obtain associate's or bachelor's degrees in early childhood education over the next few years.

We Increased the 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 safely return 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, assuring the child's safety and well-being while their parents attempt to resolve the problems that led to the out-of-home placement. When the family cannot be reunified, foster care provides a stable environment until the child can be placed permanently with an adoptive family. Adoption Assistance funds are available for a one-time payment for the costs of adopting a child as well as for monthly subsidies to adoptive families for care of the child.

Objective: Increase Adoptions to Provide Stable Homes to Children

Increase the number of adoptions

Actual Performance						Target
1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2000
26,000	28,000	31,000	36,000	46,000	Data will be available in September 2001	46,000

The Adoption Incentives program was created by the Adoption and Safe Families Act of 1997. The passage of this incentive program, along with state, local and private initiatives focusing attention on the needs of children in foster care awaiting permanent adoptive families, has

resulted in unprecedented increases in the number of children adopted from foster care.

Under the law, states may receive incentive funds for each adoption finalized in a fiscal year, which exceeds the established baseline number of adoptions. In April 2000, HHS announced the second award of nearly $20 million in adoption bonuses to 42 states and the District of Columbia and Puerto Rico for increasing the number of children adopted from public foster care. Because of the great success of adoptions, the challenge will be to keep incentives for states funded.

ACF has undertaken a number of activities designed to improve overall performance in child welfare. The most significant is that on January 25, 2000, HHS published a final rule in the *Federal Register* to establish new approaches to monitoring state child welfare programs. The new rule plays an important role in improving services to, and outcomes for, abused and neglected children, children in foster care, and children awaiting adoptive families. It promotes increased safety for children who are maltreated; quicker movement to permanent homes and families for children in foster care; and enhanced well-being for families served by state agencies. ACF undertook a major initiative to provide training and technical assistance to states regarding the regulatory requirements and improvement of their child welfare services systems.

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 risks, improving health in the United States involves improving access to health care.

Overall, approximately 43 million Americans lack health insurance. The focus of this goal is to promote increased access to health care for persons who are uninsured, underserved, or otherwise have health care needs that are not adequately addressed by the private health care system. Ensuring the fiscal integrity of the Department's health entitlement and safety net programs is critical to continued access to care.

One of this goal's objectives is to protect and improve the health and satisfaction of beneficiaries in Medicare, Medicaid and the State Children's Health Insurance programs. This includes promoting the use of preventive services, educating beneficiaries, improving Medicare services, and using research and oversight to protect beneficiaries from substandard or discriminatory care. Additionally, we seek

to increase the availability of health care services for America's underserved population, including American Indians and Alaska Natives.

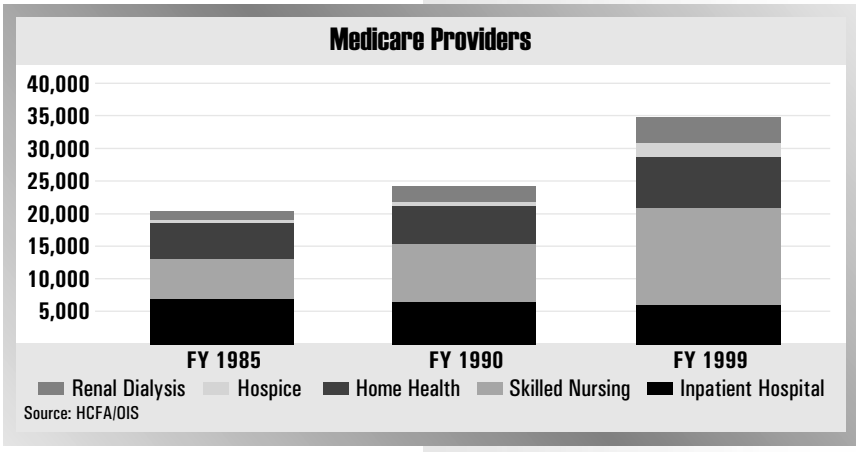
We Helped to Improve Access to Health Care

HCFA is the nation's largest health insurer, providing coverage to 39.5 million Medicare beneficiaries and 33.4 million Medicaid enrollees, some of whom are eligible for both programs. Medicare alone processes some 890 million claims each year. HCFA's total program expenses were $339.1 billion for health care services in 2000. For Medicare alone, HCFA pays claims from some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers each year.

HCFA was among the 30 federal agencies that participated in the independent American Customer Satisfaction Index ratings of customer satisfaction. Recent Medicare beneficiaries were queried for their satisfaction with their HCFA contacts and they gave a rating of 71 percent satisfaction, which exceeds the aggregated federal government rating of 68.6 percent.

Medicare covers both hospital insurance and insurance for physician and outpatient care, laboratory tests, home health care, durable medical equipment, designated therapy services, and other services not covered by hospital insurance. Medicare+Choice was created in 1997 to increase health care options for beneficiaries through a greater variety of managed care and fee-for-service plans. Over the last 30 years, Medicare has significantly contributed to life expectancy, to the quality of life, and to protection from poverty for the aged and disabled.

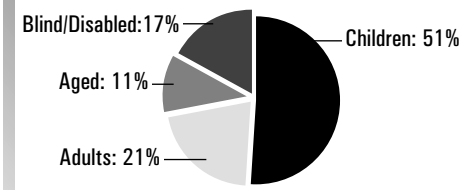
Medicaid is the primary source of health care for medically vulnerable Americans such as poor families, the disabled, and persons with developmental disabilities requiring long term care. Medicaid is administered in partnership with the states. States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines. States have a great deal of programmatic flexibility to tailor their Medicaid programs to individual state circumstances and priorities. HCFA issues the matching payment grants to states and territories for medical assistance and administrative costs. Medicaid has improved birth outcomes, childhood immunization rates, and access to preventive services, resulting in overall improvements in the health of America's children.



During FY 2000, HHS continued to help improve access to health care for those individuals who lack public or private supplemental

insurance. HCFA is working with state governments to reduce the disparity in health insurance coverage through outreach to minority populations and for children. HCFA helped to improve coverage in both Medicare and Medicaid insurance programs and the quality of care individuals received, and has worked to enforce nondiscrimination and culturally appropriate services.

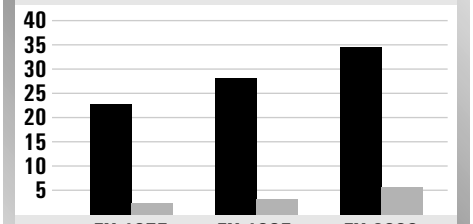
FY 2000 Medicaid Enrollees



Source: HCFA/OACT

One of HCFA's central concerns is that Medicare beneficiaries are able to get the care they need when they want it, and that they are not impeded by such factors as cost, health status, location or the availability of health care support networks. Certain subgroups, such as minorities, persons with disabilities or individuals without health care insurance, are particularly vulnerable to substandard or nonexistent medical attention.

FY 2000 Medicare Enrollment (in millions)



Source: HCFA/OACT/OIS

HCFA has expanded access to dual-eligibility programs of Medicare and at least some aspects of Medicaid, to ensure that low-income Medicare beneficiaries get assistance with cost-sharing expenses. HCFA has worked with federal agencies and states to raise awareness of the dual eligibility, leveraged improvements through grants to states, sponsored regional training sessions and developed resource guides to help expand the program and, thereby, enroll more beneficiaries.

Objective: Increase Medicare Enrollment

Improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance

Actual Performance			Target
FY 1998 Trend is a 2% increase (baseline)	FY 1999 Goal met	FY 2000 4% 5,499,349 beneficiaries were enrolled; an increase of 333,808	FY 2000 Increase enrollment by 4% over baseline

HCFA worked to expand enrollment in the dual-eligibility programs and met its goal to increase enrollment by 4 percent above the 1999 level. The actual enrollment at the end of FY 2000 was 5,499,349, an increase of 333,808.

HCFA also provided additional funds to states to encourage improvements and achieve wider health care coverage. During fiscal year 2000, in fact, HHS awarded more than $13 million in grants to promote innovations for providing uninsured citizens with access to affordable health insurance. These grants will help states determine the most effective methods to provide the uninsured with high-quality, affordable health insurance similar to plans that cover government employees or other benchmark plans.

In addition to the challenges of trust fund solvency that are discussed in Section IV of this report, some Medicare + Choice Health Maintenance Organizations are not renewing their contracts or are lim-

iting their service areas. Even though most beneficiaries will be able to enroll in another Medicare HMO, about 17 percent, or 159,000 of those affected will be left with no Medicare + Choice HMO option, although they may enroll in a private fee-for-service or the original fee-for-service Medicare.

We Contributed to the Increase in the Number of Children with Health Care Coverage

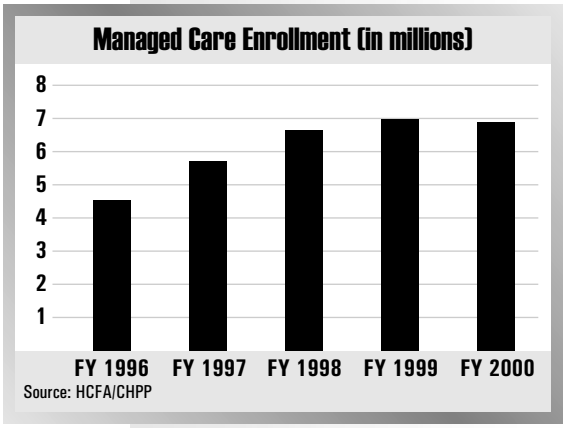
HHS continued to assist states in promoting the opportunity for eligible children to enroll in Medicaid. Among our efforts, we asked states to review their computer systems and eligibility processes to ensure that all families eligible for Medicaid benefits can keep them. We also asked states to reinstate anyone who may have been improperly terminated from the program.

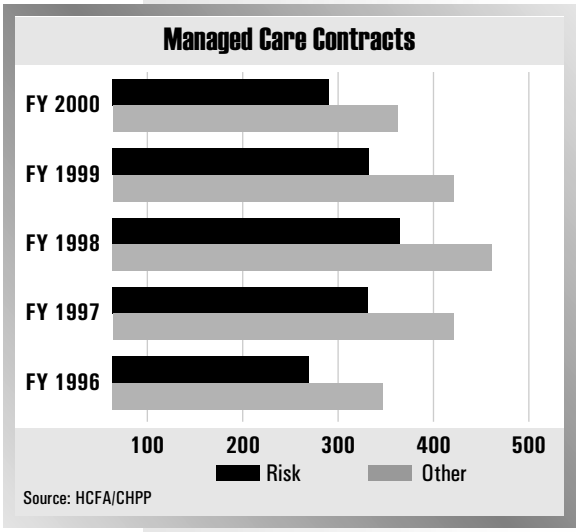
One of our most important new initiatives has been the recent implementation of the State Children's Health Insurance Program (SCHIP), the largest single expansion of health insurance coverage for children in more than 30 years.

Today, nearly 10 million American children — almost 14 percent — are uninsured. This initiative was designed to reach these children, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance.

This initiative set aside $24 billion over five years beginning in FY 1998. The implementation of SCHIP has been driving enormous change in the availability of health care coverage for children and in the way government-sponsored health care is viewed and delivered. The energy invested by states, communities, and the federal government in the SCHIP initiative has resulted in significant expansions in coverage as well as new systems for enrolling children into publicly funded coverage programs.

Over three million children have been enrolled in SCHIP since the program began, and the goal for FY 2000 was to increase the combined enrollment of children in Medicaid and SCHIP by 1 million over the 1999 level. The goal was met and surpassed in FY 2000 since an additional 1,679,000 children were enrolled in these programs.





We Helped to Improve the Quality of Care for Medicare Beneficiaries

Cardiovascular disease is the nation's number one killer among men and women of all racial and ethnic groups. It is also the number one killer in all states. More than 40 percent of all deaths in the United States, 900,000 each year, are attributable to heart disease and stroke. Associated annual costs exceed $286 billion.

Adverse health conditions clearly affect a large number of Medicare beneficiaries, and heart disease is the most common condition for which Medicare beneficiaries are hospitalized.

Improving treatment for heart attack has been a focus of HCFA's Health Care Quality Improvement Program since its inception in 1992. HCFA works through a network of health care providers to reduce deaths from heart attacks by improving hospital performance, using such techniques as aspirin administered to prevent blood clots, beta blockers to decrease the heart's workload and oxygen need, and counseling to assist patients in eliminating smoking. This nation-wide effort focused on implementing known successful interventions for properly treating heart attacks and preventing second heart attacks.

The ambitious goal to increase the one-year survival rate among beneficiaries who suffer a heart attack by decreasing the mortality rate, indicates the success of efforts to help improve the quality of care for our beneficiaries. The impact of these improvements may be especially dramatic in areas where providers have not yet fully introduced these life-saving measures.

Objective: Improve Heart Attack Survival Rates

Lower the one-year mortality rate for Medicare beneficiaries following hospital hospital admission for heart attack

Actual Performance						Target
1995–1996 31.2% mortality rate (baseline)	1996–1997 31.1%	1997–1998 31.7%	1998–1999 Expect interim data June 2001	1999–2000 Expect data June 2002	2000–2001 Expect data June 2003	FY 2000 27.4% mortality rate Target period overlaps FY 2000 and FY 2001

Although considerable improvements have been made, a number of factors make greater improvements more challenging. Interim data show a relatively constant one-year mortality rate, which may be due to several factors. First, HCFA's national programmatic effort toward this goal has been phased in gradually, and not all states have participated to the same extent. Second, the age distribution of the Medicare population represented in these data has changed during this time; the median age has increased, which is a major risk factor for mortality. Third, the rate of concomitant diseases or severity of illness may also have changed,

which can contribute to mortality. Fourth, because mortality cannot approach zero, at some point a leveling off is expected.

However, these intervention activities historically have shown promise. In a four-state pilot effort of Peer Review Organizations (PROs), the entities that review health medical procedure statistics, quality improvement activities during 1994 through January 1995 found that one-year mortality following heart attack was reduced by about one percentage point more than in other states. Because approximately 323,000 Medicare beneficiaries are hospitalized for heart attacks each year, a decrease of one percentage point results in about 3,000 saved lives.

Hospital Insurance

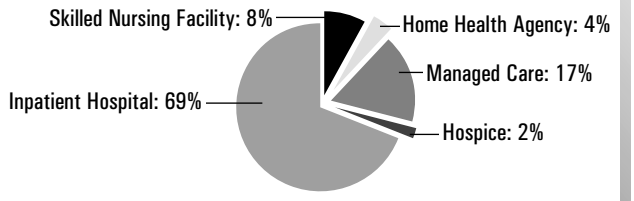
Also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security, End Stage Renal Disease or Railroad Retirement benefits.

Supplementary Medical Insurance

Also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over, End Stage Renal Disease beneficiaries and disabled people entitled to Part A.

A national intervention program, similar to the pilot project, was initiated in 2000. It is expected that this will result in a decline in one-year mortality after heart attacks by about one percentage point once interventions are widely adapted.

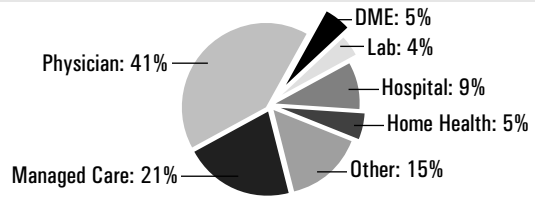
FY 2000 HI Medicare Benefit Payments



Source: HCFA/OACT

Additionally, HCFA has gathered important information on the access to quality health care. A new Medicare study gives the first clear national picture of the quality of health care provided to millions of older Americans and people with disabilities. The baseline data produced by the study are the first step of a three-year, $240 million Medicare effort to improve the health care Medicare beneficiaries receive, and required the review of thousands of documents.

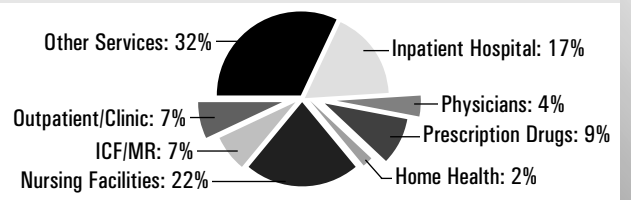
FY 2000 SMI Medicare Benefit Payments



Source: HCFA/OACT

HCFA measured 24 process-of-care measures related to primary prevention, secondary prevention, and/or treatment of six medical conditions. Ideally, if all patients received all of the items of care, the health care indicator rate or process-of-care measurement would be 100 percent. The national median for all 24 process-of-care measures was about 70 percent of Medicare fee-for-service beneficiaries, and reflects a wide variance among states and regions. Through additional study, HCFA will work to pinpoint disparities and work with states, PROs, and health care providers to further improve quality health care.

FY 2000 Medicaid Vendor Payments



Source: HCFA/OACT

We Improved the Fiscal Integrity of Medicare and Medicaid and Enhanced the Value of Services Purchased for Beneficiaries

HHS recognizes the importance of ensuring the integrity of its health care programs in order to improve services, provide the best value to beneficiaries, and to eliminate fraud and abuse.

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.

One of the major issues on which HCFA has focused its attention is the accuracy of payments in Medicare and Medicaid. In recent years, HCFA has made substantial progress in reducing the error rate and improper payments in the Medicare and Medicaid programs, a critical aspect of providing strong services and maintaining stewardship over tax dollars.

HCFA's goal is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries.

HCFA contracts with 54 private health insurers to process 890 million Medicare fee-for-service claims each year, and with 343 private health plans that provide managed care. Medicare's Fee-for-Service program is one area in which HCFA has taken increasingly strong actions in recent years. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

The complexity of Medicare payment systems and policies, and the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. HCFA has implemented a Corrective Action Plan designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate.

Objective: Reduce the Medicare Error Rate

Reduce the percentage of improper payments made under the Medicare fee-for-service program

Actual Performance					Target
FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2000
14% (baseline)	11%	7%	7.97%	6.8%	7%

HCFA's target for the error rate in 2000 was 7 percent. Our efforts paid off in FY 1998 and 1999, as the actual error rates were 7 and 7.97 percent, respectively. In FY 2000, the trend continued to improve since the rate was 6.8 percent.

In general, the substantial reduction in the error rate since FY 1996 demonstrates that the Medicare contractor claims processing system is working well.

HCFA is also committed to assisting interested states in developing methodologies and conducting pilot studies to measure and ultimately reduce Medicaid payment error rates. During FY 2000, HCFA established with the American Public Human Services Association a National Medicaid Payment Accuracy Workgroup to help define, guide, and coordinate this federal-state collaborative project. Information was collected on the significant Medicaid payment accuracy studies conducted to date (by Illinois, Texas, and Kansas), and discussions were initiated with several states that might be interested in participating in the pilot studies.

Moreover, HCFA is educating beneficiaries to identify and report instances of fraud, and implementing the Comprehensive Error Rate Testing program to produce contractor, benefit specific, and national error rates.

In fiscal year 2000, the HHS Inspector General recorded an estimated $1.2 billion in civil judgments, penalties and fines involving health care fraud, bringing the total recovered to more than $3 billion since 1996.

We Increased the Availability of Primary Health Care Services

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. 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 Health Centers and the National Health Service Corps (NHSC) combined provides primary health care services to nearly 12 million low income, underserved patients. The Health Center program supports community health centers, migrant health centers, health care for the homeless programs, public housing primary care programs, and school-based health centers. HRSA put more than 2,500 primary care clinicians in health professional shortage areas through the National Health Service Corps.

Objective: Increase Health Care for Underserved Populations

Increase utilization of health care for underserved populations

Actual Performance				Target
FY 1997 8.3 million	FY 1998 8.7 million	FY 1999 9.0 million	FY 2000 Data will be available in November 2001	FY 2000 Increase to 9.6 million 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

Objective: Assure Minority Access to Care

Assure access to preventive and primary care for minority individuals

Actual Performance				Target
FY 1997 65% of population served are minority individuals	FY 1998 64% of population served at health centers	FY 1999 64% of population served at health centers and, in addition, by the NHSC	FY 2000 Data will be available in November 2001	FY 2000 65% of population served are minority individuals

In FY 2000, more than $1 billion was invested in community health centers across the country. New access sites were established in previously unserved areas and existing sites were expanded to include new services, particularly in the areas of oral health, mental health, outreach, respite care, and pharmacy services. In addition, the new Community Access program helped communities build partnerships among health care providers to deliver more and better care to their neediest residents. Grantees in 23 states were awarded up to $1 million each in FY 2000 to build integrated health care systems among local partner organizations.

Strengthen the Nation's Health Science Research Enterprise and Enhance Its Productivity

Research into the fields of health and medical science plays an important role in improving the nation's knowledge about disease and our efforts to combat it. The "health research" goal recognizes the prominence of health research in HHS and its importance in fostering a more healthy society.

Not only does medical research provide us with the keys to unlock advances in medical sciences that save lives and improve their quality, it also can help to reduce the rate of medical errors — from which an estimated 98,000 Americans die each year.

The objectives under this goal focus on creating knowledge that ultimately is useful in addressing health challenges and in maintaining and improving the research infrastructure that produces scientific advances. HHS strives to advance the scientific understanding of normal and abnormal biological behaviors and functions, and to improve our understanding of how to prevent, diagnose, and treat disease and disability. Improving the quality and effectiveness of health services is

a strategic objective, as is accelerating private sector development of new drugs and medical technologies.

We Advanced the Scientific Understanding of Normal and Abnormal Biological Functions and Behaviors

Medical innovation is one of the principal foundations on which America's past successes in improving health care have been built.

The NIH research program represents all aspects of the medical research continuum, including basic research, which may be disease-oriented; observational and population-based research; behavioral research; clinical research, including research to understand both normal health and disease states, to move laboratory findings into medical applications, to assess new treatments or to compare different treatment approaches; and health services research. In addition, the timely dissemination of medical and scientific information is a key component of the program, as is the expeditious transfer of the results of its medical research to provide benefits to human health.

NIH accomplishes this research through grant awards and contracts to individual investigators and organizations in the extramural research community. These researchers are NIH's partners, consisting of an estimated 50,000 scientists, affiliated with some 2,000 university, hospital, and other research facilities located in all 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and points abroad. NIH also conducts research at its own intramural labs.

NIH is currently working with its partners, with the Department of Energy, and with other international collaborators on the major effort to sequence the large and complex human genome. This endeavor is widely regarded as the single most important project currently in biology and biomedical science.

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 3 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 diagnosis, treat, and prevent disease.

Many of the project's initial goals have been achieved, including building maps that locate (or identify) the position of genes in both the human and mouse genomes, and sequencing the genomes of model organisms including the bacterium *E. coli*, baker's yeast, and the roundworm *C. elegans*. In addition, sequencing the genome of the fruit fly (*Drosophila melanogaster*) was completed during fiscal year 2000. The ability to compare the sequence of genes across multiple species and develop model systems in simpler organisms will significantly enhance the ability of researchers to identify the functional roles of the encoded proteins and thereby contribute to a better understanding of the molecular basis for human health and disease.

The goal for this program is to develop critical genomic resources, including the DNA sequences of the human genome and the genomes of important model organisms and disease-causing microorganisms.

Objective: Complete the Human Genome Sequence

Actual Performance	Target
FY 2000	FY 2000
1 The Human Genome Project public consortium reached a historic milestone in FY 2000 by completing a "working draft" of the sequence of the human genome (88% complete, 99.9% accurate). The U.S. contributed 67% of the working draft sequence; 87% of the U.S. total, by NIH.	1 Worldwide effort completes "working draft" of human genome sequence (90% complete, 99% accurate). The United States contributes two-thirds of that amount, and NIH contributes 85% of U.S. total.
2 The Human Genome Project public consortium completed the "finished" (99.99% accurate) sequence of two human chromosomes — chromosome 21 and chromosome 22 — during FY 2000.	2 Finish the sequence of at least one human chromosome.
3 During FY 2000, a consortium of publicly funded scientists, in collaboration with a private company, published the substantially complete genome sequence of the fruit fly (Drosophila melanogaster).	3 Complete sequence of the genome of *Drosophila melanogaster* (excluding heterochromatin).

The NIH supported other productive research. NIH funded investigators have made the following selected achievements in the past year, including:

- the results of two studies that show that middle-aged and older adults with sleep apnea have a 45 percent greater risk of hypertension and the lower the amount of sodium in the diet, the lower the blood pressure.
- the discovery that stem cells may promote recovery from spinal injury. Stem cells derived from mouse embryos have been shown to promote recovery of a rat from spinal cord injuries, a discovery that could pave the way for future similar treatments of humans.
- researchers have found that infants who die of Sudden Infant Death Syndrome (SIDS), have abnormalities in several parts of the

brain stem, suggesting that SIDS may originate early in fetal life. Additional research is ongoing and may lead to the future prevention of SIDS.

- researchers have found that a significant increase in obesity among children threatens gains in life expectancy, and may also be one of the most important factors responsible for the observed increase in pediatric diabetes. Continued research is compiling effective means to combat the problem and lead to behavioral treatments for decreasing weight among children.

We Improved the Communication and Application of Health Research Results

Increasing awareness and supporting participation in clinical trials has been identified as one of NIH's most critical communication challenges: To enable and support NIH-funded research, a steady, diverse, and substantial pool of patient and normal volunteers is needed. The quality of clinical research and its ability to improve the public's health care depend on the nation's physicians having the opportunity to refer patients to current studies and on patients having the information they need to learn about and participate in clinical trials.

Many of today's most effective interventions are the direct result of knowledge gained through clinical trials — studies that evaluate the safety and effectiveness of new drugs and other interventions. Facilitating access to information on clinical trials is an important national goal.

At the present time, the NIH Home Page provides consolidated access to eight clinical trials databases: the NCI's Physician's Data Query; the AIDS Clinical Trials information System, Rare Disease Clinical Trials Database; Clinical Center Studies, the NEI Clinical Trials database, the NHLBI Clinical Trials database, the NIA Alzheimer's Disease Clinical Trials database, and the NIAID Clinical Trials database. The database required by the FDA Modernization Act will include all federally and privately funded clinical trials for drugs for serious or life threatening diseases and conditions submitted under Investigational New Drug applications.

The NIH goal for this effort is to establish a Clinical Trials Database, as required by the FDA Modernization Act.

Objective: Communicate Research Results

Actual Performance	Target
FY 2000 **1** The Clinical Trials Database became available to the public on February 29, 2000. At launch, it contained approximately 4,000 trials. As of November 2000, the database contains more than 5,000 clinical trials at more than 47,000 locations nation-wide. The majority of the trials presently listed in the database are NIH-supported. However, the database does include some 800 cancer and HIV/AIDS trials supported by industry and other federal agencies. Of these, approximately 700 are industry supported and 100 are supported by other federal agencies. **2** In April 2000, the NIH awarded a contract to a firm to conduct an implementation study regarding the creation of the toll-free telephone service for disseminating clinical trials database information. The purpose of the study was to define the primary operating strategies for the service and the associated characteristics and costs, and to explore potential options for enhancing the service offered. By the end of FY 2000, the contractor completed a literature review, interviews with representatives of NIH Institutes and Centers, and conducted market research with consumers and health professionals.	FY 2000 **1** Expand the Clinical Trials Database to include trials from other federal agencies and the private sector. **2** Develop options for implementation of toll-free telephone access to information in the Clinical Trials Database.

Establishing toll-free telephone access to the Clinical Trials Database will be complex. Nevertheless, improving access to clinical trial information addresses head-on one of NIH's most critical challenges — increasing public and provider awareness, understanding, and willingness to participate in clinical research (clinical trials).

HHS Performance on Other Programs of Interest

The following programs also have a significant impact on Americans. The selected performance data that are included indicate the degree of success that HHS and its partners are achieving. A detailed discussion of these programs is contained in each operating division's annual GPRA plan and report. The net costs of each of these programs is contained in Appendix C of this report.

Program: Low-Income Home Energy Assistance (LIHEAP)

Description of Program:	ACF provides grants and relies on the efforts of its grantees, including states, eligible Indian tribes/tribal organizations, and Insular areas, to help low-income households meet their heating and cooling costs. The protection of the health and safety of vulnerable household members is a key program objective. Congress established annual reporting requirements to track certain data, including the presence of vulnerable household members who are recipients of this program.
Supports HHS Strategic Goal:	2
Most Recent Performance Information:	In FY 1999 and FY 2000, the performance target was to have 75 percent of the grantees that have set participation rates of eligible households, meet their goal for households having at least one member who is aged 5 years or under. Actual performance for this measure in FY 1999 was 50 percent. FY 2000 data will be available in March 2001.

Program: Congregate and Home-Delivered Meals

Description of Program:	AoA gives funds to the Aging Network which leverages them to provide older, poorer Americans with 40 to 50 percent of daily nutrients required to maintain health and functionality.
Supports HHS Strategic Goal:	1
Most Recent Performance Information:	The performance target is to maintain the number of congregate (group or community setting) meals served. Preliminary information is available for FY 1998. At that time, 114.0 million congregate meals were served and 129.7 million home-delivered meals were served. FY 2000 data will be available in FY 2002.

Program: Research on Health Costs, Quality, and Outcomes

Description of Program:	AHRQ sponsors this research to answer questions about a wide variety of medical conditions and treatments, and translate the findings into useful tools for every day clinical practice.
Supports HHS Strategic Goal:	4
Most Recent Performance Information:	A significant performance goal for this program is to determine annually the salient findings from research in each of the following three areas: (1) outcomes, 2) quality, and 3) cost, access, and use. At least four major findings in each area must have potential to save significant amounts of money, improve quality, save lives or prevent physical suffering, or change the organization and delivery of health care. Examples of report findings in FY 2000 include: 1. Estimation of neonatal outcome and perinatal therapy use 2. Addressing socioeconomic, racial, and ethnic disparities in health care 3. Expenditures for Physician Services under Alternative Models of Managed Care Also, in FY 2000 AHRQ staff developed a draft of a long-term care research agenda that will focus long-term care population research on the major goals of quality, monitor variations in programs and access, and monitor the financial implications of the high cost of long-term care for consumers and payers.

Program: Immunization

Description of Program:	Appropriate administration of safe, effective vaccines helps to reduce and eliminate vaccine-preventable disease, disability, and death. CDC's National Immunization program awards grants to states and large local health departments, offers technical, epidemiologic, and scientific assistance to state and local areas, monitors immunization coverage, and ensures an adequate supply of vaccine. Areas of under-immunized children still exist, especially in traditionally underserved populations.
Supports HHS Strategic Goal:	Goal: 3
Most Recent Performance Information:	An FY 2000 target was to achieve or sustain immunization coverage of at least 90 percent among children two years of age for each vaccine. This data will be available in August 2001, however the most recent FY 1999 data show immunization rates of: ■ 83 percent Diptheria/Tetanus/Pertussis, ■ 94 percent H. Influenza type B, ■ 92 percent Measles/Mumps/Rubella, ■ 90 percent Polio, and ■ 59 percent Varcilla

Program: Chronic Disease Prevention

Description of Program:	The purpose of this CDC program is to prevent the occurrence and progression of chronic disease, the killer of 70 percent of all Americans, by supporting state and multiple entities' programs to reduce or eliminate risky behaviors. For example, CDC is working collaboratively to build a nation-wide program in cardiovascular health disease prevention by increasing state capacity for effective interventions, conducting surveillance on the risk factors, increasing heart-healthy policies and environmental supports, and identifying best practices.
Supports HHS Strategic Goal:	1 and 6
Most Recent Performance Information:	The FY 2000 target for reducing the morbidity and mortality from cardiovascular disease was to increase the number of states with 5 of the 7 core cardiovascular disease prevention capacities to 11 states. FY 2000 data will be available in June 2001, but FY 1999 data shows that 11 states already have these capacities.

Program: Food

Description of Program:	FDA is striving to reduce the health risks associated with food products by preventing human exposure to hazards, monitoring product quality, and correcting problems that are identified. New estimates indicate that microbial foodborne disease causes approximately 76 million illnesses, 325,000 hospitalizations and 5,000 deaths each year in the United States. FDA is expected to inspect food manufacturing establishments in the U.S. on a regular basis. FDA estimates that there are an estimated 6,250 such establishments in its inventory.
Supports HHS Strategic Goal:	4 and 5
Most Recent Performance Information:	FDA's target for FY 2000 was to Increase the percentage of high-risk domestic food establishments inspected once every year so that 90 to 100 percent are inspected every one to two years. The performance target was exceeded for FY 2000 from 3,000 inspections in FY 1999, to 5,710 in FY 2000

Program: Human Drugs

Description of Program:	FDA reduces human suffering and enhances public health by facilitating access to important, lifesaving drugs, and assuring availability of safe and effective drugs. Under the Prescription Drug User Fee Act (PDUFA) manufacturers paid for improved processing procedures and time for new drug and biologics (the study of blood and blood products) applications. The objective of PDUFA is to expedite the application review process so beneficial drugs will be available for use quickly without compromising safety or sacrificing the quality that Americans expect. The FDA had committed to certain performance goals in response to these additional resources.
Supports HHS Strategic Goal:	5
Most Recent Performance Information:	One of the performance goals is to review and act on 90 percent of standard new drug applications within 12 months of receipt. Preliminary information on FDA approval of standard new drug applications indicates that 92 of 94 (98 percent) submissions were reviewed within 12 months.

Program: HIV/AIDS

Description of Program:	This aggregated program consolidates all programs under the Ryan White Comprehensive AIDS Resources Emergency Act to improve the quality and availability of care for people with HIV/AIDS and their families. In 2000, an estimated 500,000 persons received HIV care and related supportive services through HRSA's HIV/AIDS program. HRSA's funding targets dollars toward development of a comprehensive and aggressive approach to create an effective service delivery system in partnership with states, heavily impacted metropolitan areas, and community-based providers.
Supports HHS Strategic Goal:	3
Most Recent Performance Information:	One HRSA performance goal for FY 2000 which indicates the effectiveness of this partnership, was to increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) to a level that approximates inclusion of new clients. Data on actual performance is not available yet, but is expected in FY 2002. Recent information available for FY 1999 shows that there were 1.23 million visits; 10,000 more visits than originally estimated for FY 1999.

Program: Clinical Services

Description of Program:	IHS provides health care treatment and support services to American Indians and Alaska Natives through a system of IHS, tribal, and urban (I/T/U) facilities. A recent Harvard study found that the lowest life expectancies in the country for both men and women exist in Indian communities. Diabetes is a disease that continues to be a growing problem in many AI/AN communities; the death rate is 249 percent greater than the U.S. population rate. One essential part of monitoring progress in combating this disease among the AI/AN population, is to determine the incidence rate to target prevention efforts for specific age groups in ongoing and future interventions.
Supports HHS Strategic Goal:	3
Most Recent Performance Information:	IHS uses trends in the age-specific prevalence of diabetes as a surrogate marker for diabetes incidence for the AI/AN population and as diabetes performance indicator. The performance target for FY 2000 was to maintain the database of age-specific prevalence rates that had been baselined in FY 1999. This target was met. Baseline rates were established in FY 1999 by IHS Area and sex for 4 age groups (0-19, 20-44, 45-64, and 65+); 9.6 percent of age 20 and over have diagnosed diabetes. Also, of the I/T/U clients with diagnosed diabetes and hypertension, those who had blood pressure in the "controlled" category increased from 28 percent in FY 1998 to 31 percent in FY 1999. While the clients whose blood pressure level was in the "ideal" category remained unchanged in FY 1999 at 24 percent.

Program: Mental Health

Description of Program:	The intent of this program is to create an effective community-based mental health infrastructure in the U.S. An estimated 4.5 to 6.3 million children in the U.S. have a serious emotional disturbance, yet two-thirds are not expected to receive mental health services. Therefore, SAMHSA awarded 67 grants in 43 states to assist in developing comprehensive community-based systems of care for children and adolescents with serious emotional disturbance and for their families. Improved school attendance is one of the means of determining the extent to which a system of care makes a difference in a child's life. It has a direct relationship with a child's performance in school.
Supports HHS Strategic Goal:	3
Most Recent Performance Information:	The SAMHSA FY 2000 performance target was to improve functional child outcomes from a system of care by increasing by 10 percent of children attending school 75 percent or more of the time. This target was met since 82 percent of the participating children attended school 75 percent or more of the time with 12 months of care. This represents a 17 percent increase over the FY 1997 baseline of 70 percent.