DEPARTMENT of HEALTH and HUMAN SERVICES

GENERAL DEPARTMENTAL MANAGEMENT (GDM)

FY 2012 Online Performance Appendix

Introduction

The FY 2012 Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2012 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the Summary of Performance and Financial Information Report. These documents are available at http://www..hhs.gov/budget/.

The FY 2012 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2010 Annual Performance Report and FY 2012 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The Summary of Performance and Financial Information Report summarizes key past and planned performance and financial information.

Message from the Assistant Secretary for Financial Resources

I am pleased to present the General Departmental Management (GDM) FY 2012 Online Performance Appendix (OPA). The GDM appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department in administering and overseeing the organization, programs and activities of HHS. These activities are carried out through twelve STAFF Divisions, including the Immediate Office of the Secretary, the Departmental Appeals Board (DAB), and the Offices of: Public Affairs; Legislation; Planning and Evaluation; Financial Resources; Administration; Intergovernmental Affairs; General Counsel; Disability (OD); Global Health Affairs (OGHA); and Assistant Secretary for Health (OASH formerly OPHS).

The performance information in this report represents the accomplishments of the following GDM components: DAB, OD, ASA, OGHA, and OASH. The largest single STAFFDIV within GDM is OASH, managing thirteen cross-cutting program offices that includes: Surgeon General, HIV/AIDS Policy, Adolescent Family Life, Disease Prevent and Health Promotion, President's Council on Fitness and Sports and Nutrition, Minority Health, Women's Health, Human Research Protections, Commissioned Corps Initiatives, National Vaccine Program Office, Public Health Reports, and Research Integrity, and the newly established Adolescent Health office.

OASH as the largest single STAFFDIV and contributor of the GDM OPA demonstrates their continued commitment in achieving results to support HHS-wide initiatives to improve the health and well-being of Americans. The individual narratives in this OPA highlights continued success and results for the GDM components. During the time of this reporting there were no know weaknesses in the data accuracy, completeness, or reliability.

Ellen Murray
Assistant Secretary for Financial Resources

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Summary of Performance Targets and Results Table

DEPARTMENTAL MANAGEMENT

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	103	103	100%	92	91%
2008	103	103	100%	83	81%
2009	92	92	100%	83	90%
2010	89	43	48%	38	43%
2011	75				
2012	75				

NOTE: The FY 2007 and FY 2008 targets include the following Departmental Management (DM) programs: OMHA, ONC, OGHA, ASPR, DAB, OD, OASH and specific OASH programs offices with measures developed during their program assessment. The targets in FY 2009 were reduced because the Public Health and Social Services Emergency Fund which includes ASPR, is now published as a separate Justification. Targets for the remaining fiscal years reflect the following DM programs: OMHA, ONC, DAB, OD, OGHA and OASH.

DEPARTMENTAL APPEALS BOARD

Performance Narrative

The Departmental Appeals Board (DAB) does not directly administer any of the HHS programs that support the HHS Strategic Plan goals and objectives. However, the DAB furthers these goals and objectives and directly supports HHS Strategic Goals and Objectives 4.A and 4.B, by providing timely and quality decisions that resolve disputes arising in those programs (or Alternative Dispute Resolution assistance that helps the parties resolve their own disputes). Specifically, DAB decisions help ensure that funds are spent only for authorized purposes, that healthcare quality standards are enforced, and that program and research integrity is maintained. Also, by providing a fair and transparent process to resolve disputes, the DAB enhances relationships with states, providers, universities, and others whose cooperation is needed for HHS to achieve its goals. Also, DAB supports HHS Strategic Goal and Objective 5.A., investing in and strengthening the HHS workforce, by providing interventions in workplace conflicts and training in conflict management. These activities help employees focus on their core missions, rather than being sidetracked by conflict, and be more effective in meeting the Nation's health and human service needs.

DAB is organized into four Divisions: the Appellate Division supports the Board Members, who preside in various types of cases; the Civil Remedies Division (CRD) supports DAB Administrative Law Judges (ALJs), who conduct evidentiary hearings; the Medicare Operations Division (MOD) supports DAB Administrative Appeals Judges, who review decisions by ALJs from the DHHS Office of Medicare Hearings and Appeals (OMHA) or (in some older cases) by Social Security Administration ALJs; and the Alternate Dispute Resolution Division, which provides mediation services in DAB cases and provides policy guidance and information on the use of dispute resolution methods throughout DHHS to reduce administrative and management costs.

DAB has made measurable progress in the strategic management of human capital by reengineering its operations and improving its case management techniques. DAB shifts resources across its Divisions as needed to meet changing caseloads and targets mediation services to reduce pending workloads. Performance analyses for each Division are based on actual FY 2010 data and projections for FY 2011 and FY 2012.

APPELLATE DIVISION

In FY 2010, the Board/Appellate Division closed 113 cases (71 by decision). In FY 2010, 86% of Board decisions had a case age of six months or less, meeting the target for Objective 1, which measures the percentage of total Board decisions issued in cases with a net age of six months or less. Objective 2 for the Appellate Division measures the number of Board decisions reversed or remanded in Federal court, as a percentage of all Board decisions. In FY 2010, the Board continued to meet this Objective which requires that no more than 2% of total decisions be overturned by Federal court.

Despite an increase in the number of appeals filed in FY 2011, the Board will meet Objective 1. Also, the Board will issue more decisions in FY 2011 than FY 2010. For FY 2011, the Appellate Division changed Objective 2. This is because court decisions are usually issued more than a year after the Board decision has been appealed, so the performance standard is not an accurate measure of current performance. The Appellate Division instead measured the percentage of Board decisions with regulatory deadlines for issuing decisions in which the deadline was met. In FY 2012, Appellate will hire five new staff to handle projected new Affordable Care Act (ACA) workload. In FY 2011 and FY 2012, the Appellate Division will meet all performance goals.

CIVIL REMEDIES DIVISION (CRD)

CRD received 1,014 new appeals in FY 2010 (30% more than in FY 2009) and closed 1,109 appeals. Despite the tremendous increase in cases, CRD met its FY 2010 targets for Objective 3 and 4. Objective 3 relates to OIG actions to impose civil money penalties or to exclude individuals from participating in Federal programs. The measure for this goal is the percentage of OIG cases in which DAB ALJs issue decisions within 60 days of the close of the record. The target for FY 2010 was 100%. Objective 4 ensures that increases in case receipts do not result in a greater number of aged cases. The measure is the number of cases open at the end of the year that had been received in prior years. By the end of FY 2010, CRD had only 34 cases that were open in previous fiscal years.

In FY 2010, CRD noted a significant increase in the number of appeals filed under 42 C.F.R. Part 498 by providers and suppliers whose enrollment, reenrollment, or revalidation application for Medicare billing privileges were denied or revoked. The increase was due to amendments that changed previous regulations for physician and non-physician organizations and individual practitioners with respect to effective date of Medicare billing privileges. These provider/supplier enrollment cases increased CRD's workload by the 30% percent noted above. In addition, heightened enforcement and oversight efforts by DHHS OIG, CMS, and the DHHS Office for Civil Rights (OCR) have resulted in additional new appeals.

CRD has been able to handle this increasing workload by creating a team specifically devoted to the provider/supplier enrollment cases. The Chair detailed a Board Member and Appellate Division senior attorney to lead this initiative. In addition, CRD hired two two-year term attorneys to work exclusively on these cases. In FY 2011, CRD plans to hire an ALJ to lead the team and two one-year term attorneys to work on the team and in FY 2012 plans to hire five new staff members to handle projected new ACA cases. CRD will meet its performance goals in FY 2011 and FY 2012.

MEDICARE OPERATIONS DIVISION (MOD)

In FY 2010, MOD exceeded its FY 2010 target for Objective 6 to constrain the growth in case age by reducing the average time to complete action on Medicare Part B cases to 155 days (as measured from the date MOD received the case folder). For FY 2009, MOD took an average of 147 days to complete action on Medicare Part B cases and reduced this to 132 days in FY 2010. In FY 2010, MOD issued the majority of cases prior to the 90-day deadline. MOD should continue to meet its Objective 6 targets in FY 2011 and FY 2012.

In FY 2010, MOD did not meet its target for Objective 7 of issuing 2,350 dispositions (instead issuing 1,834 dispositions). MOD had fewer dispositions than projected, because it did not receive as many cases as projected from data received from other agencies and because of the changing nature of the overall workload. A significant portion of the casework has become increasingly complex, involving larger overpayment and statistical sampling cases, which generally feature multiple volumes/boxes of beneficiary files and medical records. In addition, the loss of two experienced and highly productive legal analysts during FY 2010 contributed to the shortfall. MOD also had to devote significantly more resources to preparing certified court records for Federal district courts. While the percentage of cases appealed to Federal court has not increased, the overall size (number of beneficiaries/documents submitted) and complexity of the cases has resulted in creating an additional full-time area of responsibility for our paralegal staff. This trend will continue into FY 2011 and FY 2012. MOD anticipates that appeals originating from overpayments that the RAC identifies will be particularly burdensome since the cases typically involve thousands of pages. In FY 2011 and FY 2012, DAB will hire new staff for this work, and in FY 2012 DAB will hire five additional staff members for projected new ACA cases. The increase in the FY 2012 target for closed cases (performance measure #7) is attributable to new ACA workload and resources.

ALTERNATIVE DISPUTE RESOLUTION DIVISION (ADR)

In FY 2010, the ADR Division met its performance Objective 5.1 and 5.2 by conducting 15 conflict resolution seminars and providing ADR services to 80 DHHS cases. In FY 2010, the ADR Division successfully undertook several initiatives, including: co-sponsoring a Department-wide ADR Forum designed to promote the use of ADR in EEO cases; supplementing a small ADR staff with two unpaid law school interns; and developing a new course ("Conflict Management for FOIA professionals") to support goals of President Obama's Directive on Transparency and Open Government. In FY 2011 and FY 2012, the ADR Division will meet its performance goals and will undertake various new initiatives, including: supporting DHHS efforts to implement new Executive Order 13522 on Labor Management Relations by facilitating the formation of labor-management councils, by being available to provide training to labor-management councils in interest-based negotiation and by facilitating labor-management council meetings; and promoting increased use of video conferencing for mediation in DAB cases to save travel costs.

DAB Performance Measures Table

Long Term Objective: Strengthen program management by maintaining the efficiency of Appellate Division case processing.

Measure 1.1.1: Percentage of Board decisions with net case age of six months or less. *(Outcome)*		
FY	**Target**	**Result**
2012	86%	
2011	86%	
2010	86%	86% (Target Met)
2009	86%	86% (Target Met)
2008	50%	76% (Target Exceeded)
2007	45%	45% (Target Met)

Measure	Data Source	Data Validation
1.1.1	Controlled-access Oracle database, with case specific information.	Periodic reports from database; at end of fiscal year, the interim reports totals are cross-checked against annual reports.

Long Term Objective: Maintain reversal and remand rate of Board decisions appealed to Federal courts as a measure of quality of decisions.

Measure 1.2.1: Number of decisions reversed or remanded on appeals to Federal court as a percentage of all Board decisions issued. *(Outcome)*		
FY	**Target**	**Result**
2012	N/A	
2011	N/A	
2010	2%	2% (Target Met)
2009	2%	2% (Target Met)
2008	2%	2% (Target Met)
2007	2%	2% (Target Met)
Measure 1.2.1: (revised) Percentage of decisions meeting applicable statutory and regulatory deadlines for issuance of decisions. *(Outcome)*		
FY	**Target**	**Result**
2012	100%	

2011	100%	

Measure	Data Source	Data Validation
1.2.1	Controlled-access Oracle database, with case specific information.	Periodic reports from database; at end of fiscal year, the interim reports totals are cross-checked against annual reports.

Long Term Objective: Assure maximum compliance with regulatory time frames for deciding enforcement, fraud and exclusion cases by increasing Civil Remedies Division processing rates for Inspector General cases.

Measure 1.3.1: Percentage of decisions issued within 60 days of the close of the record. *(Outcome/efficiency)*		
FY	**Target**	**Result**
2012	100%	
2011	100%	
2010	100%	100% (Target Met)
2009	90%	100% (Target Exceeded)
2008	90%	100% (Target Exceeded)
2007	90%	90% (Target Met)
Measure 1.3.1 (revised): Percentage of decisions issued within 60 days of the close of the record in HHS OIG enforcement, fraud and exclusion cases[1]. *(Outcome*		
FY	**Target**	**Result**
2012	100%	
2011	100%	
2010	100%	100% (Target Met)
2009	97%	100% (Target Exceeded)
2008	90%	100% (Target Exceeded)
2007	90%	100% (Target Exceeded)

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

Measure 1.3.2: Percentage of decisions issued within 60 days of the close of the record in SSA OIG CMP cases and other SSA OIG enforcement cases.		
FY	**Target**	**Result**
2012	100%	
2011	100%	
2010	100%	100% (Target Met)
2009	100%	N/A

Measure 1.3.3: Percentage of decisions issued within 180 days of filing of provider or supplier enrollment appeal.		
FY	**Target**	**Result**
2012	100%	
2011	100%	
2010	100%	100% (Target Met)
2009	100%	N/A

Measure	Data Source	Data Validation
1.3.1	Controlled-access Oracle database, with case specific information.	Periodic reports from database; at end of fiscal year, the interim reports totals are cross-checked against annual reports.

Long Term Objective: Constrain growth in number of aged Civil Remedies Division cases.

Measure 1.4.1: Number of case open at end of Fiscal Year that were opened in previous Fiscal Years. *(Outcome/efficiency)*		
FY	**Target**	**Result**
2012	<=2011	
2011	<=2010	
2010	<=2009	34 (Target Met)
2009	<=2008	39 (Target Met)
2008	<=2007	45 (Target Met)
2007	<=100	Goal Met (76) (Target Exceeded)

Measure	Data Source	Data Validation

Measure	Data Source	Data Validation
1.4.1	Controlled-access Oracle database, with case specific information.	Periodic reports from database; at end of fiscal year, the interim reports totals are cross-checked against annual reports.

Long Term Objective: Enhance ADR capacity at HHS so as to decrease contentiousness and associated costs in dispute resolution and promote efficiency in management practices.

Measure 1.5.1: Number of conflict resolution seminars conducted for HHS employees. *(Outcome)*		
FY	**Target**	**Result**
2012	15 sessions	
2011	15 sessions	
2010	15 sessions	15 sessions (Target Met)
2009	11 sessions	11 sessions (Target Met)
2008	8 sessions	11 sessions (Target Exceeded)
2007	8 sessions	9 sessions (Target Exceeded)

Measure 1.5.2: Number of DAB cases (those logged into ADR Division database) requesting facilitative ADR interventions prior to more directive adjudicative processes. *(Outcome)*		
FY	**Target**	**Result**
2012	80	
2011	80	
2010	75	75 (Target Met)
2009	75	75 (Target Met)
2008	55	75 (Target Exceeded)
2007	50	59 (Target Exceeded)

Measure	Data Source	Data Validation
1.5.1 1.5.2	Training session information is recorded and tracked. Caseload data tracked with controlled-access Oracle database, with case specific information	Participant sign-in sheets, course evaluations, and reports of training sessions. Periodic reports from database; at end of fiscal year, the interim reports totals are cross-checked against annual reports.

Long Term Objective: Constrain growth in average time to complete action on Medicare Appeals cases.

Measure 1.6.1: Average time to complete action on Part B Requests for Review measured from receipt of case folder. (FY 2001 and following Fiscal Years) Note: Results for FY 05 determined after excluding outlier cases in which delays related to court proceedings beyond DAB's control. *(Outcome)*		
FY	**Target**	**Result**
2012	155 days	
2011	155 days	
2010	132 days	132 days (Target Met)
2009	160 days	147 days (Target Met)
2008	160 days	185 days (Target Not Met)
2007	125 days	169 days (Target Not Met)

Measure	Data Source	Data Validation
1.6.1	Controlled-access Oracle database, with case specific information.	Periodic reports from database; at end of fiscal year, the interim reports totals are cross-checked against annual reports.

Long Term Objective: Increase number of Medicare Appeals dispositions to resolve and respond to Medicare claims brought by program providers and beneficiaries.

Measure 1.7.1: Number of dispositions. Counting method changes in FY 05 (see narrative below); FY04 comparable results are 2183 cases. *(Output)*		
FY	**Target**	**Result**
2012	2,500	
2011	2,400	
2010	2,350	1,800 (Target Not Met)
2009	2,050	2,194 (Target Exceeded)
2008	1,800	2,689 (Target Exceeded)
2007	1,150	1,511 (Target Exceeded)

Measure	Data Source	Data Validation
1.7.1	Controlled-access Oracle database, with case specific information.	Periodic reports from database; at end of fiscal year, the interim reports totals are cross-checked against annual reports.

OFFICE ON DISABILITY

Performance Narrative

The Office on Disability's (OD) long term goal is to promote the abilities of all persons with disabilities, leading to the vision of an inclusive America. OD supports initiatives organized around the following three themes: a) Improve Access to Community Living Services and Supports; b) Integrate Health Services and Social Supports; and c) Provide Strategic Support on Disability Matters. OD has new strategic goals/objectives under each of the three themes described above that will support Presidential and Secretarial priorities in health care and community living. OD is developing new measures in support of its' new mission and strategic goals/objectives under the current leadership. Previously OD had one objective that demonstrated impact through use of performance measures, which was discontinued in FY 2010.

OD Performance Measures Table

Long Term Objective: Promote the coordination, development and implementation of programs and special initiatives to help increase the service capacity and affordability for integrated health and wellness services for persons with disabilities.

Measure 2.3.1: In partnership with HHS Office of the Assistant Secretary for Preparedness and Response (ASPR), implement and monitor the use of the disability-based tool kit and future use of public health staff education modules. *(Outcome)*		
FY	**Target**	**Result**
Out-Year Target	55 (2011)	
2010	50	Discontinued
2009	40	40 (Target Met)
2008	30	40 (Target Exceeded)
2007	20	25 (Target Exceeded)
2006	6	6 (Target Met)

Measure	Data Source	Data Validation
2.3.1	Annual Assessment Report of State Emergency Management Plans and DHS, ACF, BIA, FEMA and HIS info personnel.	Comparison of DHS Interagency Coordinating Council (ICC) State analyses.

OFFICE OF GLOBAL HEALTH AFFAIRS

Performance Narrative

United States-Mexico Border Health Commission (USMBHC)

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

The USMBHC promotes (1) sustainable partnerships which engage international, federal state and local public health entities in support of annual initiatives around critical border health priorities that for FY 2011 and FY 2012 will focus on tuberculosis, obesity and diabetes and infectious disease as impacted by public health emergencies; (2) leads the development of a comprehensive border health research agenda that will inform policy makers, researches and entities which fund research where research gaps, needs and opportunities lay; (3) hosts the annual National Infant Immunization Week/Vaccination Week of the Americas (NIIW/VWA) that promotes the benefits of infant immunization in a regional and binational approach unmatched by any region in either country and the annual Border Binational Health Week events along the entire U.S.-Mexico border, which brings together local communities for health screenings, health education interventions and other unique training and education forums. In FY 2010 for Border Binational Health Week, the USMBHC helped to host 130 events along both sides of the border, engaging over 160 partners, and providing over 32,000 free health screenings and educational opportunities to U.S. and México border residents (U.S. side nearly 16,000 and México side nearly 17,000), reflecting a composite of various resources (including financial and in-kind support) from federal, State, local and community stakeholders.

USMBHC Performance Measures Table

FY	Target	Result
Measure 3.1.1: Reduce the percent of indirect Spending on border health activities. *(Efficiency)*		
FY	**Target**	**Result**
2012	5.5%	
2011	6.0%	
2010	6.0%	3.6% (Target Exceeded)
2009	7.0%	5.5% (Target Exceeded)
2008	9.0%	6.9% (Target Exceeded)
2007	10%	2.4% (Target Exceeded)
Measure 3.1.2: The percentage of Health y Border 2010 population level health outcome objectives with baseline data that have been achieved. *(Outcome) (New Measure 2008)*		
FY	**Target**	**Result**
2012	50%	
2011	50%	
2010	50%	Pending Data
2009	50%	5.3% (Target Not Met)
2008	N/A	N/A
2007	N/A	14%
Measure 3.1.3: The incidence of tuberculosis cases per 100,000 inhabitants on the U.S. side of border. *(Outcome)*		
FY	**Target**	**Result**
2012	8.0	
2011	8.0	
2010	8.0	Pending Data
2009	8.0	10.3 (Target Not Met)
2008	N/A	N/A
2007	N/A	N/A
Measure 3.1.4: The incidence of HIV cases per 100,000 inhabitants on the U.S. side of border. *(Outcome)*		
FY	**Target**	**Result**
2012	4.2	

2011	4.2	
2010	4.2	Pending Data
2009	N/A	4.1 (Target Exceeded)
2008	N/A	N/A
2007	N/A	N/A

Measure 3.1.5: The diabetes death rate per 100,000 inhabitants on the U.S. side of the border. *(Outcome*		
FY	**Target**	**Result**
2012	23.7	
2011	23.9	
2010	24.2	Pending Data
2009	24.5	26.8 (Target Not Met)
2008	N/A	N/A
2007	N/A	N/A

Measure 3.1.6: The number of U.S. border residents who receive public health education or health screenings during Border Binational Health Week (BBHW) celebrated on both sides of the U.S. - Mexico Border. *(Output)*		
FY	**Target**	**Result**
2012	13,000	
2011	13,000	
2010	13,000	15,708 (Target Exceeded)
2009	12,000	20,666 (Target Exceeded)
2008	25,000	20,576 (Target Not Met)
2007	25,000	10,774 (Target Not Met)

Measure 3.1.7: Cumulative number of health related organizations that have adopted population-level health outcome objective of the BHC – Health Border 2010 Strategy into their planning, programming or funding process. (New Measure – 2008).		
FY	**Target**	**Result**
2012	100%	
2011	100%	
2010	100%	Pending New Survey Results
2009	100%	57% (Target Not Met)
2008	73%	57%

2007	41%	57%

Measure	Data Source	Data Validation
3.1.1	Office of Global Health Affairs	
3.1.2	U.S.-Mexico Border Health Commission (USMBHC)	
3.1.3	Centers for Disease Control & Prevention (CDC) and the National Center for Health Statistics	State and county level data
3.1.4	CDC and NCHS	State and county level data
3.1.5	CDC and NCHS	State and county level data
3.1.6	U.S.- Mexico Border Health Commission	Community partners and USMBHC questionnaire
3.1.7	U.S.- Mexico Border Health Commission	GuideStar U.S. non-profit registry

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Performance Narrative

The Office of the Assistant Secretary for Health (OASH) continues to evolve to be a stronger, more customer-centered, financially accountable organization that influences the health and well-being of millions of Americans. Three key priorities established by the ASH provide a framework for addressing public health concerns: *Creating better systems of prevention; Eliminating health disparities and Achieving health equity; and Making Health People come alive for all Americans.* OASH was successful in leveraging resources and ideas to maximize national program and policy impact; fostering consensus on key public health issues to ensure the public receives consistent, science-based communications from the Department; and developing cross-cutting initiatives to accelerate the rate of health improvement among disparity populations.

OASH is mobilizing leadership in prevention throughout HHS focusing on many Secretarial and intradepartmental initiatives. Major examples include a new Department strategic plan on ***Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan*** which outlines actions, based on scientific evidence and extensive real-world experience that will serve as a roadmap for reaching the Healthy People objective of reducing the adult smoking rate to 12 percent by 2020.

The ASH along with the Secretary and the FDA Commissioner, unveiled a new comprehensive tobacco control strategy that includes proposed new bolder health warnings on cigarette packages and advertisements. Once final, these health warnings on cigarettes and in cigarette advertisements will be the most significant change in more than 25 years.

On December 2, 2010, the Office of Disease Prevention and Health Promotion released the goals and objectives for Health People 2020. The objectives and targets are used to measure progress for health issues in specific populations, and serves as a foundation for prevention and wellness activities across various sections and within the federal government, and a model for measurement at the state and local levels.

Other various accomplishments this past year include the creation of a Pan-US-Canadian Public Health Council to respond to urgent public health threats across the border; the implementation of trainings including Test and Treat and Pre-Exposure prophylaxis, implementation of new teen pregnancy prevention initiative; the development of draft Dietary Guidelines for Americans policy with USDA; the administration of 400,000 HIV tests in Title X settings; the addition of 17 Blood Safety and Blood Disorder objectives to Healthy People 2020, which initially included only one objective; the deployment of "HI-Touch," a collaborative between the NHIT and ONC in 3 states to coordinate physician recruitment efforts in underserved communities to further the adoption of electronic health records; and the implementation of over 100 trainings to HIV partners at greatest risk, which exceeded our goal of 24 sessions by fourfold.
In those few cases where OASH did not meet their performance targets, steps are being taken to create targets that are more reflective towards a program's actual performance. It is our

understanding and goal that targets will be ambitious, yet attainable.

Associated with each of the three goals are five objectives:

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

They are complex national challenges and reach beyond the control and responsibility of the Federal government. Achievement depends on various health programs and providers, all levels of government, and the private sector. OASH provides the leadership and "glue" that makes the difference in collective efforts.

OASH revised some of its performance measures for FY 2012 to improve the usefulness of its performance data, and create a stronger alignment between the specific program and budgetary decision making. Such changes in measures are designed to improve program stewardship and accountability and increase program transparency.

OASH Performance Measures Table

Agency Long-Term Objective: Creating better systems of prevention.

Measure 1.a: Shape policy at the local, State, national and international levels (Outcome) Measure 1: The number of communities, state and local agencies, Federal entities, NGOs or international organizations that adopt (or incorporate into programs) policies and recommendations generated or promoted by OASH through reports, committees, etc.		
FY	**Target**	**Result**
2012	35,200	
2011	35,192	
2010	35,000[2]	32,147 (Target Not Met)
2009	50,000	32,145 (Target Not Met)
2008	50,000	32,611 (Target Not Met but Improved)
2007	50,000	32,578 (Target Not Met but Improved)

[2] OASH has consistently not met this target. We are changing our target to keep it more in line with our actual performance.

Measure

1.b: Communicate strategically (Output)

Measure 1: The number of visitors to Websites and inquiries to clearinghouses;
Measure 2: Number of regional/national workshops/conferences, community based events, consultations with professional and institutional associations; Measure 3: new, targeted educational materials/campaigns; Measure 4: media coverage of OASH-supported prevention efforts (including public affairs events);

FY	Target	Result
2012	38,270,500	
2011	42,506,365	
2010	41,230,280[3]	32,129,745 (Target Not Met)[4]
2009	52,000,000	40,268,111 (Target Not Met)
2008	51,000,000	52,000,000 (Target Exceeded)
2007	49,000,000	7 (Target Not Met but Improved)

Measure

1.c: Promote effective partnerships (Outcome)

Measure 1: Number of formal IAAs, MOUs, contracts, cooperative agreements, and community implementation grants with governmental and non-governmental organizations that lead to prevention-oriented changes in their agendas/efforts.

FY	Target	Result
2012	960	
2011	580	
2010	546	954 (Target Exceeded)
2009	175	1044 (Target Exceeded)
2008	160	480 (Target Exceeded)
2007	334	499 (Target Exceeded)

Measure

1.d: Strengthen the science base *(Outcome)*

Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally;
Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated;
Measure 3: the number of promising practices identified by research, demonstrations, evaluation, or other studies.

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[3] The Office of HIV/AIDS Policy (OHAP) was a big contributor to this measure. OHAP's Mobilization Campaign has ended and they collected a lot of web visitors to their campaign site. As a result, OASH had to decrease their target for this measure. A significant drop in OHAP's numbers in FY'10 can be explained due to: (1) the end of the National HIV/Testing Mobilization Campaign (NHTMC) which produced considerable numbers for both preventing disease and addressing health disparities and (2) a reduction in OHAP-generated programs and projects to focus more on HIV/AIDS policy and program review and analysis.

[4] There is a decrease in total number of visitors to websites because more and more people are using social media such as Twitter and Facebook to get information rather than visiting websites.

FY	Target	Result
2012	340	
2011	78	
2010	50	1,222 (Target Exceeded)[5]
2009	225	363 (Target Exceeded)
2008	200	159 (Target Not Met)
2007	200	447 (Target Exceeded)
Measure 1.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome) Measure 1: Number of prevention-oriented initiatives and entities within HHS, across Federal agencies, and with private agencies, and with private organizations that are convened, chaired, or staffed by OASH; Measure 2: Number of outcomes from efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc.		
FY	**Target**	**Result**
2012	575	
2011	1,461	
2010	1,390[6]	175 (Target Not Met)
2009	1,600	1,840 (Target Exceeded)
2008	1,500	1,589 (Target Exceeded)
2007	1,300	1,337 (Target Exceeded)

Measure	Data Source	Data Validation
1.a 1.b 1.c 1.d 1.e	OPHS administrative files	Project officer oversight and validation

Agency Long-Term Objective: Eliminating health disparities and achieving health equity

[5] This target dropped significantly due to OWH moving towards the ASIST program and phasing out the COE and CCOEs.

[6] OWH is the greatest contributor for this measure. In prior years, OWH had the National Centers of Excellence and the Community Centers of Excellence (established programs). OWH restructured those programs (new competition, etc) and they now have a new coordinated program linked to Healthy People which is the ASIST 2010 program. Their data also changed, therefore they submitted new and more realistic targets for this measure.

FY	Target	Result
Measure 2.a: Shape policy at the local, State, national and international levels (Outcome) Measure 1: The number of communities, NGOs, state and local agencies, or Federal entities, that adopt (or incorporate into initiatives) policies and recommendations targeting health disparities that are generated or promoted by OASH through reports, committees, etc.		
FY	**Target**	**Result**
2012	130	
2011	102	
2010	98	213 (Target Exceeded)
2009	97	328 (Target Exceeded)
2008	92	404 (Target Exceeded)
2007	96	190 (Target Exceeded)
Measure 2.b: Communicate strategically *(Outcome)* Measure 1: The number of visitors to Websites and inquiries to clearinghouses; Measure 2: number of regional/national workshops/conferences or community based events; Measure 3: new, targeted educational materials/campaigns; Measure 4: media coverage of OASH-supported disparities efforts (including public affairs events); and estimated number of broadcast media outlets airing Closing the Health Gap messages		
FY	**Target**	**Result**
2012	2,232,180	
2011	2,480,452	
2010	2,410,400	14,670,638 (Target Exceeded)[7]
2009	2,305,000	265,695,094 (Target Exceeded)
2008	1,900,000	1,949,387 (Target Exceeded)
2007	1,900,000	2,146,111 (Target Exceeded)
Measure 2.c: Promote Effective Partnerships *(Outcome)* Measure 1: Number of formal IAAs, MOUs, contracts, cooperative agreements and community implementation grants with governmental and non-governmental organizations that lead to changes in their agendas/efforts to address health disparities.		
FY	**Target**	**Result**
2012	330	
2011	200	

[7] Significant increase is due to Bones Campaign in the Office on Women's Health.

2010	136	508 (Target Exceeded)
2009	126	623 (Target Exceeded)
2008	110	331 (Target Exceeded)
2007	72	336 (Target Exceeded)

Measure 2.d: Strengthen the science base *(Outcome)* Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated; Measure 3: number of promising practices identified in research, demonstration, evaluation, or other studies.		
FY	**Target**	**Result**
2012	160	
2011	65	
2010	60	200 (Target Exceeded)
2009	45	197 (Target Exceeded)
2008	42	89 (Target Exceeded)
2007	47	275 (Target Exceeded)

Measure 2.e: Lead and coordinate key initiatives within and on behalf of the Department *(Outcome)* Measure 1: Number of disparities-oriented initiatives/entities within HHS, across Federal agencies, and with private organizations that are convened, chaired, or staffed by OASH; Measure 2: Number of specific outcomes of the efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc.		
FY	**Target**	**Result**
2012	60	N/A
2011	75	N/A
2010	70	217 (Target Exceeded)
2009	23	549 (Target Exceeded)
2008	23	120 (Target Exceeded)

2007	86	24 (Target Not Met)

Measure	Data Source	Data Validation
2.a 2.b 2.c 2.d 2.e	OASH administrative files	Project officer oversight and validation

Agency Long-Term Objective: Making Healthy People come alive for all Americans

Measure 3.a: Shape policy at the local, State, national and international levels *(Outcome)* Measure 1: The number of communities, NGOs, state and local agencies, Federal entities, or research organization that adopt (or incorporate into programs) policies, laws, regulations and recommendations promoted or overseen by OASH.		
FY	**Target**	**Result**
2012	1,020	
2011	981	
2010	951[8]	3,749 (Target Exceeded)
2009	1,800	3,575 (Target Exceeded)
2008	1,700	3,529 (Target Exceeded)
2007	2,400	2,416 (Target Exceeded)
Measure 3.b: Communicate strategically (Output) Measure 1: The number of visitors to Websites and inquiries to clearinghouses; Measure 2: number of regional/national workshops/conferences, community based events, and consultations with professional and institutional associations; Measure 3: new, targeted educational materials/campaigns		
2012	1,444,660	
2011	1,630,480	
2010	1,615,473	15,901,303 (Target Exceeded)[9]
2009	1,178,844	1,568,751 (Target Exceeded)
2008	1,000,000	2,046,913 (Target Exceeded)
2007	650,000	1,173,866 (Target Exceeded)

[8] OSG is the greatest contributor for this measure. They have increased their target as a result of prior performance.

[9] AIDS.gov media toolkit led to an increase in website hits, blogs, podcast viewings, etc. in FY 2010. Overall OWH has seen a decrease in website visits so the FY 2012 target was decreased to accurately reflect current data trends.

Measure 3.c: Promote Effective Partnerships (Outcome) Measure 1: Number of formal IAAs, MOUs, contracts, cooperative agreements and community implementation grants with governmental and non-governmental organizations that lead to changes in their agendas/efforts related to the public health or research infrastructure.		
2012	485	
2011	41	
2010	40	310 (Target Exceeded)
2009	30	486 (Target Exceeded)
2008	30	131 (Target Exceeded)
2007	6	116 (Target Exceeded)
Measure 3.d: Strengthen the science base (Outcome) Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated; Measure 3: number of public health data enhancements (e.g. filling developmental objectives or select population cells; development of state and community data) attributable to OASH leadership.		
2012	1,940	
2011	1,595	
2010	1,103	1,252 (Target Exceeded)
2009	189	7,512 (Target Exceeded)
2008	125	1,927 (Target Exceeded)
2007	67	4,205 (Target Exceeded)
Measure 3.e: Lead and coordinate key initiatives within and on behalf of the Department *(Outcome)* Measure 1: Number of relevant initiatives/entities within HHS, across Federal agencies, and with private organizations that are convened, chaired, or staffed by OASH; Measure 2: specific outcomes of the efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc		
2012	6,234	
2011	4,669	
2010	4,600[10]	1,347 (Target Not Met)[11]

[10] OASH has consistently not met this target. We are changing our target for this measure to be more realistic with our progress in this area.

[11] Target for this measure will need to be adjusted. As a consequence of the passage of the Affordable Care Act, the former United States Public Health Service Reserve Corps, and subsequently the Inactive Reserve Corps, would be abolished. As a result therefore, this measure is no longer meaningful to Inactive Reserve Corps whish was a major

2009	7,300	3,149 (Target Not Met but Improved)
2008	7,300	3,114 (Target Not Met)
2007	6,800	3,135 (Target Not Met)

Measure	Data Source	Data Validation
3.a 3.b 3.c 3.d 3.e	OASH administrative files	Project officer oversight and validation

OASH PROGRAM: ADOLESCENT FAMILY LIFE (AFL)

Agency Long-Term Objective: Encourage adolescents to postpone sexual activity by developing and testing abstinence interventions.

Measure	FY	Target	Result
2.5: Increase the scientific understanding of adolescent sexual health and family relationships through the production and dissemination of peer reviewed publications and presentations at regional and national conferences. **This measure will enable OAPP to assess activities related to the office's long term goals of promoting rigorous research and increasing the scientific understanding of adolescent sexual behavior.** (Outcome)	2012	N/A	N/A

Measure	Data Source	Data Validation
2.5	Grantee annual end of year report	Project officer oversight and validation

Agency Long-Term Objective: Ameliorate the effects of too-early-childbearing by developing and testing interventions with pregnant and parenting teens.

Measure 2.2.1: Demonstrate lower rates of repeat pregnancy among participants receiving enhanced services (intervention) as compared to participants receiving standard services (comparison) at 12-month follow-up. **Results will be reported by AFL grantee cohort.** (Outcome)		
FY	**Target**	**Result**
2012	92%	
2011	92%	

contributor to this target.

2010	92%	N/A
2009	92%	90% (Target Not Met)
2008	92%	90% (Target Not Met)
2007	Set Baseline	92% (Baseline)
Measure 2.2.2: Increase infant immunization among clients in AFL Care demonstration projects. (Outcome)		
FY	**Target**	**Result**
2012	Discontinued	
2011	Discontinued	
2010	82%	N/A
2009	80%	50% (Target Not Met)
2008	78%	65% (Target Not Met)
2007	Set Baseline	76% (Baseline)
Measure 2.2.3: Demonstrate increased positive educational outcomes among participants receiving enhanced services (intervention) as compared to participants receiving standard services (comparison) at 12-month follow-up. **Results will be reported by AFL grant cohort.** (Outcome)		
FY	**Target**	**Result**
2012	81%	
2011	80%	
2010	79%	N/A
2009	72%	81% (Target Exceeded)
2008	70%	79% (Target Exceeded)
2007	Set Baseline	68% (Baseline)
Measure 2.5: Increase the scientific understanding of adolescent sexual health and family relationships through the production and dissemination of peer reviewed publications and presentations at regional and national conferences. **Results will be reported by AFL grantee cohort.** (Outcome)		
FY	**Target**	**Result**
2012	N/A	N/A

Measure	Data Source	Data Validation
2.2.1 2.2.2	Grantee annual end of year report	Project officer oversight and validation

Measure	Data Source	Data Validation
2.2.3		
2.5	Grantee annual end of year report	Project officer oversight and validation

Agency Long-Term Objective: (1) Identify interventions that have demonstrated their effectiveness to promote premarital abstinence for adolescents. (2) Identify interventions that have demonstrated their effectiveness to ameliorate the consequences of adolescent pregnancy and childbearing.

Measure 2.3.2: Improve the quality of the Title XX independent evaluations through the provision of technical assistance and related training. Results will be reported by AFL grantee cohort. (Outcome)		
FY	**Target**	**Result**
Out-Year Target	79.8% (2015)	N/A
2012	67.2%	N/A
2011	63%	N/A
2010	58.8%	N/A
2009	54.6%	41% (Target Not Met)
2008	50.4%	55.5% (Target Exceeded)
2007	46.2%	37% (Target Not Met)

Measure	Data Source	Data Validation
2.3.2	Grantee annual end of year report	Project officer oversight and validation

Agency Long-Term Objective: Improve the efficiency of the AFL program.

Measure 2.4.2: Sustain the cost to encounter ratio in care demonstration projects. (Outcome)		
FY	**Target**	**Result**
2012	$110	
2011	$110	
2010	$110	N/A
2009	$110	$91 (Target Exceeded)
2008	$110	$72 (Target Exceeded)
2007	$125	$110 (Target Exceeded)

Measure	Data Source	Data Validation
2.4.2	Grantee annual end of year report	Project officer oversight and validation

It is anticipated that only AFL Care demonstration grants will be supported in FY 2011 and beyond. The 3 revised measures propose to report outcomes per AFL 5-year grantee cohort in order to correctly account for the yearly progress each cohort makes on each of the outcomes. These measures also compare intervention participants to those receiving standard services (comparison) which will yield meaningful results.

Data collection and analysis for the AFL performance measures are conducted each spring. The most recent program data available for AFL is from FY 2009 (analyzed in spring 2010). Based on the data from FY 2009, the AFL program was able to report on additional data points for all of its objectives, thus moving beyond baseline measures only. The AFL program experienced mixed results with the most recent data collected. The actual result for one of the objectives exceeded the proposed target by nine percentage points, while the targets for two of the five objectives were not met. The target for 2.2.1 was 92% and the actual result was 90% (FY 07 result was 92%). The target for 2.2.2 was 80% and the actual result was 50% (FY 07 result was 76%). The target for 2.2.3 was 72% and the actual result was 81% (FY 07 result was 68%). The target for 2.3.2 was 54.6% and the actual result was 41% (FY 07 result was 37%). This decline was due to one AFL grantee cohort experiencing implementation problems when they began fully delivering their intervention in the community. The actual results for the efficiency measure also exceeded the target by $9 per client hour. The target for 2.4.2 was $110 and the actual result was $91 (FY 07 result was $110). The increase from FY 2008 ($72 to $91) could be attributed to the fact that the cost of implementing Title XX demonstration projects increases annually due to inflation and other factors.

Since the AFL demonstration projects are funded for up to five years, it is challenging to show consistent improvement in the performance measure data from year to year. At any given time, there are multiple grantee cohorts within the AFL program, in different years of implementation. New AFL grantees do not have the same number of years of AFL expertise and program implementation experience as others, possibly contributing to a reduction in outcome measure performance during initial reporting years. Other possible explanations for reduced performance include inconsistent grantee data collection and inadvertent inclusion of an excluded set of clients in the care grantee data set (i.e., as written, the care measures only look at follow-up data at 12 months and some grantees may have included follow-up data at 12 months and 24 months).

OAPP's performance measures will now capture program success as defined by data collected on treatment participants and comparison participants. The AFL program funds demonstration project which require rigorous experimental or quasi-experimental designs and demonstrate success among members of a treated group relative to outcomes observed in a control or comparison group. This will assist us to more confidently state that percentage differences between the two groups are truly due to the program and not to chance.

OASH PROGRAM: OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (ODPHP)

Agency Long-Term Objective: Communicate strategically by increasing the reach of ODPHP disease prevention and health promotion information and communications

Measure I.a: Awareness of Dietary Guidelines for Americans (will be measured at least two times between 2005 and 2010) (Outcome)		
FY	**Target**	**Result**
2009	47%	N/A
2008	41%	N/A[12]
2007	39%	45% (Target Exceeded)
Measure I.b: Visits to ODPHP-supported websites (Output)		
FY	**Target**	**Result**
2012	17.6 Million	
2011	16 Million	
2010	15.75 Million	14.83 Million (Target Not Met but Improved)
2009	15.5 Million	12.662 Million (Target not met)
2008	13.649 Million	15.029 Million (Target Exceeded)
2007	12.756 Million	19.416 Million (Target Exceeded)
Measure I.c: Consumer Satisfaction with healthfinder.gov, measured every three years at a minimum (Output)		
FY	**Target**	**Result**
2012	78%	N/A
2010	78%	76% (Target Not Met but Improved)
2008	78%	75% (Target Not Met)
Measure I.d: Increase the percentage of Healthy People 2010 focus area progress review summaries that have been written, cleared, and posted on the internet within 16 weeks of the progress review date (Efficiency)		
FY	**Target**	**Result**
2010	98%	N/A
2009	95%	N/A
2008	75%	92% (Target Exceeded)

[12] Survey not fielded

Measure I.a: Awareness of Dietary Guidelines for Americans (will be measured at least two times between 2005 and 2010) (Outcome)		
FY	**Target**	**Result**
2007	50%	40% (Target Not Met)

Measure	Data Source	Data Validation
I.a	Special Dietary Guidelines for Americans supplement to the FDA Health and Diet Survey.	Project officer oversight and validation.
I.b	National Health Information Center service level reports.	Project officer oversight and validation.
I.c	American Customer Satisfaction Index's Forsee Results Survey.	Project officer oversight and validation.
I.d	ODPHP Performance Reports	Project officer oversight and validation.

Agency Long-Term Objective: Shape prevention policy at the local, State and national level by establishing and monitoring National disease prevention and health promotion objectives

Measure II.a: Percentage of States that use the national disease prevention and health promotion objectives in their health planning process (Outcome)		
FY	**Target**	**Result**
2012	55% [13]	
2011	99%	
2010	98%	N/A
2009	98%	100% (Target Exceeded)
2008	98%	N/A
2007	98%	N/A
Measure II.b: Increase the percentage of Healthy People 2010 objectives that have met the target or are moving in the right direction (Outcome)		
FY	**Target**	**Result**
2010	60.0%	N/A

[13] The FY2012 target reflects the FY 2011 launch of Healthy People 2020. All previous years' targets apply to Healthy People 2010. Based on comments in the 2012 OPA, ODPHP increased this target to 55%.

Measure	Data Source	Data Validation
II.a	Assessment of Users of Healthy People Survey; Reporting from Healthy People State Coordinators	Project officer oversight and validation.
II.b	National Center for Health Statistics, CDC	Project officer oversight and validation

Measure I.a Dietary Guidelines

In 2004, 2005 and 2007, ODPHP supported fielding a "Dietary Guidelines Supplement" of the FDA Health and Diet Survey, which was the data source for the measure. However, the decision was made (by ODPHP) not to field the supplemental survey in 2008 and determine a more appropriate nutrition outcome measure and data source. Therefore, in 2008, 2009, and 2010 data were not collected. Identification or development of a more appropriate data source is in discussion.

Measure I.b Healthfinder.gov

Improvement actions include: (1) Major effort toward Search Engine Optimization is underway; (2) Outreach campaign underway including new media such as Twitter (healthfinder.gov now has over 50,000 followers): (3) healthfinder.gov has recently (June 2010) been incorporated into healthcare.gov which is driving significant traffic to healthfinder.gov.

Target was not met because, as expected, healthfinder.gov lost some users when the site was redesigned in 2009 to focus only on prevention and wellness. The redesign was a necessary step toward a site which more accurately reflects the mission of ODPHP and OASH. Recent national attention on prevention is expected to make this a wise decision despite what is believed to be a brief dip in visits.

Measure 1.c Consumer Satisfaction

Improvement actions include major redesign efforts and continual quality improvement. Based on user research and health literacy principles, these efforts are expected to improve customer satisfaction.

The target for 2008 (the most recent data point) was not met due to the change from a general health portal to one that focuses on prevention and wellness.

Measure 1.d: Healthy People progress reviews

This measure will be updated for Healthy People 2020, which was launched in December 2010. ODPHP plans to resume the Healthy People progress reviews in FY 2012.

OASH PROGRAM: <u>OFFICE OF MINORITY HEALTH (OMH)</u>

Measure 4.3.1: Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support (2006 Baseline: 18,960) (Efficiency)		
FY	**Target**	**Result**
2012	15,980[14]	
2011	15,515[15]	
2010	15,063[16]	18,419 (Target Exceeded)[17]
2009	Set Baseline[18]	7,312 (Baseline)[19]
2008	20,115[20]	18,283 (Target Not Met)[21]

[14]While the target–setting methodology has not changed, the FY 2012 target was adjusted at the end of FY 2010 to reflect revised calculation procedures as described in the footnote for the FY 2010 target. The change in the target is simply a reflection of the change in the calculation procedure rather than a material change in efficiency.

[15]While the target–setting methodology has not changed, the FY 2011 target was adjusted at the end of FY 2010 to reflect revised calculation procedures as described in the footnote for the FY 2010 target. The change in the target is simply a reflection of the change in the calculation procedure rather than a material change in efficiency.

[16]The footnote concerning the resets for the FY 2009 baseline and results also noted that, in reviewing its methodology for calculating the efficiency estimates, OMH determined that the denominator for these calculations should be a PORTION of the annual total funding available, rather than the TOTAL annual funding available, based on the number of reporting periods (bi–annual or quarterly) during which the participant date are collected. This will enable more accurate estimates and tracking of OMH& a pos;s performance on this measure throughout the year. Thus, using the reset FY 2009 baseline/result (7312) to recalculate a target for FY 2010, during which data continued to be collected on a bi–annual basis, the total annual funding available in FY 2010 for grantees reporting PDS data (previously used as the denominator) would be divided by half for each data reporting period, effectively doubling the basis for setting the FY 2010 target to 14,624. A 3 percent increase over this baseline result would be 15,063 as the recalculated FY 2010 target. The target–setting methodology has not changed, but all previous targets have now been adjusted to reflect the revised calculation procedures.

[17]In early May 2010, OMH launched its Performance Data System (PDS) which replaced the Uniform Data Set (UDS) previously used to obtain OMH grantee and program activity data. The PDS, unlike the UDS, is designed to reflect the logical approach used in the Strategic Framework and the Evaluation Planning Guidelines developed by OMH; enable collection of more performance–oriented data tied to OMH–wide performance measurement and reporting needs (including relevant OASH GPRA measures and the objectives of the National Partnership for Action to End Health Disparities and Healthy People 2010/2020); and reduce respondent burden through improved layout, logical flow, etc.). All data quality and integrity issues experienced with the UDS have been corrected, and OMH can now systematically document and track grantee and grant program progress. The first grantee reporting period (for the first half of FY 2010) using the PDS occurred throughout May 2010, and the reporting period for the second half of FY 2010 occurred throughout November 2010. The current FY 2010 estimates include the final results of the May 2010 collection and PRELIMINARY results of the November 2010 collection. Data for the second half of FY 2010 are currently being reviewed and validated and are not yet complete (i.e., OMH is awaiting data from a couple of grantees whose reporting deadlines have been extended). Final results are expected by the end of December 2010.

[18]The OMH basis for setting an initial baseline, establishing performance targets, & calculating progress for FYs 2006–2008 has been periodic summary data tables of grant program activities provided by a contractor who, up to May 2009, had been supporting the development & maintenance of the OMH online data source for this measure, the Uniform Data Set (UDS). In May 2009, the UDS was transferred to a new contractor, with guidance from OMH to: redesign/restructure the online data collection tool to be more clearly aligned with OMH grant program– & office–wide performance measures & desired outcomes, to improve the layout & logical flow of data collection for easier use & error prevention, & to enable aggregation at the program & OMH levels; strengthen training & technical assistance to grantees & other users to ensure greater accuracy, consistency, & completeness of data being submitted; ensure that data tables provided to OMH for this measure can be substantiated against the database; & comply with HHS security & accessibility requirements. As part of this transition to the OMH Performance Data System (PDS), in October 2009, OMH employed specific protocols solely for the collection of FY 2009 efficiency measure data which now excludes, as much as possible, participants who are not directly served by or involved in the OMH–funded efforts being conducted by the grantees, duplicate entries, & other obvious outliers. This process greatly enhances OMH ability to substantiate & document its figures for this measure, but has resulted in reduced actual numbers. Thus, for FY 2009 & beyond, OMH proposed a reset of the baseline for FY 2009 & the targets for subsequent fiscal years, without changes to the target–setting methodology of a 3% increase per year. Of note, in FY 2010, OMH re–examined its method for calculating efficiency estimates up through 2009 during which time the denominator used was the TOTAL annual funding available rather than a PORTION of the annual total funding available based on the number of reporting periods (usually 2 due to bi–annual reporting) during which the participant data are collected. If the methodology were changed, the proposed baseline/result for FY 2009 would have been 14,624 (twice the 7,312 figure proposed). This methodology was reassessed for setting future targets & calculating results, reflected in these tables after FY 2009.

[19]Also see footnote for (reset) FY 2009 baseline. In May 2009, the initial OMH online data set for collecting grantee activity data in support of this measure (the Uniform Data Set) was transferred to a new support contractor. In examining all performance data tables submitted to OMH for this measure by the previous contractor against data actually in the database, OMH and its new contractor could not validate the figures in the data tables used for previous efficiency measure calculations against actual data. Reconciling data from these two sources raised serious questions about the accuracy of the data collected via the UDS and the integrity of the figures in data tables submitted to OMH for this measure. These issues were sustained over the course of UDS support by the previous contractor, and may have inappropriately inflated the figures for this measure to date. Concurrent with its aggressive pursuit of corrective action to ensure the accuracy, completeness, and integrity of grantee performance data via an online data collection system, the FY 2009 baseline and target were reset to reflect more realistic efforts and expectations. Lastly, OMH notes that the denominator for calculating efficiency estimates up through FY 2009 has been the TOTAL annual funding available rather than a PORTION of the annual total funding available based on the number of reporting periods (bi–annual or quarterly) during which the participant date are collected. This methodology was reassessed for setting future targets and calculating results, reflected in these tables after FY 2009.

[20]The previous target (20,313) was incorrect and did not accurately reflect the 3% annual increase assumed over FY 2007, per the target–setting methodology. It has been corrected as of December 2010.

[21]Like the data to establish the initial (2006) baseline/result and report on estimated or final results for FY 2007, data for FY 2008 came from grantee activity–oriented information submitted via the OMH Uniform Data Set (UDS) for one or both halves of the fiscal year, and provided to OMH by its then support contractor to comply with OASH (now OASH) reporting timetables. For FY 2008, results were based on an estimate of grantee activity data submitted via the UDS for the second half of the fiscal year and provided to OMH by its contractor. The reason provided by OMH grant program managers for the FY 2008 result (less than the target) was that

Measure 4.3.1: Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support (2006 Baseline: 18,960) (Efficiency)		
FY	**Target**	**Result**
2007	19,529[22]	19,774 (Target Exceeded)[23]
4.4.1: Unique visitors to OMH-supported websites (Output)		
FY	**Target**	**Results**
2012	580,000.0[24]	
2011	575,000.0[25]	
2010	420,000.0	573,732.0 (Target Exceeded)[26]
2009	400,000.0	484,574.0 (Target Exceeded)
2008	375,000.0	394,909.0 (Target Exceeded)
2007	Set Baseline	374,053.0 (Baseline)[27]

Measure	Data Source	Data Validation
4.3.1	The OMH Uniform Data Set (UDS) for grant program activities was replaced in the Spring of FY 2010 with the OMH Performance Data System (PDS) which now serves as the data source for this measure.	Project officer oversight and validation
4.4.1	OMH Resource Center tracking system.	OMH management review and oversight.

Agency Program 4.3.1, Measure 4.3.1

Comparison of actual performance with the target levels of performance as set out in the performance goals in previous performance budgets: Given actions undertaken by OMH since May 2009, with the transfer and overhaul of its online performance data system to a new support

performance data was not yet available for 3 OMH grant programs (Bilingual/Bicultural Services, HIV/AIDS Health Promotion & Education, & Community Partnerships) that were in start–up mode during FY 2008, and for most (17) of the grantees for the OMH HIV/AIDS Technical Assistance/Capacity Building Program who were in their last/close–out year. OMH began to work with a new support contractor in FY 2009 to provide systematic evaluation training/technical assistance to grantees which incorporated attention to cost–efficiency in the curricula.

[22] After the baseline year (2006), annual targets were set assuming a 3% increase in efficiency per year.

[23] Like the data to establish the initial (2006) baseline/result, data to report on estimated or final results for FY 2007 came from grantee activity–oriented information submitted via the OMH Uniform Data Set (UDS) for one or both halves of the fiscal year, and provided to OMH by its then support contractor to comply with OASH (now OASH) reporting timetables.

[24] The original FY 2012 target of 450,000 was raised relative to the FY 2010 actual result. See footnote for the FY 2010 result for further information.

[25] The original FY 2011 target of 430,000 was raised relative to the FY 2010 actual result. See footnote for the FY 2010 result for further information.

[26] Due to increases in referrals from Google, OMH realized a substantial increase in unique visitors to its Resource Center website in FY 2010. These increases resulted from steps taken by OMH during the year to improve results in Google searches and also convert to a new URL (www.minorityhealth.hhs.gov), which identifies the OMH web site as part of a trusted source, the HHS family of web sites. Given this success, OMH is raising the targets for FY 2011 and beyond to reflect an expectation of sustained increases on this measure.

[27] This new output measure — which is an OMH GPRA measure supportive of an OASH–wide GPRA measure for strategic communications — was entered into the PPTS by OMH in July 2010. The measure is also consistent with similar measures in other OASH offices (e.g., ODPHP and OWH) which were previously accepted by OMB.

contractor, OMH's ability to substantiate and document its figures for this measure has been immensely enhanced.

Improvements in the nature of the information being collected via this online system as well as the establishment of protocols to ensure adequacy, accuracy, and completeness of data collected, however, resulted in reduced actual numbers and, hence, a 'reset' of the baseline for FY 2009 and the targets for subsequent fiscal years by OMH (although no changes were made to the target-setting methodology of a 3% increase per year). OMH has since reviewed its method for calculating efficiency estimates up through 2009 during which time the denominator used was the total annual funding available rather than a PORTION of the annual total funding available based on the number of reporting periods (usually 2 due to bi-annual reporting) during which the participant data are collected. If the methodology were changed, the proposed baseline/result for FY 2009 would have been 14,624 (twice the 7,312 figure proposed). A 3 percent increase over this baseline result would be 15,063 as the recalculated FY 2010 target. This methodology was reassessed for setting future targets & calculating results, reflected in these tables after FY 2009.

Analysis of the most recent – FY 2010, if available -- program performance results (or the most recent results) that are informed by relevant, credible, evaluation studies, investigations, and audits: The first grantee reporting period (for the first half of FY 2010) using OMH's "new and improved" Performance Data System (PDS) occurred throughout May 2010, and the reporting period for the second half of FY 2010 occurred throughout November 2010. The current FY 2010 estimates include the final results of the May 2010 collection and PRELIMINARY results of the November 2010 collection. Data for the second half of FY 2010 are currently being reviewed and validated and are not yet complete (i.e., OMH is awaiting data from a couple of grantees whose reporting deadlines have been extended). Final results are expected by the end of December 2010. The PDS includes improvements in the nature of the information being collected via this online system as well as the establishment of protocols to ensure adequacy, accuracy, and completeness of data collected.

Discussion of improvement actions aimed to improve or ensure future program performance: OMH will continue to work with its grantees to ensure greater cost-efficiency while expanding the reach of and participation in its grant programs. Training and technical assistance efforts now include instruction on efficiency vs. effectiveness.

Explanation for any performance targets that were materially exceeded or not met: The change in the target is primarily a reflection of the change in the calculation procedure rather than a material change in efficiency.

Discussion of past performance trend data, where appropriate or available, that provides sufficient information on how a program is progressing compared to its past achievements and shortfalls (including charts that display past performance trends, where appropriate): With the transfer of responsibilities for support of OMH's online performance data system to a new contractor in May 2009 and the subsequent overhaul of the Uniform Data Set (UDS) into the current Performance Data System (PDS), all previous data quality and integrity issues have been corrected, and OMH has been able to more systematically document and track grantee and grant program progress during and since FY 2010. FY 2010 results presented here as of mid-

December 2010 are preliminary. Data collected during November 2010 for the second half of FY 2010 continues to be reviewed and validated and are not yet complete (i.e., OMH is awaiting data from a couple of grantees whose deadlines have been extended). Final results are expected by the end of December 2010. Based on preliminary results, however, OMH expects to meet or exceed its target for FY 2010.

See notes indicated in the above performance table (for FY 2009 baseline and target) relative to resetting the baseline and targets for FY 2009 and subsequent years. While the revised targets for FY 2010 and subsequent years appear to be substantial increases relative to the reset FY 2009 baseline/result, the increases are primarily a reflection of the change in the calculation procedure rather than a material change in expected efficiency. The target-setting methodology of annual increases of 3 percent has not changed. By using the revised calculation procedure, OMH will have more accurate estimates of relative efficiency throughout each year.

Prior to May 2010, the data source for this measure was the Uniform Data Set (UDS), previously used to obtain OMH grantee and program activity data. The UDS was replaced in May 2010 by the OMH Performance Data System (PDS) which, unlike the UDS, was designed to reflect the logical approach used in the Strategic Framework and the Evaluation Planning Guidelines developed by OMH; enable collection of more performance-oriented data tied to OMH-wide performance measurement and reporting needs (including relevant OASH GPRA measures and the objectives of the National Partnership for Action to End Health Disparities and Healthy People 2010/2020); and reduce respondent burden through improved lay-out, logical flow, etc.). All data quality and integrity issues experienced with the UDS have been corrected, and OMH has been able to more systematically document and track grantee and grant program progress during and since FY 2010. FY 2010 results presented here as of mid-December 2010 are preliminary. Data collected during November 2010 for the second half of FY 2010 continues to be reviewed and validated and are not yet complete (i.e., OMH is awaiting data from a couple of grantees whose deadlines have been extended). Final results are expected by the end of December 2010. Based on preliminary results, however, OMH expects to meet or exceed its target for FY 2010.

Agency Program 4.3.1, Measure 4.4.1

OMH is consistently exceeding numerical targets, which comprise one type of intermediate indicator of OMH's progress toward larger goals of increasing public awareness of minority health disparities and facilitating programs and partnerships aimed at health equity.

As electronic communication becomes the primary vehicle of open and transparent communication with the public, including minority communities, and an increasing priority for the Administration, OMH seeks regularly to incorporate both content and technical improvements in its web outreach. Content improvements include generation of new content in Spanish, communications regarding progress of the National Partnership for Action, the Healthy Baby campaign and other key OMH initiatives, and connecting OMH customers with the National HIV/AIDS strategy, aids.gov, healthcare.gov, flu.gov and other important HHS electronic communications efforts. Technical improvements include ensuring accessibility of web content to users with disabilities, facilitating easier methods of subscribing to OMH's electronic information and introducing web and social media services that will allow users both

to acquire, customize and share relevant content related to the department's services to minority communities and to participate in government decision-making.

Due to increases in referrals from Google, OMH realized a substantial increase in unique visitors in FY 2010. This resulted from steps taken by OMH during the year to improve results in Google searches and also convert to a new URL (http://www.minorityhealth.hhs.gov), which identifies the OMH web site as part of a trusted source, the HHS family of web sites. Given this success, OMH is raising the targets for FY 2011 and beyond to reflect an expectation of sustained increases on this measure.

Agency Long-Term Objective: Increased percentage of measurable racial/ethnic minority-specific Healthy People 2010 objectives and sub-objectives that have met the target or are moving in the right direction

Measure 4.1.1: Increased percentage of measurable racial/ethnic minority-specific Healthy People 2010 objectives and sub-objectives that have met the target or are moving in the right direction. (2005 Baseline: 62.4%) (Outcome)		
FY	**Target**	**Result**
2011	Discontinued	N/A
2010	68.6%	Dec 31, 2010[28]
2008	N/A	67.8% (Historical Actual)[29]
2007	N/A	66.4% (Historical Actual)[30]
Measure 4.1.2: Increased percentage of measurable racial/ethnic minority-specific Healthy People 2020 objectives and sub-objectives that have met the target or are moving in the right direction. (Outcome)		
FY	**Target**	**Result**
Out-Year Target	Set Baseline	N/A

Measure	Data Source	Data Validation
4.1.1	National Center for Health Statistics, CDC	OMH oversight and validation.
4.1.2	National Center for Health Statistics, CDC	OMH oversight and validation.

Agency Long-Term Objective 4.1.1, Measure 4.1.2

Based on NCHS analysis of the most recent data (2008) available, the Nation continues to be on track to reach the long-term target by the end of 2010.

[28] See footnote for 2009 actual.
[29] Although not required, by using more recently available 2008 data (in Healthy People DATA 2010) and NCHS calculations of the progress quotient, OMH was able to obtained another interim result in April 2010. The data analysis indicates that the Nation continues to be on track to reach the long–term target by the end of 2010.
[30] OMH, working with NCHS, was able to use FY 2007 data to conduct an interim assessment of progress for this measure. This interim result was not required, but does confirm that progress is in the right direction and that the Nation is on track to meet the long-term target at the end of FY 2010.

Although not required, OMH, working with data analysts at NCHS, was able to calculate interim results by using *Healthy People DATA 2010* and NCHS calculations (based on 2008 – the most recent – data) of the progress quotient, obtained in April 2010. More recent data to calculate 2009 and 2010 results relative to HP2010 targets are not yet available. This measure will be retained until such results are available for the purpose of completing reports of progress during the decade ending in 2010.

OMH continues to exercise its leadership and coordination role to increase awareness of, attention to, and action towards improvement of racial/ethnic minority health and reductions in racial/ethnic health care and health status disparities. OMH supports the establishment of minority health infrastructure at the regional and State levels; a resource center, website, health communication campaigns, and national and regional conferences to inform, educate, and share best practices; numerous partnerships to promote greater effectiveness and efficiency in resources and actions; a wide range of health disparities-oriented initiatives to call attention to high-priority issues; and a number of department-wide and/or Federal entities to focus policy-relevant and programmatic efforts relevant to minority health and health disparities. Based on the trends reflected in interim data collected to date, OMH – and the Nation – are on track to meet the target for this long-term measure.

The target for 2020 will be determined after analyses and reports of actual results for the 1st decade of the 21st century ending in 2010 have been completed. The baseline data will be available in FY 2015, after the mid-decade assessment of progress has been conducted.

Agency Long-Term Objective: Increased awareness of racial/ethnic minority health status and health care disparities in the general population

Measure 4.2.1: Increased awareness of racial and ethnic health status and health care disparities in the general population, measured every 3 years at a minimum (1999 Baseline: 54.5%) (Outcome)		
FY	**Target**	**Result**
2012	63.1% [31]	Dec 31, 2013[32]
2011	61.9% [33]	Dec 31, 2013[34]
2010	60.7% [35]	58.9% (Target Not Met)[36]
2009	59.5% [37]	59.7% (Target Exceeded)[38]

[31]See note for 2007 target.
[32]See note for 2011 actual.
[33]See note for 2007 target.
[34]Due to funding limitations, OMH will not be conducting the general household survey in FY 2011. Given that these are trend studies, conducting these studies every 3 years at a minimum should be sufficient to identify progress over time.
[35]See note for 2007 target.
[36]The fielding of the 2010 general household survey was completed in June 2010 and final analyses and reporting were completed in September 2010, with scientific presentations of results at the annual meeting of the American Public Health Association in November 2010. OMH has submitted these results to peer–reviewed journals for publication, to be linked to the official release of the study results by the Department. No statistical difference in the level of public awareness of health disparities between the 2010 and 2009 survey results was found. Given the trends in performance, the 2 percent annual increase over the previous year's target may be too ambitious and unrealistic to achieve across the country as a whole, and may suggest the need to reduce the increases in annual targets and expected results to 1 percent every year or two. This change will be considered and, if needed, proposed for future performance plans and reports.
[37]See note for 2007 target.
[38]See note for 2007 result. This is the final result of the first (2009) OMH general household survey of public awareness of racial/ethnic health status and health care disparities. OMH has submitted these results to peer–reviewed journals for publication, to be linked to the official release of the study results by the Department.

Measure 4.2.1: Increased awareness of racial and ethnic health status and health care disparities in the general population, measured every 3 years at a minimum (1999 Baseline: 54.5%) (Outcome)		
FY	**Target**	**Result**
2008	58.3% [39]	59.7% (Target Exceeded)[40]
2007	57.2% [41]	59.7% (Target Exceeded)[42]

Measure	Data Source	Data Validation
4.2.1	The data from which the initial baseline was established came from a 1999 survey conducted by Kaiser Family Foundation (KFF) and Princeton Survey Research Associates (PSRA). Tracking and trend data for the 2009 and 2010 surveys have been collected via national random sample surveys conducted by the NORC at the University of Chicago. The KFF/PSRA survey asked respondents for their perceptions of disparities between Whites and African Americans and Hispanics/Latinos only. The OMH/NORC studies in 2009 and 2010 included additional questions to assess perceptions of disparities between Whites and Asian Americans/Pacific Islanders. OMH will being reporting these figures after the next round of data collection, once a trend is established.	Project officer oversight and validation

Agency Long-Term Objective 4.2.1, Measure 4.2.1

The 2010 OMH-funded study was conducted by NORC at the University of Chicago. It is based on a national random sample of 3,159 landline telephone interviews with adults age 18 and over, including Whites, African Americans (AAs), Hispanics/Latinos (H/Ls), and Asian Americans/Pacific Islanders (AA/PIs). Interviews with the public were conducted in the respondent's language of choice. Results from OMH's 2010 studies (awaiting publication, not yet released) were compared with the 1999 finding by the KFF/PSRA survey that 62% of Americans were not aware that AAs and H/Ls fare worse than Whites in infant mortality, health insurance coverage, and other key health indicators. OMH results indicate that, while awareness of racial and ethnic health disparities by the general public has increased over the last 10 years and that the increase is statistically significant, the rate of increase is more modest than many public health experts assume and that work focused on informing the U.S. population of health conditions that disproportionately impact specific racial and ethnic minority groups remains unfinished. Unlike the KFF/PSRA study in 1999, the OMH/NORC surveys included over-sampling of AA/PI households. The two years worth of data that have been collected to include AA/PIs do not yet provide enough information to establish a trend in overall public awareness that includes this group; however, the results are provided below (with no statistical difference

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[39]See note for 2007 target.

[40]See note for 2007 result.

[41]See the Comments section for an explanation of a change made at the end of FY 2010 in the methodology for establishing the baseline, setting targets relative to the baseline, and reporting of actual results in awareness levels for this measure. Given that the baseline was changed to provide a more statistically valid means for calculating trends in public awareness over time (using an Awareness Index developed for the 2009 and 2010 OMH/NORC studies), the targets relative to the new baseline have also been reset accordingly. NO change has been made in the initial target–setting methodology, i.e., OMH has assumed a 5 percent increase over the 1999 baseline for the general population by 2007, and a 2 percent increase over the 2007 target for 2008 and each subsequent year.

[42]See the Comments section for an explanation of a change made at the end of FY 2010 in the methodology for establishing the baseline, setting targets relative to the baseline, and reporting of actual results in awareness levels for this measure. With the use in the OMH/NORC studies of the Awareness Index, a more statistically valid means for calculating trends in public awareness over time, the figures resulting from calculations of the results have changed accordingly.

between 2009 and 2010 results). For purposes of measure 4.2.1., OMH will continue to track by Awareness Index for Whites, AAs, and HLs (all included in the baseline study). OMH will also provide separate information on the general population from 2009 that includes AA/PIs.

OMH will continue to lead and coordinate initiatives, education and communication campaigns, national conferences, and other programmatic and policy-relevant efforts with its partners and grantees to increase awareness of, attention to, and action towards improvement of racial/ethnic minority health and reductions in racial/ethnic health care and health status disparities.

Given the trends, the 2% annual increase over the previous year's target may be too ambitious and may suggest a need to reduce the increases in annual targets and expected results to 1% per year. This change may be considered and proposed for future performance plans and reports.

OASH PROGRAM: OFFICE ON WOMEN'S HEALTH (OWH)

Agency Long-Term Objective: Advance superior health outcomes for women

Measure 5.1.1: Increase the percentage of women-specific Healthy People 2010 objectives and sub-objectives that have met their target or are moving in the right direction. (Outcome)		
FY	**Target**	**Result**
2012	75.0%	Sep 30, 2014
2011	74.5%	Sep 30, 2013
2010	74.0%	Sep 30, 2012
2009	72.5%	63.4% (Target Not Met)
2008	71.0%	Sep 30, 2010
2007	67.5%	69.5% (Target Exceeded)
Measure 5.1.2: Increase the Percentage of women-specific Healthy People 2020 objectives and sub-objectives that have met their target or are moving in the right direction. (Outcome)		
FY	**Target**	**Result**
Out-Year Target	N/A (2015)	N/A

Measure	Data Source	Data Validation
5.1.1	National Center for Health Statistics, CDC	Project officer oversight and validation
5.1.2		

Agency Long-Term Objective: Increase heart attack awareness in women

Measure 5.2.1: Increase the percentage of women who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911. (Outcome)		
FY	**Target**	**Result**
2012	75.0%	Sep 30, 2014
2011	72.5%	Sep 30, 2013
2010	70.0%	Sep 28, 2012
2009	67.5%	53.0% (Target Not Met)
2008	70.0%	70.0% (Target Met)
2007	60.0%	65.8% (Target Exceeded)

Measure	Data Source	Data Validation
5.2.1	National Center for Health Statistics, CDC	Project officer oversight and validation

Agency Long-Term Objective: Expand the number of users of OWH communication resources

Measure 5.3.1: Number of users of OWH communication resources (e.g., National Women's Health Information Center; womenshealth.gov website; and girlshealth.gov website). (Output)		
FY	**Target**	**Result**
2012	26,000,000 user sessions	Sep 30, 2013*
2011	25,000,000 user sessions	Sep 28, 2012
2010	26,000,000 user sessions	Sep 30, 2011
2009	34,000,000 user sessions	26,508,685 user sessions (Target Not Met)
2008	31,500,000 user sessions	31,600,000 user sessions (Target Exceeded)
2007	24,500,000 user sessions	28,400,000 user sessions (Target Exceeded)

Measure	Data Source	Data Validation
5.3.1	National Women's Health Information Center, womenshealth.gov, and girlshealth.gov service level reports	Project officer oversight and validation

*With the increase of social media, there has been a general downward trend in web-site user sessions due to improved search engines. However, what is more significant is that OWN has had an increase of pages viewed per user meaning the service per user has increased.

Agency Long-Term Objective: Increase the number of people that participate in OWH-funded programs per million dollars spent annually

Measure 5.4.1: Number of girls ages 9-17 and women ages 18-85+ that participate in OWH-funded programs (e.g., information sessions, web		
FY	**Target**	**Result**
2012	770,461	Sep 30, 2013
2011	740,828	Sep 28, 2012
2010	770,461	Sep 30, 2011
2009	1,216,046	785,536* (Target Not Met)
2008	1,114,453	1,191,580 (Target Exceeded)
2007	813,904	1,006,245 (Target Exceeded)

Measure	**Data Source**	**Data Validation**
5.4.1	OWH administrative files	Project officer oversight and validation

*With the increase of social media, there has been a general downward trend in web-site user sessions due to improved search engines. However, what is more significant is that OWN has had an increase of pages viewed per user meaning the service per user has increased.

The Office on Women's Health (OWH) continues to implement our Strategic Plan in FY2011. OWH completed our first set of community based, system change, evidence-based interventions in ASIST2010. The 13 grantees implemented evidence-based programs to address nearly 50 HP 2010 objectives and met or exceeded HP 2010 targets for the majority of measures. The national evaluation of the program will end in FY 2011, but local accomplishments include major policy changes and implementation of new policies being sustained. The success of the program led to the launch of the *Coalition for a Healthier Community* program, a new gender-based national initiative that encourages grantees and public health stakeholders to integrate and implement gender-responsive programming within their community programs. The initiative supports projects to develop, implement and evaluate gender-based interventions with local communities in an effort to establish evidence-based programs which stand as replicable model programs for the Nation.

The HHS Coordinating Committee on Women's Health (CCWH) worked with hundreds of constituents to develop an Action Planning Agenda for the Department. The top priorities for the Action Agenda included: Health Care Reform for Women's Health, Improving data systems to generate race by gender data, and Zero tolerance for domestic violence. The CCWH continues focusing on the Action Agenda with additional recommendations on: Encouraging young women and girls in pursuing studies in Science, Technology, Engineering and Mathematics (STEM) and Facilitating the increase of research into health care access and utilization studies that are analyzed and reported by sex, gender, gender, race/ethnicity and age. In the course of the CCWH Action Agenda work, it was noted there is a *paradigm shift in health care delivery*

AND a *population shift to older Americans* and the impending impact of this cohort on the Medicare, Medicaid and Social Security systems. Specifically, OWH and CMS are collaborating to address older women's health issues. OWH has a unique opportunity to strategically build infrastructure and services to address the health disparities within, and deliver support for, women between the ages of 50-65 years of age. As noted in our Strategic Plan, we have also planned for the creation of a Federal Advisory Committee for our office. OWH's annual and long-tem outcome measures link to the program's mission and make it possible to measure progress in achieving long-term performance goals.

Our Performance Measures routinely have exceeded the target for the numbers of girls and women reached by our programs. These numbers had increased due to outreach by ASIST2010, the Heart Truth Champions, Regional education initiatives, and by communications programs. However, OWH saw some decreases in reaching program targets because established programs ended new programs were being implemented. Another reason for these results is the increased use of social media, chat rooms, and tweeter technologies which compete with our websites. OWH has moved into this new technology recently by opening up Facebook and Tweeter sites, which are growing rapidly. We will continue to crosslink our website with our funded program websites.

OWH will launch two new media campaigns which will also drive more traffic to our website: The *STD Prevention* and *Heart Attack Symptoms and Call 911* campaigns (another OMB measure). The *National Media Campaign on Heart Attack Symptoms and Calling 911* is a national advertising 2-year campaign through television, radio, newsprint, out of door billboards, social media and internet to alert women and the public to the signs and symptoms of a heart attack and to call 911 for immediate help. The percentage of women calling 911 has decreased in recent years. The new Campaign hopes to overcome this trend through a multi-modal media and grassroots campaign. Currently, between 7% and 56% of women know any of the symptoms of a hart attack. These statistics have not improved in ten years and OWH is collaborating to develop a National Public Service Announcement campaign to draw attention to the signs and symptoms of a heart attack.

OWH only has direct responsibility for its own programs. Prior program objectives assumed that we could control the activities of all office and agencies in the Department in meeting the *Healthy People* objectives for women. Because this is not realistic, OWH proposed to change the Healthy People measure to one that is similarly worded in the Office of Disease Prevention and Health Promotion table. Their objective (Measure II. a.) tracks the percentage of States that use the national disease prevention and health promotion objectives in their healthy planning process. We proposed to do likewise for OWH programs that we fund. At the current time in FY2011, 93% of our program areas address HP 2020 objectives. Since the launch of the HP2020 objectives in December 2010, we plan to increase this percentage by 1% each year over the next 5 years.

OASH PROGRAM: COMISSIONED CORPS READINESS AND RESPONSE

Agency Long-Term Objective: Increase the size and operational capability of the Commissioned Corps.

Measure 6.1.1: Increase the percentage of Officers that meet Corps readiness requirements, thus expanding the capability of the individual Officer. (Outcome)		
FY	**Target**	**Result**
2012	97.5%	
2011	96%	
2010	95%	N/A
2009	90%	94.4% (Target Exceeded)
2008	82.5%	89.4% (Target Exceeded)
2007	80%	82.3% (Target Exceeded)
Measure 6.1.2: Increase the percentage of Officers that are deployable in the field, thus expanding the capability of the Corps. (Baseline - 2005: 40%) (Outcome)		
FY	**Target**	**Result**
2012	85%	
2011	85%	
2010	82.5%	N/A
2009	77.5%	79.4% (Target Exceeded)
2008	60%	75.4% (Target Exceeded)
2007	55%	61.6% (Target Exceeded)
Measure 6.1.3: Increase the percent of individual responses that meet timeliness, appropriateness, and effectiveness requirements. (Baseline - 2007: 77%) (Outcome)		
FY	**Target**	**Result**
2012	97.5%	
2011	95%	
2010	93%	N/A
2009	90%	92.5% (Target Exceeded)

2008	80%	89.3% (Target Exceeded)
2007	Set Baseline	77% (Baseline)

Measure
6.1.4: Increase the percent of team responses that meet timeliness, appropriateness, and effectiveness requirements. (Baseline - 2007: 89%) (Outcome)

FY	Target	Result
Out-Year Target	100% (2013)	
2012	99%	
2011	98%	
2010	97.5%	N/A
2009	95%	95% (Target Met)
2008	92.5%	93.2% (Target Exceeded)
2007	Set Baseline	89% (Baseline)

Measure
6.1.5: Increase the number of response teams formed, thus enhancing the Department's capability to rapidly and appropriately respond to medical emergencies and urgent public health needs. (Baseline - 2005: 0) (Outcome)

FY	Target	Result
2012	46	
2011	46	
2010	46	N/A
2009	36	41 (Target Exceeded)
2008	26	26 (Target Met)
2007	26	26 (Target Met)

Measure
6.1.6: Increase the number of response teams which have met all requirements, including training, equipment, and logistical support, and can deploy in the field when needed as fully functional teams, thus enhancing the Department's capability to appropriately respond to medical emergencies and urgent public health care needs. (Baseline - 2006: 0) (Outcome)

FY	Target	Result
2012	36	
2011	36	
2010	26	N/A
2009	20	21 (Target Exceeded)

2008	20	20 (Target Met)
2007	10	20 (Target Exceeded)

Measure 6.1.7: Cost per Officer to attain or maintain readiness requirements. (Efficiency)		
FY	**Target**	**Result**
2012	$90	
2011	$90	
2010	$90	N/A
2009	$100	$91.14 (Target Exceeded)
2008	$100	$93.87 (Target Exceeded)
2007	$105	$119.68 (Target Not Met)

Measure	Data Source	Data Validation
6.1.1 6.1.2 6.1.3 6.1.4 6.1.5 6.1.6 6.1.7	OFRD web-based database	Project officer oversight and validation

The mission of the Commissioned Corps Readiness and Response Program is to provide a timely, appropriate, and effective response by U.S. Public Health Service officers to public health and medical emergencies, urgent public health needs and challenges, and National Special Security Events as mandated in the Public Health Service Act (as amended most recently by ACA and PAPHA). The Office of Force Readiness and Deployment (OFRD) in the Office of the Surgeon General executes this program by ensuring that individual Corps officers are appropriately trained for deployment, and the Corps deploys the appropriate team or individual(s) in a timely, appropriate and effective manner.

OFRD developed a series of improvement plans and seven ambitious annual measures designed to stimulate and monitor the efficiency of program activities and the appropriateness, timeliness, and effectiveness of team and individual deployments. At the end of FY 2009, OFRD met one and exceeded six of its seven assessment targets and had already exceeded three of its FY 2010 performance targets. For example, in FY 2009 OFRD achieved the highest level of officers meeting readiness requirements in the Corps' history, exceeding its FY 2009 performance target by almost 5%, with 94.37% of the Corps qualified for deployment and over 80% of officers were deemed fully deployable in the field. Demonstrating actual efficacy in the field, the Corps is anticipating also exceeding its FY 2010 performance measure with regard to individual officers: 96% of individual officers met timeliness, appropriateness, and effectiveness requirements

during deployments (an excess of 3.5% over the Corps FY 2010 performance target). Deployed teams composed of Corps officers also performed well by mid-year; the Corps was ahead of its FY 2010 performance measure in this regard with 98% of response teams having met timeliness, appropriateness, and effectiveness requirements during deployments. Lastly, the Corps has developed TWO new team types ahead of schedule including five Capital Area Provider teams (CAP) and five Services Access Teams (SAT). The SAT teams have already been deployed in support of the Haiti Earthquake response and have been fully integrated into and are now an integral part of the Interagency Federal Patient Movement Concept of Operations. They also fully trained during the innovative field training activities conducted by OFRD in FY 2010.

Collectively, these results demonstrate the Corps' strong capability to respond to a variety of public health emergencies, urgent public health needs and National Special Security Events both domestically and abroad.

OASH PROGRAM: HIV/AIDS IN MINORITY COMMUNITIES

Agency Long-Term Objective: Long-Term Outcome Goals

Measure 7.1.1: Increase the number of ethnic and racial minority individuals surviving 3 years after a diagnosis of AIDS (Outcome)		
FY	**Target**	**Result**
2012	88.25%	
2011	88%	
2010	87.75%	N/A
2009	86.75%	82% (Target Not Met)
2008	85%	83% (Target Not Met)
2007	84.25%	85% (Target Exceeded)
Measure 7.1.2: Reduce the percentage of AIDS diagnosis within 12 months of HIV diagnosis among racial and ethnic minority communities (Outcome)		
FY	**Target**	**Result**
2012	34%	
2011	34.75%	
2010	35.25%	N/A
2009	36.25%	32.75% (Target Exceeded)
2008	38.25%	38% (Target Exceeded)
2007	39.25%	38% (Target Exceeded)

Measure 7.1.3: Reduce the rate of new HIV infections among racial and ethnic minorities in the United States (Outcome)		
2012	43%	
2011	43.7%	
2010	46%	N/A
2009	48.4%	48.8% (Target Not Met but Improved)
2008	50.9%	49.35% (Target Exceeded)
2007	53.7%	47.2% (Target Exceeded)
Measure 7.1.4: Increase the number of African American individuals surviving 3 years after a diagnosis of AIDS (Outcome)		
2012	89.5%	
2011	89%	
2010	88%	N/A
2009	87%	80% (Target Not Met but Improved)
2008	85%	79% (Target Not Met)
2007	83%	82% (Target Not Met)
Measure 7.1.5: Increase the number of Hispanic individuals surviving 3 years after a diagnosis of AIDS (Outcome)		
2012	91.5%	
2011	91%	
2010	90%	N/A
2009	90%	85% (Target Not Met)
2008	89%	85% (Target Not Met)
2007	89%	88% (Target Not Met)
Measure 7.1.6: Increase the number of Asian/Pacific Island individuals surviving 3 years after a diagnosis of AIDS (Outcome)		
2012	94.5%	
2011	94%	
2010	93%	N/A
2009	89%	85% (Target Not Met)

2008	88%	89% (Target Exceeded)
2007	88%	90% (Target Exceeded)
Measure 7.1.7: Increase the number of American Indian/Alaskan Native individuals surviving 3 years after a diagnosis of AIDS (Outcome)		
2012	81.5%	
2011	81%	
2010	80%	N/A
2009	79%	77% (Target Not Met but Improved)
2008	78%	73% (Target Not Met)
2007	77%	75% (Target Not Met)
Measure 7.1.8: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among African American communities (Outcome)		
2012	32.5%	
2011	33%	
2010	34%	N/A
2009	35%	32% (Target Exceeded)
2008	36%	35% (Target Exceeded)
2007	37%	38% (Target Not Met)
Measure 7.1.9: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Hispanic communities (Outcome)		
2012	36.5%	
2011	37%	
2010	38%	N/A
2009	39%	37% (Target Exceeded)
2008	40%	41% (Target Not Met but Improved)
2007	41%	42% (Target Not Met)
Measure 7.1.10: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Asian/Pacific Islander communities (Outcome)		
2012	33.5%	

2011	34%	
2010	35%	N/A
2009	36%	33.5% (Target Exceeded)
2008	39%	38% (Target Exceeded)
2007	40%	38% (Target Exceeded)
Measure 7.1.11: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among American Indian/Alaskan (Outcome)		
2012	34.5%	
2011	35%	
2010	36%	N/A
2009	37%	38% (Target Not Met)
2008	38%	38% (Target Met)
2007	39%	39% (Target Met)
Measure 7.1.12: Increase the number of individuals who learn their HIV status for the first time through MAI Fund programs (Outcome)		
2012	185,000	
2011	178,537	
2010	167,662	N/A
2009	158,172	Jun 30, 2011
2008	149,219	147,726 (Target Not Met but Improved)
2007	132,805	139,750 (Target Exceeded)
Measure 7.1.13: Maintain the actual cost per MAI Fund HIV testing client below the medical care inflation rate (Efficiency)		
2012	$102.5	
2011	$105.3[43]	
2010	$101.71	Jun 30, 2012
2009	$98.29	Jun 30, 2011
2008	$94.88	Dec 31, 2010

[43] This target is premature and tentative.

2007	$91.46	$88 (Target Exceeded)
Measure 7.1.14: Maintain the actual cost per MAI Fund physician and other clinical staff trained below the medical care inflation rate (Efficiency)		
2012	$1,500	
2011	$1,713.02	
2010	$1,670.78	N/A
2009	$1,280.57	Jun 30, 2011
2008	$1,089.36	Dec 31, 2010
2007	$1,050.15	Dec 31, 2010

Measures 7.1.1, 7.1.2, 7.1.3, 7.1.4, 7.1.5, 7.1.6, 7.1.7, 7.1.8, 7.1.9, 7.1.10, and 7.1.11 of the HIV/AIDS in Minority Communities Program are all long-term performance health outcomes of critical value to abate the HIV/AIDS epidemic. Unfortunately, the Minority AIDS Initiative (MAI) Fund-sponsored activities would have inconsequential direct influence on the success or failure of reaching the established targets and that would assume that this type of statistical and surveillance data collection for MAI activities actually existed. It does not. The CDC's annual statistics and surveillance reports had to be used to complete each of the yearly actuals rather than performance from MAI programs and activities. In FY 2011, new performance measures will be developed.

The HIV/AIDS in Minority Communities program will then be assessed by a total of five measures, three of which are original measures:

- 7.1.12: *Increase the number of individuals who learn their HIV status for the first time through MAI Fund programs (outcome)*;
- 7.1.13: *Maintain the actual cost per MAI Fund HIV testing client below the medical care inflation rate (efficiency)*; and
- 7.1.14: *Maintain the actual cost per MAI Fund physician and other clinical staff trained below the medical care inflation rate (efficiency).*

Currently under consideration are the following two measures:

(1) *Increase the proportion of MAI Fund-identified, high-risk HIV-negative clients who are linked to appropriate prevention services.*
(2) *Increase the proportion of newly diagnosed MAI Fund-identified HIV-positive clients linked to clinical care within three months*.

This change in the performance measures is significantly more responsive to the programs and activities funded under MAI. In addition, with their emphasis on HIV testing, knowing one's status, clinical training and linkage to prevention and care services, they are keeping with the directives of the recently released National HIV/AIDS Strategy (NHAS), including its specific

mention of the MAI: *HHS OS will work with the relevant HHS agencies to consider ways to enhance the effectiveness of prevention and care services provided for high risk communities, including services provided through the Minority AIDS Initiative*, (National HIV/AIDS Strategy, Federal Implementation Plan: Reducing HIV-related Health Disparities, Step 2.1, July 2010).

With regard to Measure 7.1.12, Increase the number of individuals who learn their HIV status for the first time through MAI Fund programs, the most recent indicators show that that target was not met but there was improvement. This measure is essentially a HIV testing measure and an ambitious one at that. Clearly, the agencies and offices have received the message around the centrality of HIV testing in our prevention and care strategies and are responding in their MAI programming and data collection. We should continue with this approach in this new NHAS era. The two Efficiency Measures 7.1.13 and 7.1.14, HIV testing and clinical training, respectively, continue to reflect the challenge of anticipating the fluctuation in costs associated with testing and training depending on the venues targeted, the specific subjects involved, the type of testing or training required and the myriad staff and administrative costs built into this measure. We may consider a refinement or revision to these two measures in the future if our targets consistently miss their mark.

OASH DISCONTINUED PERFORMANCE MEASURES

PROGRAM: ADOLESCENT FAMILY LIFE (AFL)

Agency Long-Term Objective: Encourage adolescents to postpone sexual activity by developing and testing abstinence interventions.

Measure 2.1.1: Increase communication among parents and adolescents on topics relating to puberty, pregnancy, abstinence, alcohol, and/or drugs. (Outcome)		
FY	**Target**	**Result**
2010	Discontinued	N/A
2009	48.8%	47% (Target Not Met but Improved)
2008	48.8%	43% (Target Not Met but Improved)
2007	46.6%	42% (Target Not Met)
Measure 2.1.2: Increase adolescents' understanding of the positive health and emotional benefits of abstaining from premarital sexual activity. (Outcome)		
FY	**Target**	**Result**
2010	Discontinued	N/A
2009	74%	70% (Target Not Met but Improved)
2008	68%	57.5% (Target Not Met but Improved)
2007	83%	54% (Target Not Met)

Agency Long-Term Objective: (1) Identify interventions that have demonstrated their effectiveness to promote premarital abstinence for adolescents.(2) Identify interventions that have demonstrated their effectiveness to ameliorate the consequences of adolescent pregnancy and childbearing.

Measure 2.3.1: Improve the quality of the Title XX prevention independent evaluations. (Outcome)		
FY	**Target**	**Result**
2010	Discontinued	N/A
2009	35.75%	32% (Target Not Met)
2008	27.5%	48.5% (Target Exceeded)
2007	19.25%	22.2% (Target Exceeded)

Agency Long-Term Objective: Improve the efficiency of the AFL program.

Measure 2.4.1: Sustain the cost to encounter ratio in Title XX prevention programs. (Outcome)		
FY	**Target**	**Result**
2010	Discontinued	N/A
2009	$29	Apr 30, 2010
2008	$29	$25 (Target Exceeded)
2007	$37	$29 (Target Exceeded)

HHS STRATEGIC PLAN
FY 2010 – 2015

The development of the Departments Strategic Plan for the next five years reflects Operating and Staff Division overarching contributions. In keeping with the guidance to publish Strategic Plan measures in the OPA the GDM OPA highlights the following measures for OS:

Goal 2 – Objective B: Foster innovation with HHS to create shared solutions

Innovation is a key element of HHS's intra-agency Open Government initiative. Through this initiative, the Obama administration is promoting agency transparency, public participation, and public-private collaboration across Federal departments.

Measure 2.B.1 Increase number of identified opportunities for public engagement and collaboration across agencies		
FY	**Target**	**Result**
Out-Year Target	TBD (2015)	
FY 2012	TBD	
FY 2011	TBD	
FY 2010	80	September 30, 2011

Measure 2.B.1 Increase number of identified opportunities for public engagement and collaboration across agencies		
FY	**Target**	**Result**
Out-Year Target	TBD (2015)	
FY 2012	127	
FY 2011	122	
FY 2010	117	September 30, 2011

Measure 2.C.1 Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice		
FY	**Target**	**Result**
Out-Year Target	TBD (2015)	
FY 2012	TBD	
FY 2011	TBD	
FY 2010	7	September 30, 2011

Measure	Data Source	Data Validation
2.B.1	Data collection associated with development of Open Government Plan	Collection on annual basis and update on Open.Gov; quarterly updates requested through HHS Innovation Council
2.B.2	HHS Data Council	Quarterly reports on data.gov submissions posted on hhs.gov/open
2.B.3	HHS Innovation Council	Community of Practice Website (www.hhs.gov/open/opengovermentplan/participation/strategic.html) the production version of the site due to launch January 2011 Regular Updates to the HHS Innovation Council

Goal 4 – Objective A: Ensure program integrity and responsible stewardship of resources

Responsible stewardship of new resources, such as funds provided by the Recovery Act, involves allocating these resources in an effective way that activities generate the highest benefits. Recovery Act funds have had an immediate impact on the lives of individuals and communities across the country affected by the economic crisis and the loss of jobs.

Measure 4.A.1 Ensure that ARRA Recipients submit at least 96% of expected quarterly reports required under Section 1512 of the Recovery Act		
FY	**Target**	**Result**
Out-Year Target		
FY 2012	TBD	
FY 2011	TBD	
FY 2010	Baseline	

Measure	Data Source	Data Validation
4.A.1	Recovery.gov	

Goal 4 – Objective D: Improve HHS environmental, energy, and economic performance to promote sustainability.

These goals are in concert with implementation of the HHS Strategic Sustainability Performance Plan (SSPP) prepared under Executive Order (EO) 13514, which requires HHS to reduce green house gas (GHG) emissions by technological, programmatic and behavioral changes.

4.D.1 (SSPP Goal 2: Scope 3 Greenhouse Gas Reduction) Increasing the percentage of Tele-working employees promotes the goals of the EO and reduces the vehicle miles traveled, which reduces GHG and other pollutants in our air, soil and water, which can be harmful to human

health. Typical commuting causes employee stress and decreases the amount of time employees can devote to other health activities such as physical activity, planning and preparing healthy meals and developing social capital by spending time with family or in the community. Widespread telework coupled with office sharing and swing space can reduce overall facilities costs in rents, waste removal, waste-water treatment and energy use.

4.D.2 (SSPP Goal 1: Scope 1 Greenhouse Gas Reduction) HHS has committed to continue the acquisition strategy of obtaining alternative fuel vehicles (AFV) while simultaneously decreasing gasoline-powered (carbon-based units in the fleet). HHS will continue to make progress toward this goal by reducing petroleum use in fleet vehicles.

4.D.3 (SSPP Goal 9: Electronic Stewardship and Data Centers) The HHS SSPP commits to implementation of power management for computers, laptops and monitors to decrease energy use that contributes to GHG. Power management is an EO requirement. Both EO 13423 and EO 13514 include goals and objectives applicable to Electronic Stewardship.

Measure 4.D.1 Increase percentage of employees who use telework or an alternative work schedule (AWS) to reduce commuting by four days per pay period		
FY	**Target**	**Result**
Out-Year Target	20% (Baseline TBD)	
2012	TBD	
2011	TBD	
2010	TBD (Developing w/Strategic Sustainability Plan)	
Measure 4.D.2 Reduce total HHS fleet emissions by 2%		
FY	**Target**	**Result**
Out-Year Target	2%	
2012		
2011		
2010	13, 778 (FY08 Baseline)	
Measure 4.D.3 Ensure power management is enabled in 100% of HHS computers, laptops, and monitors		
FY	**Target**	**Result**
2012	100%	
2011	75%	
2010	32% (Baseline)	

Measure	Data Source	Data Validation
4.D.1	Department wide Data Calls through Human Resources and Program Support Center (PSC)	HR/PSC Scope 3 Green House Gas baseline
4.D.2	Department wide Data Calls though Program Support Center	PSC through Scope 1 and Scope 3 data reporting
4.D.3	Department wide Data Calls through Office of the Chief Information Officer (CIO)	CIO through SSPP Goal 9, electronic Stewardship

Goal 5 – Objective A: Invest in the HHS workforce to meet America's health and human services needs today and tomorrow.

Measure 5.A.1 Reduce HHS-wide hiring lead times from their current levels to 65 days or less (Time from receipt of the complete recruitment request in the HR Office to the date the employee enters on duty)		
FY	**Target**	**Result**
Out-Year Target	65 business days	
FY 2012	70 business days	
FY 2011	80 business days	
FY 2010	130 business days (baseline)	

Measure	Data Source	Data Validation
5.A.1	Capital HR	Capital HR interfaces with OHR's workflow tracking system that provides monthly reports on the timeliness of HR actions through the end-to-end hiring process.

DEPARTMENTAL MANAGEMENT
LINKAGE TO THE HHS STRATEGIC PLAN

The table below is a consolidated display of Departmental Management's support for the HHS Strategic Plan. These programs contribute to activities associated with the mission of the Office of the Secretary. Detailed narratives can be found in the individual programs Online Performance Appendix.

HHS Strategic Goals	Departmental Appeals Board	Office on Disability	Assistant Secretary for Administration	Global Health Affairs	Assistant Secretary for Health	Medicare Hearings and Appeals	National Coordinator of Health Information Technology
1 Transform Health Care							
1.A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured							
1.B Improve health care quality and patient safety					X	X	
1.C: Emphasize primary and preventive care linked with community prevention services					X		
1.D: Reduce the growth of health care costs while promoting high-value, effective care					X		
1.E: Ensure access to quality, culturally competent care for vulnerable populations					X		
1.F: Promote the adoption of health information technology					X		X
2 Advance Scientific Knowledge and Innovation							
2.A: Accelerate the process of scientific discovery to improve patient care					X		
2.B: Foster innovation at HHS to create shared solutions					X		
2.C: Invest in the regulatory sciences to improve food and medical product safety							
2.D: Increase our understanding of what works in public health and human service practice					X		
3 Advance the Health, Safety and Well-Being of the American People							
3.A: Ensure the safety, well-being, and healthy development of children and youth				X	X		
3.B: Promote economic and social well-being for individuals, families and communities					X		
3.C: Improve the accessibility and quality of supportive services for people with disabilities and older adults		X					
3.D: Promote prevention and wellness				X	X		

HHS Strategic Goals	Departmental Appeals Board	Office on Disability	Assistant Secretary for Administration	Global Health Affairs	Assistant Secretary for Health	Medicare Hearings and Appeals	National Coordinator of Health Information Technology
3.E: Reduce the occurrence of infectious diseases				X	X		
3.F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies					X		
4 Increase Efficiency, Transparency, and Accountability of HHS Programs							
4.A: Ensure program integrity and responsible stewardship of resources	X			X	X	X	
4.B: Fight fraud and work to eliminate improper payments	X			X			
4.C: Use HHS data to improve the health and well-being of the American people					X		
4.D: Improve HHS environmental, energy, and economic performance to promote sustainability			X		X		
5 Strengthen the Nation's Health and Human Service Infrastructure and Workforce							
5.A: Invest in the HHS workforce to meet America's health and human services needs today and tomorrow	X		X	X	X		
5.B: Ensure that the Nation's health care workforce can meet increased demands					X		
5.C: Enhance the ability of the public health workforce to improve public health at home and abroad				X	X		
5.D: Strengthen the Nation's human services workforce					X		
5.E: Improve national, state, and local surveillance and epidemiology capacity					X		

DEPARTMENTAL MANAGEMENT

Summary of Full Cost

(Budgetary Resources in Millions)

	DM		
HHS Strategic Goals and Objectives	**FY 2010**	**FY 2011**	**FY 2012**
1. Transform Health Care	230.6	231.5	238.5
1.A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured		1.0	1.0
1.B: Improve health care quality and patient safety	72.1	72.1	71.2
1.C: Emphasize primary and preventive care linked with community prevention services	4.3	4.2	3.4
1.D: Reduce the growth of health care costs while promoting high-value, effective care	5.0	5.0	4.0
1.E: Ensure access to quality, culturally competent care for vulnerable populations	81.0	81.0	78.6
1.F: Promote the adoption of health information technology	68.2	68.2	80.3
2. Advance Scientific Knowledge and Innovation	20.4	20.1	16.9
2.A: Accelerate the process of scientific discovery to improve patient care	10.2	10.0	8.3
2.B: Foster innovation at HHS to create shared solutions	4.0	4.0	3.0
2.C: Invest in the regulatory sciences to improve food and medical product safety	3.0	3.0	3.0
2.D: Increase our understanding of what works in public health and human services practice	3.2	3.1	2.6
3. Advance the Health, Safety, and Well-Being of the American People	313.0	312.5	288.5
3.A: Ensure the safety, well-being, and healthy development of children and youth	119.2	119.2	111.3
3.B: Promote economic and social well-being for individuals, families, and communities	37.5	37.5	34.8
3.C: Improve the access ability and quality of supportive services for people with disabilities and older adults	3.0	3.0	2.5
3.D: Promote prevention and wellness	70.0	70.0	65.7
3.E: Reduce the occurrence of infectious diseases	69.0	68.5	62.9
3.F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies	14.3	14.3	11.3
4. Increase Efficiency, Transparency, and Accountability of HHS Programs	63.0	63.0	54.3
4.A: Ensure program integrity and responsible stewardship of resources	42.3	42.3	37.0
4.B: Fight fraud and work to eliminate improper payments	7.1	7.1	6.0
4.C: Use HHS data to improve the health and well-being of the American people	10.4	10.4	8.7
4.D: Improve HHS environmental, energy, and economic performance to promote sustainability	3.2	3.2	2.6
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	61.0	61.0	51.6
5.A: Invest in the HHS workforce to help meet America's health and human service needs today and tomorrow	30.0	30.0	26.7
5.B: Ensure that the Nation's health care workforce can meet increased demands	9.0	9.0	7.8
5.C: Enhance the ability of the public health workforce to improve public health	10.0	10.0	8.4

and home and abroad			
5.D: Strengthen the Nation's human service workforce	10.0	10.0	7.3
5.E: Improve national, state, local, and tribal surveillance and epidemiology capacity	2.0	2.0	1.4
TOTAL PROGRAM LEVEL	**688.0**	**688.1**	**649.8**

This table is a consolidated display of Discretionary program level support (includes GDM, OMHA and ONC) for HHS through budgetary resources. Detailed allocations can be found in the individual programs Online Performance Appendices

SUMMARY of PROGRAM EVALUATIONS

OASH

Office of Minority Health Title: Assessment of Data Collection/Reporting Policies & Practices in the Conduct of Community-Based Health Screening Programs, and a Final Summary Report on the Testing of Standardized Screening Forms

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year, including program improvement resulting from the evaluation, will be posted online shortly.

Office of Minority Health Title: Culturally Competent Nursing Modules (CCNM) Two-Year Evaluation Report

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year, including program improvement resulting from the evaluation, will be posted online shortly.

Office of Minority Health Title: Maintenance of the Uniform Data Set (UDS) for Assessing Impacts of OMH-Funded Activities

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year, including program improvement resulting from the evaluation, will be posted online shortly.

Office of Minority Health Title: National Consensus Panel on Emergency Preparedness for Racially and Ethnically Diverse Communities

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year can be found at
http://www.omhrc.gov./templates/content.aspx?lvl=1&lvlID=44&ID=7895
including program improvement, resulting from the evaluation.

Disclosure of Assistance by Non-Federal Parties

The preparation of Annual Performance Reports and Annual Performance Plans is an inherently government function that is only to be performed by Federal Employees. GMD has not received any material assistance from any non-Federal parties in the preparation of this FY 2012 Online Performance Appendix.