DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR

2011

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

Justification of Estimates for
Appropriations Committees

Introduction

This FY 2011 Congressional Justification is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 (GPRA) and with Office of Management and Budget Circulars A-11 and A-136, through the HHS agencies' FY 2011 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Citizens' Report. These documents are available at http://www.hhs.gov/budget.

The FY 2011 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2009 Annual Performance Report and FY 2011 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Summary of Performance and Financial Information summarizes key past and planned performance and financial information.

Message from the Acting Assistant Secretary for Financial Resources

I am pleased to present the Congressional Justification for Departmental Management (DM) activities within the Office of the Secretary. This Budget Request represents the Administration's priorities for guiding the Department of Health and Human Services (HHS) to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

The DM Budget Request supports the Secretary in her role as chief policy officer and general manager of HHS. The request totals $693 million and includes 3,413 full-time equivalent (FTE) staff in FY 2011. These levels will ensure the Secretary's ability to successfully manage the Department while increasing accountability in oversight functions and improving the transparency of information and decision-making. It also includes resources needed to guide nationwide implementation of interoperable health information technology, including secure electronic health records.

The FY 2011 Budget for DM includes funding increases to more effectively target teen pregnancy prevention, utilizing evidence-based models and promising practices. In addition, the Request increases funding for the Office of Medicare Hearings and Appeals, to ensure its continued ability to process cases within legally mandated timeframes while providing clients with unfettered access. Finally, the Budget proposes funding increases for reducing health disparities among minority populations.

The Secretary looks forward to working with the Congress toward the enactment and implementation of an FY 2011 Budget that advances the Nation's health and supports families.

Richard J. Turman
Acting Assistant Secretary for
Financial Resources

Departmental Management Overview

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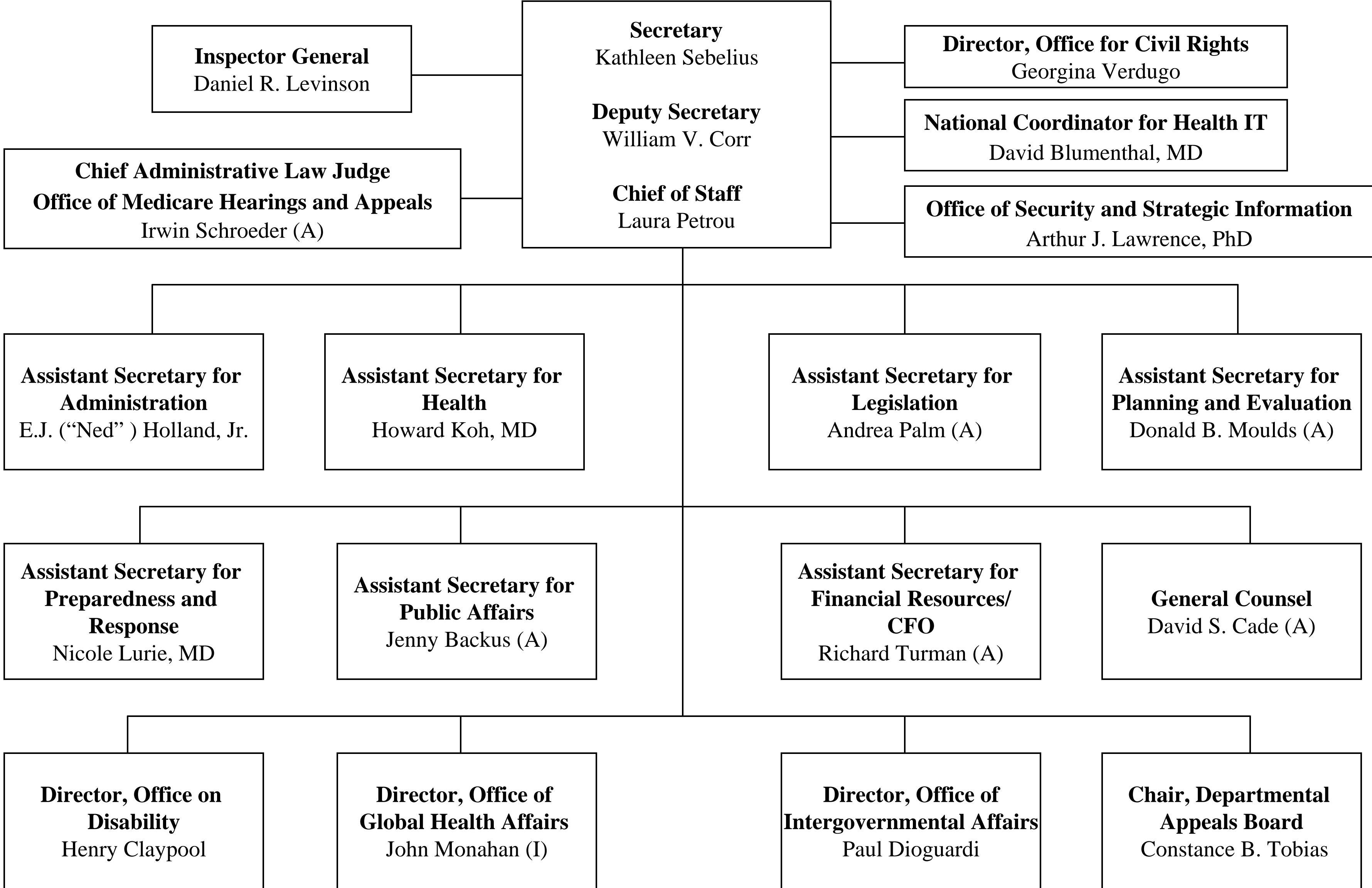
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY



DEPARTMENTAL MANAGEMENT

OVERVIEW

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

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

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

The overall FY 2011 budget request for DM totals $693,281,000 in appropriated budget authority, and 3,413 full-time equivalent (FTE) positions – a total increase of $89,364,000 (or 15%) above the comparable FY 2010 Enacted level. Please see the DM Budget by Appropriation table on the following pages.

The **General Departmental Management** (GDM) appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department in administering and overseeing the organization, programs, and activities of HHS. The Secretary's roles are carried out through twelve Staff Divisions (STAFFDIVs), including the Immediate Office of the Secretary, the Departmental Appeals Board, and the Offices of: Administration; Disability; Financial Resources; General Counsel; Global Health Affairs; Intergovernmental Affairs; Legislation; Planning and Evaluation; Public Affairs; and Public Health and Science. For FY 2011, GDM is requesting a total of $537,149,000 in appropriated budget authority and 1,417 FTE.

The **Office of Medicare Hearings and Appeals** (OMHA) was created in response to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). As mandated by MMA, OMHA opened its doors on July 1, 2005, to hear Medicare appeals at the Administrative Law Judge level, for cases under titles XVIII and XI of the Social Security Act. OMHA is funded entirely from the Medicare Hospital Insurance and Supplemental Medical Insurance Trust Funds, and requests $77,798,000 and 422 FTE in FY 2011.

The **Office of the National Coordinator for Health Information Technology** (ONC) became operational on August 19, 2005, in response to Executive Order 13335. ONC was officially authorized by the Health Information Technology for Economic and Clinical Health Act, signed by President Obama on February 17, 2009. For FY 2011, HHS requests budget authority of $78,334,000 and 120 FTE, to coordinate national efforts related to the implementation and use of electronic health information exchange. By encouraging providers to adopt health information

technology (IT), both the quality of care and the efficiency with which health IT is delivered can be improved.

The **Service and Supply Fund** (SSF), the HHS revolving fund, is composed of two parts: the Program Support Center (PSC) and the Non-PSC activities. However, the budget justification for both parts is presented as a single submission, to allow greater understanding and transparency of the Fund's overall operations. The SSF provides consolidated financing and accounting for business-type operations which involve the provision of common services to customers. The SSF does not have its own appropriation, but is funded entirely through charges to its customers for their usage of Fund goods and services. For FY 2011, the SSF is projecting total revenue of $1,064,817,000 and usage of 1,454 FTE.

NOTE:

The HHS Nonrecurring Expenses Fund (NEF) was established in the Office of the Secretary by the Consolidated Appropriations Act, 2008 (P.L. 110-161). This authority permits expired unobligated balances from discretionary accounts in fiscal years 2008 and later to be transferred into the no-year NEF account, prior to cancellation. Since FY 2008 funds will not be cancelled until the end of FY 2013, NEF funding is not expected to be available until just prior to September 30, 2013. NEF funds may be used only for nonrecurring capital acquisitions (facilities infrastructure and information technology infrastructure) which have a broad value to the Department. Advance notification of all proposed uses of these funds will be submitted to the relevant Appropriations Committee, and apportionment of the funds will be submitted to OMB. HHS currently has no plans to transfer any funds to the NEF during FY 2011.

DEPARTMENTAL MANAGEMENT

BUDGET BY APPROPRIATION
(Dollars in thousands)

	FY 2009 Enacted		FY 2010 Enacted		**FY 2011** Request	
	FTE	Amount	FTE	Amount	FTE	Amount
General Departmental Management	1,358	$381,987	1,417	$490,439	1,417	$537,149
Office of Medicare Hearings and Appeals	357	$64,604	378	$71,147	422	$77,798
Office of the National Coordinator for Health Information Technology	31	$43,552	75	$42,331	120	$78,334
Subtotal, Budget Authority	**1,746**	**$490,143**	**1,870**	**$603,917**	**1,959**	**$693,281**
Service and Supply Fund	1,335	$0	1,394	$0	1,454	$0
TOTAL, Budget Authority	**3,081**	**$490,143**	**3,264**	**$603,917**	**3,413**	**$693,281**
[Trust Fund transfers included above, GDM + OMHA]..		($70,455)		($76,998)		($77,798)
PHS Evaluation Funds (GDM + ONC)		*$64,435*		*$84,222*		*$65,211*
HCFAC Funds (GDM)		*$5,714*		*$8,714*		*$8,714*
TOTAL, Program Level		***$560,292***		***$696,853***		***$767,206***

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General Departmental Management

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APPROPRIATIONS LANGUAGE

GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management, including hire of six sedans, and for carrying out titles III, IV, XVII, XX, and XXIX of the Public Health Service Act ("PHS Act"), the United States-Mexico Border Health Commission Act, and research studies under section 1110 of the Social Security Act, [$493,377,000, together with $5,851,000 to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund,] ***$537,149,000*** and $65,211,000 from the amounts available under section 241 of the PHS Act to carry out national health or human services research and evaluation activities: *Provided,* That of this amount, $53,891,000 shall be for minority AIDS prevention and treatment activities[; $5,789,000 shall be to assist Afghanistan in the development of maternal and child health clinics, consistent with section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002; and $1,000,000 shall be transferred, not later than 30 days after enactment of this Act, to the National Institute of Mental Health to administer the Interagency Autism Coordinating Committee]: *Provided further,* That [all] ***none*** of the funds made available under this heading ***shall be available*** for carrying out [title XX of the PHS Act shall be for] activities specified under section 2003(b)[(1) of such title XX]***(2) of (3) of title XX of the PHS Act:*** *Provided further,* That of the funds made available under this heading, [$110,000,000] ***$129,218,000*** shall be for making competitive contracts and grants to public and private entities to fund medically accurate and age-appropriate programs that reduce teen pregnancy and for the Federal costs associated with administering and evaluating such contracts and grants, of which not less than [$75,000,000]***$85,000,000*** shall be for replicating programs

that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors, of which not less than **[**$25,000,000**]*****$28,000,000*** shall be available for research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy, and of which any remaining amounts shall be available for training and technical assistance, evaluation, outreach, and additional program support activities: *Provided further,* That of the amounts provided under this heading from amounts available under section 241 of the PHS Act, $4,455,000 shall be available to carry out evaluations (including longitudinal evaluations) of teenage pregnancy prevention approaches: *Provided further,* That funds provided in this Act for embryo adoption activities may be used to provide, to individuals adopting embryos, through grants and other mechanisms, medical and administrative services deemed necessary for such adoptions: *Provided further,* That such services shall be provided consistent with 42 CFR 59.5(a)(4): **[***Provided further,* That $1,650,000 shall be used for the projects, and in the amounts, specified under the heading "General Departmental Management" in the statement of the managers on the conference report accompanying this Act**]** ***Provided further, That $10,000,000 of the funds made available under this heading shall be available for health and wellness pilot initiatives for Federal employees, of which up to $5,000,000 may be transferred to other agencies, with the approval of the Director of the Office of Management and Budget, to assist those agencies in the implementation of such initiatives***.

(Department of Health and Human Services Appropriations Act, 2010.)

LANGUAGE ANALYSIS

Language Provision	Explanation
"together with $5,851,000 to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund"	HHS proposes that annual Trust Fund transfers from CMS be deleted from GDM (and OCR) appropriation language, and that the Trust Funds amount be replaced by regular Budget Authority, so that GDM's bottom-line total is not reduced. The numerous accounting intricacies associated with these Trust Fund transfers now outweigh whatever benefit may have been present when the transfers were initiated years ago. HHS is not aware of any legislative requirement mandating these transfers, or of any prohibition against ending them. Deleting the transfers should also make appropriations scorekeeping easier for Congressional staff.
"$5,789,000 shall be to assist Afghanistan in the development of maternal and child health clinics, consistent with section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002;"	HHS proposes that this Afghanistan program be permanently moved to CDC. CDC already participates substantially in this program. This will also move an operational program out of the Office of Global Health Affairs (OGHA), so that OGHA can better focus on policy leadership and coordination.
"and $1,000,000 shall be transferred, no later than 30 days after enactment of this Act, to the National Institute of Mental Health to administer the Interagency Autism Coordinating Committee"	HHS proposes that this funding be included in the annual appropriation for NIMH, where it rightfully belongs, and no longer be included in GDM (where it has no logical reason for inclusion).
"Provided further, that $10,000,000 of the funds made available under this heading shall be available for health and wellness pilot initiatives for Federal employees, of which up to $5,000,000 may be transferred to other agencies, with the approval of the Director of the Office of Management and Budget, to assist those agencies in the implementation of such initiatives."	HHS proposes that a new health and wellness initiative be created for Federal employees government-wide, to be coordinated and funded by the Office of Public Health and Science (OPHS) in GDM. The initiative will begin with pilot programs at various Federal agencies. This language will allow non-HHS agencies to also contribute funds from their own budgets.

AMOUNTS AVAILABLE FOR OBLIGATION[1]

	FY 2009 Enacted	FY 2010 Enacted	FY 2011 Request[2]
General funds:			
Annual appropriation	$389,925,000	$493,377,000	$537,149,000
Actual transfer to:			
NIMH for Interagency Autism Coordinating Cmte	-1,000,000	-1,000,000	–
Comparable transfers to:			
AoA for Lifespan Respite Care grants	-2,500,000	–	–
CDC for Afghanistan Health Initiative (OGHA)	-5,789,000	-5,789,000	–
CDC for Health Diplomacy Initiative (OGHA)	-4,500,000	-2,000,000	–
Subtotal, adjusted general funds	376,136,000	484,588,000	537,149,000
Trust funds:			
Annual appropriation	5,851,000	5,851,000	–
Subtotal, adjusted budget authority	381,987,000	490,439,000	537,149,000
Unobligated balance lapsing	-2,112,000	–	–
Total obligations	$379,875,000	$490,437,000	$537,149,000

[1] Excludes the following amounts for reimbursable activities carried out by this account: FY 2009 – $200,000,000; FY 2010 – $223,000,000; FY 2011 – $226,000,000.

[2] Excludes $7,000,000 for Acquisition Reform, which is reflected in the HHS General Provisions.

SUMMARY OF CHANGES

2010	General funds appropriation	$493,377,000
	HI/ SMI trust funds transfer	5,851,000
	Total adjusted budget authority	499,228,000
2011	Request – General funds	537,149,000
	Request – HI/SMI trust funds transfer	0
	Total estimated budget authority	537,149,000
	Net change	+37,921,000

	2010 Estimate		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Increases:				
A. Built-in:				
1. Anualization of January 2010 pay raise (2.0%)	(1,417)	$126,897,000	(--)	+635,000
2. Effect of January 2011 pay raise (1.4%)	(1,417)	126,897,000	(--)	+1,332,000
3. Within-grade increases and career ladder promotions	(1,417)	126,897,000	(--)	+1,269,000
4. Total Rent/ Operations & Maintenance payments	(--)	26,460,000	(--)	+2,582,000
5. Total Common Expenses/ Service and Supply Fund payments	(--)	27,833,000	(--)	+6,404,000
Subtotal, Built-In Increases			(--)	+12,222,000
B. Program:				
1. OPHS: Teen Pregnanacy Prevention Initiative (TPP)	(12)	110,000,000	(+4)	+19,218,000
2. OPHS: Programs and offices other than TPP	(281)	98,702,000	(-11)	+2,213,000
3. OPHS: Federal Employee Health and Wellness Initiative	(--)	0	(--)	+10,000,000
4. OPHS: Office of Minority Health	(63)	56,000,000	(--)	+1,980,000
5. Secretarial Initiatives and Flexibility	(--)	1,250,000	(--)	+1,250,000
Subtotal, Program Increases			(--)	+34,661,000

Total Increases			(--)	+46,883,000

Decreases:

B. Program:

1. One-time Congressional projects included in FY 2010 GDM appropriation	(--)	1,650,000	(--)	-1,650,000
2. Net change for other FTE and administrative costs	(--)	53,297,000	(+7)	-1,523,000
Total Decreases			(--)	-3,173,000
Net Change			(--)	+43,710,000

BUDGET AUTHORITY BY ACTIVITY
(Dollars in Thousands)

	FY 2009 Enacted		FY 2010 Enacted		**FY 2011 Request**	
	FTE	Amount	FTE	Amount	FTE	Amount
Rent/ Operations & Maintenance 1/	-	$ 17,001	-	$ 16,935	-	$ 19,424
Common Expenses/ SSF Payment 1/	-	$ 12,570	-	$ 14,522	-	$ 20,743
Enterprise IT	-	$ 347	-	$ 347	-	$ 350
HCAS Payment	-	$ 122	-	$ -	-	$ -
Immediate Office of the Secretary	66	$ 11,073	69	$ 10,925	69	$ 11,148
Administration	116	$ 17,390	118	$ 18,874	118	$ 19,857
Financial Resources	171	$ 25,781	176	$ 26,233	179	$ 27,877
Health, OPHS	334	$ 163,791	356	$ 264,702	349	$ 298,113
Legislation	19	$ 3,430	26	$ 3,554	26	$ 3,592
Public Affairs	26	$ 4,432	28	$ 4,829	29	$ 5,314
General Counsel	359	$ 37,581	361	$ 38,692	364	$ 40,131
Departmental Appeals Board	66	$ 9,981	66	$ 10,548	66	$ 11,143
Disability	4	$ 805	7	$ 864	7	$ 976
Global Health Affairs	24	$ 6,451	24	$ 6,424	24	$ 6,452
Intergovernmental Affairs	24	$ 6,244	33	$ 6,099	33	$ 6,438
Healthcare-Associated Infections activities	-	$ 5,000	-	$ 5,000	-	$ 5,000
Secretarial Initiatives and Flexibility	-	$ -	-	$ 1,250	-	$ 2,500
Minority HIV/AIDS Initiative	-	$ 51,891	-	$ 53,891	-	$ 53,891
Embryo Adoption Awareness Campaign	-	$ 4,200	-	$ 4,200	-	$ 4,200
Congressional Projects	-	$ 3,897	-	$ 1,650	-	$ -
IOM Study on Mental Health Workforce	-	$ -	-	$ 900	-	$ -
Planning and Evaluation	133	$ -	136	$ -	136	$ -
Center for Faith-Based & Neighborhood Partnerships	6	$ -	7	$ -	7	$ -
Presidential Commission for Bioethical Issues	10	$ -	10	$ -	10	$ -
Acquisition Reform	-	$ -	-	$ -	-	$ 7,000
Subtotal, Budget Authority	1,358	$ 381,987	1,417	$ 490,439	1,417	$ 544,149
CHIPRA and FMAP	-	$ 10,000	-	$ 10,000	-	$ -
Total Budget Authority	1,358	$ 391,987	1,417	$ 500,439	1,417	$ 544,149
Trust Fund transfers, included above		*$ 5,851*		*$ 5,851*		*$ -*
PHS Evaluation Funds; non-add		*$ 46,756*		*$ 65,211*		*$ 65,211*

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

BUDGET AUTHORITY BY OBJECT
(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	76,109	82,134	+6,025
Other than full-time permanent (11.3)	7,456	8,264	+808
Other personnel compensation (11.5)	8,102	9,294	+1,192
Military personnel (11.7)	8,332	9,023	+691
Special personnel services payments (11.8)	-	-	-
Subtotal, Personnel Compensation (11.0)	99,999	108,715	+8,716
Civilian benefits (12.1)	22,367	26,391	+4,024
Military benefits (12.2)	4,505	5,008	+503
Benefits to former personnel (13.0)	26	26	-
Subtotal, Pay Costs	**126,897**	**140,140**	**+13,243**
Travel and transportation of persons (21.0)	6,811	7,935	+1,124
Transportation of things (22.0)	281	295	+14
Rental payments to GSA (23.1)	24,567	25,549	+982
Communication, utilities, and misc. charges (23.3)	5,689	6,486	+797
Printing and reproduction (24.0)	3,098	3,734	+636
Other Contractual Services:			
Advisory and assistance services (25.1)	57,995	65,350	+7,355
Other services (25.2)	45,010	45,251	+241
Purchase of goods and services from government accounts (25.3)	50,347	55,934	+5,587
Operation and maintenance of facilities (25.4)	10,123	10,637	+514
Research and Development contracts (25.5)	323	319	-4
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	3,097	3,076	-21
Subsistence and support of persons (25.8)	-	-	-
Subtotal, Other Contractual Services (25.0)	166,895	180,567	+13,672
Supplies and materials (26.0)	3,626	3,568	-58
Equipment (31.0)	4,082	6,030	+1,948
Grants, subsidies, and contributions (41.0)	158,493	169,845	+11,352
Subtotal, Non-Pay Costs	**373,542**	**404,009**	**+30,467**
Total, Budget Authority	**500,439**	**544,149**	**+43,710**
CHIPRA and FMAP, included above (unobligated balances)	*18,000*	*0*	*-18,000*

SALARIES AND EXPENSES
(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	76,109	82,134	+6,025
Other than full-time permanent (11.3)	7,456	8,264	+808
Other personnel compensation (11.5)	8,102	9,294	+1,192
Military personnel (11.7)	8,332	9,023	+691
Special personnel services payments (11.8)	-	-	-
Subtotal, Personnel Compensation	99,999	108,715	+8,716
Civilian benefits (12.1)	22,367	26,391	+4,024
Military benefits (12.2)	4,505	5,008	+503
Benefits to former personnel (13.0)	26	26	-
Subtotal, Pay Costs	**126,897**	**140,140**	**+13,243**
Travel and transportation of persons (21.0)	6,811	7,935	+1,124
Transportation of things (22.0)	281	295	+14
Communication, utilities, and misc. charges (23.3)	5,689	6,486	+797
Printing and reproduction (24.0)	3,098	5,734	+2,636
Other Contractual Services:			
Advisory and assistance services (25.1)	57,995	68,350	+10,355
Other services (25.2)	45,010	50,251	+5,241
Purchase of goods and services from government accounts (25.3)	50,347	56,934	+6,587
Operation and maintenance of facilities (25.4)	10,123	10,637	+514
Research and Development Contracts (25.5)	323	319	-4
Operation and maintenance of equipment (25.7)	3,097	3,076	-21
Subsistence and support of persons (25.8)	-	-	-
Subtotal, Other Contractual Services	166,895	189,567	+22,672
Supplies and materials (26.0)	3,626	3,568	-58
Total, Salaries and Expenses	**313,297**	**353,725**	**+40,428**

AUTHORIZING LEGISLATION

	2010 Amount Authorized	2010 Enacted	2011 Amount Authorized	2011 Budget Request[5]
General Departmental Management, except accounts below:				
Reorganization Plan No. 1 of 1953	Indefinite	$225,637,000	Indefinite	$239,036,000
Office of Public Health and Science:				
Public Health Service Act,				
Title III, Section 301	Indefinite	188,105,000	Indefinite	207,985,000
Title XVII, Section 1701 (ODPHP)	[1]	7,200,000	[1]	7,929,000
Title XVII, Section 1707 (OMH)	[2]	56,000,000	[2]	57,980,000
Title XX, Section 2010 (AFL)	[3]	16,658,000	[3]	16,658,000
Title XXI (NVPO)	[4]	6,839,000	[4]	7,561,000
Subtotal		264,802,000		298,113,000
Total appropriation		$490,439,000		$537,149,000

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

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

[3] Authorizing legislation under Section 2001 of the PHS Act expired September 30, 1985. Reauthorization will be proposed.

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

[5] Excludes funding for Acquisition Reform, which is reflected in the HHS General Provisions.

APPROPRIATIONS HISTORY TABLE
(Non-Comparable)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2002				
Appropriation	$415,348,000	$333,036,000	$416,361,000	$341,703,000
Rescissions	–	–	–	-1,667,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
FY 2003				
Appropriation	387,880,000	352,600,000	368,535,000	361,364,000
Rescission	–	–	–	-2,349,000
OER Transfer	–	–	–	-13,856,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
Rescission	–	–	–	-38,000
FY 2004				
Appropriation	348,100,000	343,284,000	344,808,000	357,358,000
Rescissions	–	–	–	-3,174,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
Rescission	–	–	–	-35,000
FY 2005				
Appropriation	431,971,000	349,298,000	376,704,000	371,975,000
Rescissions	–	–	–	-3,530,000
Trust Funds	5,851,000	5,851,000	5,851,000	55,851,000
Rescission	–	–	–	-447,000
SSA Transfer	–	–	–	-49,600,000
FY 2006				
Appropriation	353,325,000	338,695,000	353,614,000	352,703,000
Rescission	–	–	–	-3,527,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
Rescission	–	–	–	-58,000
FY 2007				
Appropriation	362,568,000	–	–	350,945,000
Rescission	–	–	–	-500,000
KLL Supplemental	13,512,000	–	–	–
Trust Funds	5,851,000	–	–	5,793,000

APPROPRIATIONS HISTORY TABLE
(Cont.)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2008				
Appropriation	$386,705,000	$342,224,000	$386,053,000	$355,518,000
Rescission	–	–	–	-6,211,000
NIMH Transfer	–	–	–	-983,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,792,000
Rescission	–	–	–	-101,000
FY 2009				
Appropriation	374,013,000	361,825,000	361,764,000	389,925,000
NIMH Transfer	–	-1,000,000	-1,000,000	-1,000,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
CHIPRA (PL 111-3)	–	–	–	15,000,000
ARRA (PL 111-5)	–	–	–	5,000,000
FY 2010				
Appropriation	403,698,000	397,601,000	477,928,000	493,377,000
NIMH Transfer	–	-1,000,000	-1,000,000	-1,000,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
FY 2011				
Appropriation	537,149,000			
Trust Funds	–			

GENERAL DEPARTMENTAL MANAGEMENT

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010 Appropriation
BA	$381,987,000	$0	$490,439,000	$537,149,000	+$46,710,000
FTE*	1,358	0	1,417	1,417	--

*Includes reimbursable FTE other than SSF

FY 2011 Authorization ....Indefinite
Allocation Method ....Direct Federal

Overview of Budget Request

The FY 2011 budget request for General Departmental Management (GDM) includes $537,149,000 in appropriated budget authority and 1,417 full-time equivalent (FTE) positions. This request is $46,710,000 (or 9.5%) higher than the comparable FY 2010 Enacted level; there is no change in FTE.

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. The Secretary's roles are carried out through twelve Staff Divisions (STAFFDIVs), including the Immediate Office of the Secretary, the Departmental Appeals Board, and the Offices of: Administration; Disability; Financial Resources; General Counsel; Global Health Affairs; Intergovernmental Affairs; Legislation; Planning and Evaluation; Public Affairs; and Public Health and Science.

The largest single STAFFDIV within GDM is the Assistant Secretary for Health (ASH)/ Office of Public Health and Science (OPHS). ASH/ OPHS serves as the focal point for leadership and coordination across the Department in public health and science, and provides advice and counsel to the Secretary on public health and science issues. OPHS also exercises management responsibility for 13 cross-cutting program offices, including: Surgeon General, HIV/AIDS Policy, Adolescent Family Life, Adolescent Health, Disease Prevention and Health Promotion, President's Council on Physical Fitness and Sports, Minority Health, Women's Health, Human Research Protections, Commissioned Corps Initiatives, National Vaccine Program Office, Public Health Reports, and Research Integrity.

This justification includes narrative sections describing the activities of each STAFFDIV funded under the GDM account, plus the Rent and Common Expenses accounts. (Resource tables reflect only funding provided from the GDM appropriation. FTE figures include full-time, part-time, and temporary employees.) This justification also includes selected performance information.

The FY 2011 request for GDM reflects the following significant increases over FY 2010:

- Teen Pregnancy Prevention (TPP) Initiative (+$19,218,000) – TPP is a new discretionary grant program which addresses rising teen pregnancy rates by supporting evidence-based prevention approaches. This increase will be used to fund additional competitive grants and contracts to public and private entities, in support of medically accurate and age-appropriate programs that reduce teen pregnancy. These funds will support both the replication of proven evidence-based models, the creation of new research and demonstration models to identify new effective approaches, and rigorous evaluation. (NOTE: A legislative proposal will also be submitted for $50,000,000 in mandatory funds to support States, territories and tribes in their teen pregnancy prevention efforts.)

- Federal Employee Health and Wellness Initiative (+$10,000,000) – This request would fund a government-wide Health and Wellness Initiative for Federal employees, as requested by the President. The goal is to create a culture of wellness, improve employee health, and reduce health care costs through programs at Federal worksites. Funding for a rigorous evaluation of the initiative, to document its effectiveness, is also included.

- Service and Supply Fund (SSF) Payment (+$5,315,000) – This increase in the SSF payment covers the estimated increase in the Office of the Secretary charges attributable to GDM, based on the FY 2011 Budget amounts approved by the SSF Board.

- Rent (+$2,489,000) – This increase is requested to fund the following mandatory increases, none of which can be reduced without major impacts on HHS operations: Rent in the Humphrey, Switzer, Cohen, and 801 N. Capitol Street buildings; security costs for the Federal Protective Service; labor rate increases in service contracts; and building utility costs.

- Office of Minority Health (OMH) in OPHS (+$1,980,000) – The requested increase will be used to address health disparities, including grants to increase awareness of the significance of health disparities, their impact on the Nation, and the actions necessary to improve health outcomes. OMH will also use the funds to increase emphasis on the use of evidence-based guidelines, and to improve cross-sector collaborations between public and private agencies to minimize duplication in health disparities programs.

- Secretarial Initiatives and Flexibility (+$1,250,000) – This increase will allow the Secretary to provide necessary support and leadership to the OPDIVs and STAFFDIVs as they establish or improve programs and initiatives in support of the Administration's priorities. These supportive activities will also enable the Secretary to ensure appropriate accountability and transparency, particularly regarding responses to the current critical health needs of the public.

- Acquisition Reform (+$7,000,000) – As part of a government-wide initiative to advance contracting reform, HHS is making a first-time request for funding to improve the capability, capacity and effectiveness of its acquisition workforce. These funds will be used to expand and improve acquisition-related staffing, training and systems. (NOTE: This amount has been requested separately in an HHS General Provision, not within GDM Budget Authority).

RENT, OPERATIONS AND MAINTENANCE, AND RELATED SERVICES

Program Description and Accomplishments

The Office for Facilities Management and Policy (OFMP), in the Office of the Assistant Secretary for Administration (ASA), administers the Rent, Operations and Maintenance (O&M), and Related Services funding and requirements for all headquarters facilities occupied by the Office of the Secretary (OS), plus other assigned space. OFMP ensures mission-enabling facilities and a safe, secure work environment for the Hubert H. Humphrey (HHH) Building and the rest of the Southwest complex in Washington DC. OFMP also provides stewardship and fiscal responsibility in managing the Department's real property assets; monitors the amount and type of space occupied by each STAFFDIV; coordinates efforts to achieve the most efficient use of space while maintaining a quality work environment; manages and maintains physical security requirements; provides event management services; and ensures the continuous operation of assigned Federal buildings and leased space.

- Rental Payments (Rent): OFMP manages and administers the space assigned to HHS by the General Services Administration (GSA), including office space, non-office space and parking facilities in owned or leased buildings.

- O&M: OFMP manages and administers the operation, maintenance and repair of the HHH Building, which is HHS Headquarters, under a delegation of authority from GSA, which owns the building. O&M services include heating, lighting, air conditioning, other utilities, and upkeep on building systems and facility equipment.

- Related Services: OFMP manages and administers non-rent activities in GSA-owned buildings, including space management, events management, guard services and other security, as well as building repairs and renovations.

OFMP is committed to a high level of performance in the management of the HHH Building through the improvement of operational efficiency and reductions in operating costs, in accordance with best practices and industry standards. Examples include implementing and maintaining traffic and security improvements to control building access, modernizing lighting systems to improve energy efficiency while minimizing costs, and completing other building improvement projects.

From FY 2001 to FY 2009, OFMP achieved all of its performance targets. OFMP's current practices and procedures adhere to GSA guidelines for responding to building services complaints within 72 hours of receipt. To verify performance, an independent analysis of computer-generated data from the contractor's service call system is conducted regularly. To ensure accuracy, individual work orders (issued as a result of estimates for service) are randomly pulled and reviewed on a periodic basis. These reviews have consistently supported the automated reports.

In FY 2009, OFMP also implemented new traffic and security changes to the two main entrances of the HHH Building, to increase effectiveness of building and personal security; began enhancements to security monitoring equipment to improve controlled access to the building; and thorough modernized lighting, energy efficiency will improve throughout the facility.

Common Expenses/ Service and Supply Fund (SSF) Payment

Common Expenses include funds to cover administrative items and activities which cut across and impact all STAFFDIVs under the GDM appropriation. The major costs in this area include:

- Worker's Compensation
- Federal Employment Information and Services
- Records storage at the National Archives and Records Administration
- Radio Spectrum Management Services
- Federal Executive Board in Region VI
- Telecommunications (e.g., FTS and commercial telephone expenses)
- CFO and A-123 audits
- Federal Laboratory Consortium
- Postage and Printing
- Unemployment Compensation

Payments to the SSF are included in the overall Common Expenses category, but are broken out separately here for display purposes. These payments cover the usage of goods and services provided through the SSF:

- Personnel and Payroll Services
- Finance and Accounting activities
- Electronic communication services (e.g., voice-mail and data networking)
- Unified Financial Management System (UFMS) Operations and Maintenance

NOTE: In FY 2009, funding to pay for computer service charges were moved from the Common Expenses account to the individual STAFFDIV budgets, to ensure the proper alignment of incentives in ordering services and in paying these bills.

Budget Request

The FY 2011 request for the consolidated GDM Rent and Common Expenses account is $20,743,000, an increase of $6,221,000 over the comparable FY 2010 Enacted level. These funds are necessary to cover centralized payments for Rent/O&M, Related Services, Common Expenses, and the Service and Supply Fund. These payments are made from centrally-managed accounts on behalf of all GDM accounts except the Office of Public Health and Science (OPHS), the Office of the General Counsel (OGC), the Office of Intergovernmental Affairs (IGA – ten Regional Directors offices only), and the Departmental Appeals Board (DAB); the costs for these accounts are included in their individual sections of the budget.

The FY 2011 budget request for Rent, O&M, and Related Services is $19,424,000, an increase of $2,489,000 over the FY2010 Enacted level. The increase covers GSA-mandated Rent increases; mandatory security increases imposed by the Department of Homeland Security (DHS); mandatory statutory contract labor rate increases for nine service contracts (under the McNamara-O'Hara Service Contract Act of 1965, as amended, and Collective Bargaining Agreements mandated by the Department of Labor); and utility cost increases (steam and electricity) billed by utility providers. None of the mandatory increases can be reduced without a major impact on HHS operations and the health and well-being of affected personnel.

- Rent costs have been formulated based on published GSA rates. HHH building space re-measurement by GSA increased GDM rentable square footage (RSF) in the HHH Building by 20% and the rate per RSF billed by GSA increased by 11%. Other GSA RSF rate increases include the Switzer building (60% increase), Cohen building (10% increase) and 800 N. Capitol Street building (10% increase).

- Security increases will be imposed by DHS for the Federal Protective Service (FPS). FPS costs are estimated to increase 15%, due to anticipated mandatory wage determinations under FPS guard services contracts for managed buildings.

- Service contract labor rates are projected to increase across all contracts, as a result of pre-negotiated firm-fixed pricing and/or anticipated wage increases mandated by statute. These increases include services for CAD, movers, events management, X-ray maintenance and card key access, all projected to increase by an estimated 5%. Physical security service contracts will similarly increase by 7%, due to wage increases mandated by statute. Commercial facilities maintenance contracts are estimated to increase by 9% as noted by the assigned contracting officials.

- Utility cost increases (steam and electricity) billed by utility providers to maintain existing minimum levels for occupied facilities are projected to increase by 10%, based on historical cost increases. In addition, GSA fire alarm and high-voltage electrical maintenance fees are increasing by 50%, due to a new GSA contract providing these services.

The increase in the SSF payment of $5,315,000 covers the estimated increase in the Office of the Secretary (OS) charges attributable to GDM, based on the FY 2011 Budget approved by the SSF Board. Within the total SSF Payment amount, $1,000,000 is specifically for continued necessary improvements to the OS websites. These websites are managed by the Assistant Secretary for Public Affairs' Web Communications Division, which is funded through the SSF. These funds will be used to continue support for significant new activities – including transparency in Recovery Act reporting, implementation of any Health Reform plan enacted by Congress, the Children's Health Insurance Program, and initiatives for Disease Prevention and Health IT – and to enhance the accessibility of OS content, including Spanish language presentation and Section 508 compliance. Funds will also be used to implement additional Web 2.0 social media applications, in order to interactively deliver content and involve the public in a more open government process via the Web.

RENT AND COMMON EXPENSES

	FY 2009 Enacted	FY 2010 Enacted	FY 2011 Request	FY 2011 +/- FY 2010
Rent:				
GDM	$10,504,000	$10,470,000	$11,956,000	+1,486,000
OPHS	7,878,000	8,035,000	8,148,000	+113,000
OGC	3,509,000	3,579,000	3,651,000	+72,000
IGA	675,000	689,000	722,000	+33,000
DAB	312,000	312,000	323,000	+11,000
Total	22,878,000	23,085,000	24,800,000	+1,715,000
Operations and Maintenance:				
GDM	3,375,000	3,375,000	4,242,000	+867,000
Related Services:				
GDM	3,122,000	3,090,000	3,226,000	+136,000
OGC	3,509,000	3,579,000	3,651,000	+72,000
Total	6,631,000	6,669,000	6,877,000	+208,000
Subtotal, GDM only	*$17,001,000*	*$16,935,000*	*$19,424,000*	*+2,489,000*
Common Expenses:				
GDM	2,692,000	2,837,000	3,743,000	+906,000
OPHS	1,915,000	1,941,000	1,962,000	+21,000
OGC	369,000	374,000	382,000	+8,000
Total	4,976,000	5,152,000	6,087,000	+935,000
Service & Supply Fund/ Web Communications:				
GDM	9,878,000	11,685,000	17,000,000	+5,315,000
OPHS	9,695,000	9,986,000	10,126,000	+140,000
OGC	990,000	1,010,000	1,024,000	+14,000
Total	20,563,000	22,681,000	28,150,000	+5,469,000
Subtotal, GDM only	*$12,570,000*	*$14,522,000*	*$20,743,000*	*+6,221,000*
Totals:				
GDM	$29,571,000	$31,457,000	$40,167,000	+8,710,000
OGC	8,377,000	8,542,000	8,708,000	+166,000
OPHS	19,488,000	19,962,000	20,236,000	+274,000
IGA	675,000	689,000	722,000	+33,000
DAB	312,000	312,000	323,000	+11,000
Total	$58,423,000	$60,962,000	$70,156,000	+9,194,000

IMMEDIATE OFFICE OF THE SECRETARY

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	11,073,000	$0	10,925,000	11,148,000	+ 223
FTE	66	0	69	69	0

FY 2011 Authorization……………………………………………………………Indefinite
Allocation Method…………………………………………………………………Direct Federal

Overview of Budget Request

In FY 2011 the Immediate Office of the Secretary (IOS) budget request will be used to support agency policy direction and effective oversight and management on issues that the Secretary and Health and Human Services (HHS) confront daily in leading more than 300 programs covering a wide spectrum of activities. The FY 2011 budget also supports overseeing the operations and functions of IOS components including: Deputy Secretary's Office, Scheduling and Advance, the Executive Secretariat, and the White House Liaison's Office.

Program Description and Accomplishments

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

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

IOS Narrative by Activity:

- Leads efforts to reform health care across all HHS programs by improving the quality of the health care system and lowering its costs, computerizing all medical records, and

protecting the privacy of patients. In addition, IOS increases the quality of care to all Americans by instituting temporary provisions to make health care coverage more affordable.

- Provides the advisory management and executive leadership essential for the Secretary to manage and direct the myriad of programs in the HHS. This includes the Executive Secretariat which coordinates and facilitates policy decisions within the HHS by ensuring that appropriate decision makers contribute relevant information into the decision making process and policy implementation.

- The IOS Executive Secretariat works with pertinent components to develop comprehensive briefing documents, facilitates discussions among staff and operating divisions, and ensures final products reflect policy decisions.

- Provides assistance, direction, and coordination to the White House and other Cabinet agencies regarding HHS issues.

- Sets the HHS regulatory agenda and reviews of all new regulations and regulatory changes to be issued by the Secretary and performs on-going reviews of regulations which have already been published, with particular emphasis on reducing the regulatory burden.

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

Funding History

FY 2006	$ 8,728,000
FY 2007	$ 9,959,000
FY 2008	$10,728,000
FY 2009	$11,073,000
FY 2010	$10,925,000

Budget Request

The FY 2011 request for IOS is $11,148,000, an increase of $223,000 above the FY 2010 President's Budget request. This increase will help offset increased personnel costs such as: annualization of the January 2010 pay raise; the anticipated January 2011 pay raise; and increases in other services to support achieving the Department's Health Care, Human Services, Scientific Research and Development Strategic Goals. Personnel costs account for 80% of the IOS budget with the remaining 20% allocated for other mission critical operating expenses including Secretarial travel in support of the HHS mission of protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

ASSISTANT SECRETARY FOR ADMINISTRATION

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY2010
BA	$17,390	$0	$18,874	$19,857	+ 983
FTE	116	0	118	118	0

FY 2011 Authorization……….……………………….…………………………..….Indefinite
Allocation Method……………………………………………………………….Direct Federal

Program Description and Accomplishments

Effective December 7, 2009, HHS reorganized the former Office of the Assistant Secretary for Administration and Management (ASAM) to increase the efficiency and effectiveness of the office by consolidating administrative functions under the new Office of the Assistant Secretary for Administration (ASA).

ASA advises the Secretary on all aspects of administration; provides leadership, policy, oversight, supervision, and coordination of long and short-range planning for HHS; and supports the agency's strategic goals and objectives. ASA also provides critical Departmental policy and oversight in the following major areas through its components: the Immediate Office, the Office of Human Resources, the Office of Facilities Management and Policy, the Office of the Chief Information Officer, the Office of Business Management and Transformation, the Office of Diversity Management and Equal Employment Opportunity, and the Program Support Center (which is funded through other sources and not included in this request).

Office of Human Resources (OHR)
OHR provides leadership in the planning and development of personnel policies and human resource programs that support and enhance the Department's mission. OHR also provides technical assistance to the HHS Operating Divisions (OPDIVs) to most effectively and efficiently accomplish the OPDIV's mission through improved planning and recruitment of human resources and serves as the Departmental liaison to central management agencies on related matters.

Office for Facilities Management and Policy (OFMP)
OFMP provides Department-wide leadership and direction in master planning, facilities planning, design and construction, leasing, capital program budget management, space utilization, sustainable buildings, operations and maintenance, environmental and energy management, historic preservation, and occupational health and safety. OFMP is responsible for the HHS Real Property Asset Management program, and in this role provides management oversight across the HHS portfolio of real property assets to ensure appropriate stewardship and accountability is maintained. In addition, OFMP is responsible for the operation of and physical security for the HHS headquarters facility, the Hubert H. Humphrey Building, and oversight of HHS-occupied space in the Southwest Complex of Washington, DC.

OFMP also provides technical assistance to HHS OPDIVs in evaluating the effectiveness of their facilities programs and policies, and fosters creativity and innovation in the administration of these functions.

Office of the Chief Information Officer (OCIO)
OCIO advises the Secretary and the ASA on matters pertaining to the use of information and related technologies to accomplish Departmental goals and program objectives. OCIO establishes and provides assistance and guidance on the use of technology-supported: business process reengineering; investment analysis; performance measurement; strategic development and application of information systems and infrastructure. OCIO issues policies to improve management of information resources and technology and focuses on providing better, more efficient service to OCIO's clients and employees.

OCIO leads the HHS Records Management team and provides policy, processes, and validation of file plans for all HHS OPDIVs. In conjunction with OHR, OCIO provides training for new employees and addresses disposition of records for departing employees. During FY 2009, OCIO completed the segment architecture for records management, establishing an integrated project team to provide a transition plan to consolidate and automate the Department's records processing and retention. HHS met the September 30, 2009 E-Government Act of 2002 deadline, documenting 1,460 IT systems that contain electronic records, 97% of which were successfully scheduled with NARA.

OCIO coordinates activities throughout HHS to implement requirements under the Paperwork Reduction Act (PRA) and the Clinger-Cohen Act, and ensures compliance as HHS implements the Recovery Act. OCIO continues to promulgate HHS IT policies supporting security and enterprise project lifecycle management. OCIO leads the HHS IT CPIC process, through the Office of IT Capital Planning and Investment Control, with an approximate annual portfolio of $6 billion: $3 billion in direct IT expenditures and $3 billion in IT grants to state and local entities. In its leadership role, OCIO coordinates the implementation of CPIC guidance from OMB and the Government Accountability Office (GAO) throughout HHS OPDIVs and ensures the IT investments remain aligned with HHS' strategic goals and objectives and the Enterprise Architecture.

OCIO leads the HHS-wide program for transitioning long-distance telecommunications services from FTS2001, an expiring contract, to the recently-awarded Networx contract. Under the Networx contract, OCIO manages the complete portfolio of telecommunications services across HHS. OCIO is responsible for compliance, service level agreement management, delivery of services, service and access optimization, technology refreshment, interoperability and migration of new services. This reduces redundant OPDIV- level functions and obtains economies of scale through pooling and managing of HHS requirements, usage volumes, and quantity discounts to control costs.

OCIO represents HHS in support of GSA through membership and participation in the Interagency Management Council. Additionally, OCIO staff members act as co-chairs of the OMB-mandated Trusted Internet Connection (TIC) Initiative working group with the intent to bolster IT security across the federal government. OCIO staff members also represent HHS at the Council of Principles

(COP) in support of maintaining critical infrastructure and in support of the Government Emergency Telecommunications System, Telecommunications Service Priority.

Office of Business Management and Transformation (OBMT)
OBMT provides results-oriented strategic and analytical support for key management initiatives and coordinates the business mechanisms necessary to account for the performance of these initiatives and other objectives as deemed appropriate. OBMT also manages the budget and financial resources for the direct support of the ASA, and oversees Department-wide multi-sector workforce management activities. OBMT provides business process reengineering services, including the coordination of the review and approval process for reorganization and delegation of authority proposals that require the Secretary's or designees' signature.

Office of Diversity Management and Equal Employment Opportunity (ODME)
ODME provides leadership in creating and sustaining a diverse workforce and an environment free of discrimination at HHS. ODME works proactively to enhance the employment of women, minorities, veterans, and people with disabilities through efforts that include policy development, oversight, complaint prevention, investigations and processing, outreach, commemorative events, and standardized education and training programs. ODME also provides resource management and equal opportunity service functions for the Department. To accomplish its mission, ODME provides functional oversight and works in collaboration with the Equal Employment Opportunity offices that service each of the Department's OPDIVs. ODME also conducts Department-wide program analysis to determine barriers to diversity and inclusion.

Funding History

FY 2006	$15,644,000
FY 2007	$15,458,000
FY 2008	$16,855,000
FY 2009	$17,390,000
FY 2010	$18,874,000*

*Reflects reorganization of Office of Chief Information Officer into ASA.

Budget Request Overview

The ASA FY 2011 budget request is $19,857,000, an increase of $983,000 over the FY 2010 President's Budget. This increase is needed to cover the mandatory costs of annualization of the January 2010 pay raise and the anticipated 2011 pay raise. Additionally, the increase is needed to administer the newly-established consolidated labor union contract, broaden the Department's diversity outreach initiatives, and support the Department's Real Property Management program.

Additionally, this budget's funding request provides funding for the following programs:

OHR will use increased funding to evaluate and refine workforce and processes to ensure they are integrated with agency budget proposals, employee performance contracts, and organizational restructuring plans; identify business process improvements to support accelerated hiring timeframes; provide oversight and accountability for all ARRA resource investments; and partner

with collective bargaining members to effectively manage the new consolidated bargaining agreement.

OFMP will use additional funding to: support the Department's Real Property Management and Safety programs; allow OFMP to finalize the implementation of Environmental Management Systems across the Department (per EO 13423); provide Departmental oversight and accountability for all HHS real property assets and the facilities capital budget planning and delivery process (per EO 13327); lead the Comprehensive Historic Preservation Program to protect and preserve properties in accordance with the National Historic Preservation Act of 1996, as amended; provide effective oversight of all construction projects including environmental and energy savings analyses to ensure compliance with all National Environmental Policy Act (NEPA) requirements in addition to other appropriate laws and regulations; lead the Department's Occupational Safety and Health Management program; and finalize the implementation of the Safety Management Information System, which supports the Safety and Health Management program.

OCIO will use additional funding to cover the mandatory costs of annualization of the January 2011 pay raise and the anticipated FY 2012 pay raise. Additionally, the increase is needed to support stronger oversight and accountability of the segment architecture for records management for the Department's plan to consolidate and automate its records.

OMBT will use additional funding to support activities that measurably improve HHS' levels of transparency, partnership and collaboration in support of OMB's OpenGov initiative and to participate in strategic programmatic initiatives (e.g., Health Care Reform, Innovation Council) in a value-add capacity, demonstrating sustained effort and engagement in relationship-building across the Department. Additionally, OBMT will use increased funding to hire two fiscal staff to enhance accountability and oversight of the budgetary processes and resources for the STAFFDIV.

ODME will use increased funding to enhance the Department's diversity outreach programs and strengthen recruitment strategies to under-represented populations in the HHS workforce, and to provide technical assistance and coordination with OHR on management and recruitment initiatives, assessment reviews and OPDIV-review processes related to improving diversity and EEO programs. In addition, ODME will provide oversight/technical assistance in connection with Alternate Dispute Resolution (ADR)-EEO programs and collaborate with the Departmental Appeals Board and others to facilitate the use of ADR techniques in the resolution of EEO complaints.

ASSISTANT SECRETARY FOR FINANCIAL RESOURCES

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010 Appropriation
BA	$25,781,000	$0	$26,233,000	$27,877,000	+$1,644,000
FTE*	166	0	176	179	+3

*Includes reimbursable FTE other than SSF

FY 2011 Authorization…..Indefinite
Allocation Method…..Direct federal; Contracts

Program Description and Accomplishments

The Office of the Assistant Secretary for Financial Resources (ASFR) advises the Secretary on all aspects of budget, grants, acquisition and financial management, and provides for the direction of these activities throughout HHS. ASFR also coordinates HHS's implementation and reporting regarding the American Recovery and Reinvestment Act of 2009 (Recovery Act).

In carrying out these functions, the Assistant Secretary has several formal and informal roles, including Chief Financial Officer (CFO), Chief Acquisition Officer, HHS audit follow-up official, and lead official for budget, grants, and reducing improper payments. The Assistant Secretary is also a close advisor to the Secretary on policy issues.

ASFR accomplishes its work through its four component offices:

Office of Recovery Act Coordination (ORAC) - This office is responsible for meeting performance goals and objectives related to the timely and effective implementation of the Recovery Act, and related Executive Orders and Presidential Memoranda. The Recovery Act provided an estimated $141 billion to HHS to support approximately 40 programs managed by eight Operating Divisions (OPDIVs), the Office of the Secretary (OS), and the Office of Inspector General. The Office of Recovery Act Coordination (ORAC) was created in March 2009 using a small cadre of staff detailed from within HHS, which allowed the Office to begin functioning immediately. Since then, ORAC has recruited more full-time staff for continuity and stability in operations.

ORAC is the central HHS office responsible for addressing the transparency and accountability required by the Recovery Act and subsequent Office of Management and Budget (OMB) and Recovery Act Implementation Office (RIO) guidance. ORAC collaborates with the various major business functions across HHS – grants, contracts, budget, finance, information technology, personnel, facilities and environmental quality standards compliance, as well as offices such as the Office of General Counsel and the Office for Civil Rights – to develop special

guidance as necessary to meet these new requirements. ORAC provides leadership for the establishment and reporting of financial and program performance objectives for each supported program grant and contract, and the design and operation of risk management strategies to prevent fraud, abuse, and waste. ORAC also works to develop new procedures to achieve transparency and accountability in the award of Recovery Act funds to States, communities, universities, institutions and individuals, and in the use of funds by award recipients. The Office is also responsible for ensuring that HHS meets the requirements and deadlines established by the Recovery Act in accordance with the guidelines and schedules prepared by OMB, RIO, and the Accountability and Transparency Board.

Office of Budget (OB) – The Office of Budget:

- Manages the preparation of the HHS annual performance budget and prepares the Secretary to present and defend the budget to OMB, the public, the media, and Congressional committees;
- Serves as the HHS appropriations liaison;
- Manages HHS' apportionment activities, which provide funding to the HHS OPDIVs and Staff Divisions (STAFFDIVs);
- Prepares analyses, options, and recommendations on all budget and related policy issues for HHS, and works with OMB and the Congress to accomplish the Secretary's objectives;
- Manages the budget process for OS and the Service and Supply Fund; and
- Manages the implementation of the Government Performance and Results Act (GPRA) and performance improvement activities, including preparing the HHS Performance Highlights and an On-line Performance Appendix, managing OPDIV development of integrated performance budgets, developing and instituting the Program Performance Tracking System, and coordinating performance measurement information and performance management products across HHS.

In FY 2009, in addition to meeting its responsibilities for the annual budget process, OB successfully managed two major budget-related workloads required in response to the H1N1 influenza pandemic and in support of the Recovery Act at HHS (including working with the OPDIVs and STAFFDIVs to develop spend plans and begin implementing new activities and provisions). OB also supported the annual performance budget and other program budget analysis and estimates that occurred throughout the year. The Office met its responsibilities for issuing guidance, providing technical assistance and submitting budget proposals in each of these areas that were high quality and complete in a timely manner. Examples of documents produced in high quality and on-time include the FY 2010 HHS Performance Highlights, On-line Performance Appendix and budget justifications.

Office of Finance (OF) – The OF provides financial management leadership to the Secretary through the CFO and the OPDIV CFOs. In accordance with the CFO Act, OMB Circulars, the Federal Accounting Standards Advisory Board (FASAB) and other Federal financial management legislation, OF manages and directs work in the development and implementation of financial policies, standards and internal control practices (as required by FMFIA and OMB Circular A-123). The OF prepares HHS' annual consolidated financial statements and

coordinates the HHS' financial statement audit. The OF oversees HHS' financial management systems portfolio, and also has business ownership responsibilities for the Unified Financial Management System (UFMS). In addition, the OF has HHS-wide responsibility for ensuring that grantee audit findings (under OMB Circular A-133) are resolved in a timely and appropriate manner. The OF also has responsibility for overseeing the progress in managing the elimination of improper payments (as required by Executive Order 13520, *Reducing Improper Payments and the IPIA*). OF works with the CFO Community, throughout OS, and with OIG to carry out its mission and drive results in these business areas.

Consistent with the Reports Consolidation Act and GPRA, Federal agencies prepare an annual Performance and Accountability Report (PAR), or its alternative, which includes consolidated financial statements, the auditor's opinion and other statutorily required annual reporting. In FY 2009, the OF and OB worked together to complete the third PAR pilot, including the Agency Financial Report, the Agency Performance Report included in the Congressional Budget Justification, and the Citizen's Report on HHS' performance and financial information. For the eleventh consecutive year, HHS earned an unqualified or "clean" opinion on the HHS' audited financial statements. In its efforts to achieve a "clean" opinion in FY 2009, the OF united the CFO community in the development and implementation of corrective action plans. This HHS-wide coordination enabled HHS to eliminate two material weaknesses (Budgetary Accounting and Medicare Claims Processing) in the Auditor's Report on Internal Control for FY 2008 and maintained that status in FY 2009. Another result of this unity was that OF and the OPDIV CFOs developed an HHS CFO Community Strategic Plan. Several of the corrective action initiatives started in FY 2008 continued in FY 2009, and some were completed. These efforts support the HHS' management strategy towards HHS-wide improved financial management.

The OF develops HHS-wide policies and standards for financial and mixed financial system portfolios, including the development and business management of UFMS. UFMS is an integrated financial management system that operates across the OPDIVS and six HHS accounting centers. In FY 2008 and FY 2009, HHS successfully executed its annual financial reporting closing across all HHS OPDIVs. HHS continues its UFMS stabilization efforts and is focusing significant resources to improve the financial management and reporting services across the HHS. The OF is currently working on the development of a Consolidated Reporting tool that will enable the OF to consolidate all reporting from UFMS, the Healthcare Integrated General Ledger Accounting System (HIGLAS), and the NIH National Business System (NBS) more effectively and efficiently. The HIGLAS implementation continues on schedule and HHS is working toward the incorporation of Medicare Parts C and D financial accounting into the system. As one of HHS' six accounting centers, NBS continues its integration of accounting and legacy systems to ensure comprehensive financial management practices.

In connection with its financial management responsibilities, OF coordinates HHS activities related to management initiatives to improve financial management and Eliminate Improper Payments in Federal programs. The OF, in collaboration with the OPDIVs, continues progress toward meeting the criteria for improved financial management.

<u>Office of Grants and Acquisition Policy and Accountability (OGAPA)</u> – In November 2009, HHS reunited its policy offices for grants, acquisition, and small business. The result was the

creation of OGAPA, which provides Department-wide leadership and management in the areas of grants and acquisition management through policy development, performance measurement, oversight and workforce training, development and certification. OGAPA also fosters collaboration, innovation, and accountability in the administration and management of the grants and acquisition functions throughout the Department.

Within the *Division of Grants*, the Office of Grants Policy, Oversight, and Evaluation develops and implements policy and business management mechanisms that foster stewardship and accountability for HHS financial assistance and ensure the Department's resources are managed with integrity to the greatest public benefit. Additionally, the Office for Grants Systems Modernization ensures that HHS fulfils its role as managing partner of Grants.gov and develops and maintains electronic systems, or partners with owners of grants systems outside the agency, to efficiently promote HHS grants policies and maximize Departmental resources in carrying out grants policies. It also coordinates HHS' implementation and reporting regarding the Federal Funding Accountability and Transparency Act (FFATA).

Within the *Division of Acquisition*, the Office of Acquisition Policy develops Department-wide policies governing acquisition activities; publishes and maintains the HHS Acquisition Regulation (HHSAR); manages the Department's training and certification programs; manages the Departmental Contracts Information System (DCIS) and related contract system initiatives; and participates in government-wide acquisition rule-making through the Civilian Agency Acquisition Council. The Office of Acquisition Program Support establishes appropriate acquisition-related internal controls and conducts procurement management reviews; responds to acquisition-oriented GAO and IG audits; leads the Department's Strategic Sourcing and Purchase Card programs; and manages the acquisition aspects of HHS' environmental program.

OGAPA also provides administrative leadership and support to the *Office of Small and Disadvantaged Business Utilization*, which provides Department-wide leadership, strategy, and policy direction for the HHS Small Business Program, as required under Public Law 95-507 (Small Business Act) to: ensure that small businesses receive the opportunity to compete for and receive a fair share of HHS procurement expenditures; establish, manage and track small business goal achievements for the OPDIVs and the Department as a whole; provide technical assistance and Small Business Program training to OPDIV contracting and program officials; and conduct outreach and provide marketing and technical guidance to small businesses on contracting opportunities with HHS.

Funding History

FY 2006	$18,943,000
FY 2007	$20,662,000
FY 2008	$23,162,000
FY 2009	$25,781,000*
FY 2010	$26,131,000**

*Reflects creation of the Office of Recovery Act Coordination.
**Reflects creation of the Office of Grants and Acquisition Policy and Accountability.

Budget Request

The FY 2011 request for ASFR is $27,877,000 and 179 FTE, an increase of $1,644,000 and 3 FTE over the comparable FY 2010 level. This request will allow ASFR to address its increasing responsibilities associated with: improving financial management; expanding e-gov initiatives; improving budget and performance analysis and support; improving grants and acquisition policies and practices, and the transparency of grants and acquisition data; enhancing the budget, acquisition and grants workforce; and eliminating improper payments.

As part of HHS's efforts to support risk mitigation efforts for ongoing HHS activities, these additional resources will also help ASFR keep pace with the increased demands that have been placed upon it by the growth in HHS programs, allowing it to create guidance, policies, and controls crucial to the effective management of HHS programs, and achieve the Administration's accountability, Open Government, and transparency goals. These efforts include improved support for financial reporting and financial controls, more robust budgetary execution controls and performance tracking. The Budget increase also provides critical staff and resources to continue the pivotal responsibility of overseeing and coordinating the implementation of the Recovery Act in HHS. Specific information is included in the sections below.

Office of Recovery Act Coordination (ORAC) – In FY 2011, ORAC will continue its principal functions: coordinating new program funding; measuring program performance, managing quarterly recipient reporting, monitoring agency risk management strategies and collaborating with the Vice President's Recovery Implementation Office, OMB, and other Federal agencies on Recovery Act policy and implementation. By the end of FY 2010, HHS will have obligated approximately 75% of the $141 billion available to it under the Recovery Act, with the remaining 25% ($33 billion) to be awarded and spent in FY 2011 and subsequent years. The primary focus of new program funding will be the Medicaid Federal Medical Assistance Percentage (FMAP) program, and Medicare and Medicaid incentive payments for health information technology.

Program outlays from prior year obligations will also continue in FY 2011, and ORAC will lead HHS efforts to monitor achievement of program performance goals for these programs and measure results. At the same time, more than 20,000 recipients of Recovery Act funds will be submitting required quarterly reports, and ORAC will continue to manage the data quality review of these reports. Finally, ORAC will actively monitor the implementation of agency risk management plans, to identify program, financial and management risks, and actions to mitigate those risks. This will involve working closely with HHS's Office of Inspector General, the Recovery Accountability and Transparency Board, and the GAO.

Office of Budget (OB) – OB will continue to manage the preparation of HHS's annual performance budget, and prepare the Secretary to support the budget to the public, the media, and Congressional committees. OB will also continue to improve the analyses, options, and recommendations on all budget and related policy for HHS, and to work with OMB and the Congress to accomplish HHS priorities. The budget request will also allow OB to continue its other responsibilities associated with GPRA, and to support the Program Performance Tracking System. In addition, the request provides additional funding for staff to address increased

workload requirements and responsibilities, as well as increasing requirements related to the Administration's priorities to employ rigorous standards of accountability and transparency throughout the Federal government.

Office of Finance (OF) – OF's FY 2011 request will provide continued support for financial management and reporting needs under the management initiatives for Improving Financial Management and Eliminating Improper Payments, with specific efforts to resolve outstanding financial statement audit findings, and auditor reported material weaknesses and significant deficiencies. The request will also sustain the implementation of OMB Revised Circular A-123, *Management's Responsibility for Internal Control*. In response to the Executive Order *Reducing Improper Payments and Eliminating Waste in Federal Programs and the Improper Payments Information Act (IPIA)*, OF will continue to support HHS efforts to reduce error rates for all program components under the Eliminating Improper Payments initiative. Using an HHS-wide CFO Community Strategic Plan, OF will continue to work across HHS to address outstanding significant deficiencies and material weaknesses, as identified by management and auditors. The FY 2011 request also supports the extension of OF's role as HHS's central audit liaison, and enables OF to lead the CFO community through the implementation and execution of the requirements of Recovery Act reporting. The OF continues its leadership role for reporting by managing and evaluating new and expanded reporting requirements to be implemented throughout HHS. OF staff will also participate as key members of Recovery Act implementation and execution teams as subject matter experts.

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

The Office of Grants and Acquisition Policy and Accountability (OGAPA) – The Division of Acquisition will continue to standardize and modernize HHS' acquisition processes and expand its oversight and accountability role. Additionally, it will work with the Department's contracting activities to increase the use of full and open competition, reduce the use of high-risk contracting authorities, and increase the appropriate use of performance-based contracts, manage the division of acquisition policy for the Department, and develop and maintain an acquisition career management program, in concert with Government-wide initiatives.

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

The Office of Small and Disadvantaged Business Utilization (OSDBU) will continue to increase HHS's use of mechanisms and programs which maximize opportunities for small businesses. OSDBU will also work to disseminate best practices and policies to ensure that sufficient numbers of small businesses are considered during the procurement process, including those necessary to meet contract needs under the Recovery Act.

ASSISTANT SECRETARY FOR HEALTH
OFFICE OF PUBLIC HEALTH AND SCIENCE
Executive Summary

Agency Overview

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

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

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

Mission

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

Vision

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

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

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

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

Values

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

Put People First

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

Integrity

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

Excellence

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

Diversity

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

Leadership Through Collaboration

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

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

Discussion of Strategic Plan

The following three goals and associated objectives and strategies are the methods to reach the vision. Over the next four years, OPHS leadership will concentrate resources and management efforts on achieving these goals:

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

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

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

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

Discussion of OPHS Performance Plan

Associated with each of the three goals are five objectives:

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

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

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

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

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

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

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

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

Objective B: Communicate Strategically

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

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

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

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

Objective C: Promote Effective Partnerships

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

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

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

Objective D: Build a Stronger Science Base

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

Strategy 1.D.2: Lead, with the United States Department of Agriculture, the promotion and evaluation of evidence-based *Dietary Guidelines for Americans*, which provides information and advice for choosing a nutritious diet that will meet nutrient requirements,

maintain a healthy weight, keep foods safe to avoid food-borne illness, and reduce the risk of chronic disease.

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

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

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

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

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

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

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

Goal 2: Reduce, and ultimately, eliminate health disparities

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

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

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

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

Objective B: Communicate strategically

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

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

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

Objective C: Promote effective partnerships

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

Strategy 2.C.2: Provide technical assistance to minority communities so that they are at the forefront in the fight against HIV/AIDS.

Objective D: Build a stronger science base

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective B: Communicate strategically

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

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

Objective C: Promote effective partnerships

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

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

Objective D: Build a stronger science base

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

Strategy 3.D.2: Educate the broad research community on research integrity to minimize cases of research misconduct and to decrease the number of misconduct cases that go unreported.

Strategy 3.D.3: Ensure that Public Health Reports remains a pre-eminent peer-reviewed journal on public health practice and public health research for healthcare professionals.

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

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

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

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

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

OPHS CJ Performance Measures Table

Program: **Office of Public Health and Science**

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
1.a: Shape policy at the local, State, national and international levels (Outcome)	FY 2009: 32,145 (Target Not Met)	35,000/4	35,192	+192
1.b: Communicate strategically (Outcome)	FY 2009: 40,268,111 (Target Not Met)	41,230,280/5	42,506,365	+1,276,085
1.c: Promote effective partnerships (Outcome)	FY 2009: 1044 (Target Exceeded)	546	580	+34
1.d: Strengthen the science base (Outcome)	FY 2009: 363 (Target Exceeded)	50	78	+28
1.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome)	FY 2009: 1,840 (Target Exceeded)	1,390/6	1,461	+71

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
2.a: Shape policy at the local, State, national and international levels (Outcome)	FY 2009: 328 (Target Exceeded)	98	102	+4
2.b: Communicate strategically (Outcome)	FY 2009: 265,695,094 (Target Exceeded)	2,410,400	2,480,452	+70,052
2.c: Promote Effective Partnerships (Outcome)	FY 2009: 623 (Target Exceeded)	136	200	+64
2.d: Strengthen the science base (Outcome)	FY 2009: 197 (Target Exceeded)	60	65	+5

4/OPHS has consistently not met this target. We are changing our target to keep it more in line with our actual performance.
5/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, OPHS 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.
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.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
2.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome)	FY 2009: 549 (Target Exceeded)	70	75	+5

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
3.a: Shape policy at the local, State, national and international levels (Outcome)	FY 2009: 3,575 (Target Exceeded)	951/7	981	+30
3.b: Communicate strategically (Outcome)	FY 2009: 1,568,751 (Target Exceeded)	1,615,473	1,630,480	+15,007
3.c: Promote Effective Partnerships (Outcome)	FY 2009: 486 (Target Exceeded)	40	41	+1
3.d: Strengthen the science base (Outcome)	FY 2009: 7,512 (Target Exceeded)	1,103	1,595	+492
3.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome)	FY 2009: 3,149 (Target Not Met but Improved)	4,600/8	4,669	+69

Program: ADOLESCENT FAMILY LIFE

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
2.1.1: Increase communication among parents and adolescents on topics relating to puberty, pregnancy, abstinence, alcohol, and/or drugs. (Outcome)	FY 2008: 43% (Target Not Met but Improved)	51%	N/A	N/A
2.1.2: Increase adolescents' understanding of the positive health and emotional benefits of abstaining from premarital sexual activity. (Outcome)	FY 2008: 57.5% (Target Not Met but Improved)	80%	N/A	N/A

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

7/OSG is the greatest contributor for this measure. They have increased their target as a result of prior performance.
8/OPHS has consistently not met this target. We are changing our target for this measure to be more realistic with our progress in this area.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
2.2.1: Maintain the incidence of clients in AFL Care demonstration projects who do not have a repeat pregnancy. (Outcome)	FY 2008: 90% (Target Not Met)	92%	92%	Maintain
2.2.2: Increase infant immunization among clients in AFL Care demonstration projects. (Outcome)	FY 2008: 65% (Target Not Met)	82%	84%	+2
2.2.3: Increase the educational attainment of clients in AFL Care demonstration projects. (Outcome)	FY 2008: 79% (Target Exceeded)	74%	76%	+2

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	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
2.3.1: Improve the quality of the Title XX prevention independent evaluations. (Outcome)	FY 2008: 48.5% (Target Exceeded)	44%	N/A	N/A
2.3.2: Improve the quality of the Title XX care independent evaluations. (Outcome)	FY 2008: 55.5% (Target Exceeded)	58.8%	63%	+4.2

Long Term Objective: **Improve the efficiency of the AFL program.**

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
2.4.1: Sustain the cost to encounter ratio in Title XX prevention programs. (Outcome)	FY 2008: $25 (Target Exceeded)	$29	N/A	N/A
2.4.2: Sustain the cost to encounter ratio in care demonstration projects. (Outcome)	FY 2008: $72 (Target Exceeded)	$110	$110	Maintain

Program: **OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION**

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
I.a: Awareness of Dietary Guidelines for Americans (will be measured at least two times between 2005 and 2010) (Outcome)	FY 2007: 45% (Target Exceeded)	49%	51%	+2

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
I.b: Visits to ODPHP-supported websites (Output)	FY 2008: 15.029 Million (Target Exceeded)	15.75 Million	16 Million	+0.25
I.c: Consumer Satisfaction with healthfinder.gov, measured every three years at a minimum (Output)	FY 2008: 75% (Target Not Met)	80%	N/A	N/A
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 2008: 92% (Target Exceeded)	98%	N/A/9	N/A

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	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
II.a: Percentage of States that use the national disease prevention and health promotion objectives in their health planning process (Outcome)	FY 2009: 100% (Target Exceeded)	98%	99%	+1
II.b: Increase the percentage of Healthy People 2010 objectives that have met the target or are moving in the right direction (Outcome)	N/A	60.0%	N/A	N/A

Program: **OFFICE OF MINORITY HEALTH**

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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 2009: 7,312 (Baseline)/10	7,531/11	7,757/12	+226

9/This measure will no longer be relevant in FY2011 as all of the HP 2010 Progress reviews will have been completed.
10/In April 2009, the Uniform Data Set (UDS) -- OMH's initial online data system for collecting grantee activity data in support of this measure -- 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. OMH has aggressively pursued corrective action in this regard which has resulted in the need to 'reset' the baseline and annual targets to reflect more realistic efforts and expectations. Also see footnote for FY 2009 baseline.
11/See footnote under baseline for FY 2009.
12/See footnote under baseline for FY 2009.

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	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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 2007: 66.4% (Historical Actual)/13	68.6%	N/A	N/A

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
4.2.1: Increased awareness of racial and ethnic health status and health care disparities in the general population (1999 Baseline: 47.5%) (Outcome)	FY 2009: 52.5% (Target Exceeded)/14	52.8%	53.8%	+1

Program: **OFFICE ON WOMEN'S HEALTH**

Long Term Objective: **Advance superior health outcomes for women**

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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 2007: 69.5% (Target Exceeded)	74.0%	N/A	N/A
: 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)	N/A	N/A	N/A	N/A

13/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.

14/This is the preliminary result of OMH's first annual general household survey of the public's awareness of racial/ethnic health status and health care disparities. OMH is in the process of reviewing the draft final report and planning for official release of the study results.

Long Term Objective: **Increase heart attack awareness in women**

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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 2007: 65.8% (Target Exceeded)	70.0%	72.5%	+2.5

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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 2008: 31,600,000 user sessions (Target Exceeded)	32,000,000 user sessions	33,000,000 user sessions	+1,000,000

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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 sites, and outreach) per million dollars spent annually. (Efficiency)	FY 2008: 1,191,580 (Target Exceeded)	1,321,838	1,427,667	+105,829

Program: **Commissioned Corps: Readiness and Response Program**

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
6.1.1: Increase the percentage of Officers that meet Corps readiness requirements, thus expanding the capability of the individual Officer. (Outcome)	FY 2009: 94.4% (Target Exceeded)	92.5%	95%	+2.5
6.1.2: Increase the percentage of Officers that are deployable in the field, thus expanding the capability of the Corps. (Baseline - 2005: 40%) (Outcome)	FY 2009: 79.4% (Target Exceeded)	80%	82.5%	+2.5

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
6.1.3: Increase the percent of individual responses that meet timeliness, appropriateness, and effectiveness requirements.(Baseline - 2007: 77%) (Outcome)	FY 2009: 92.5% (Target Exceeded)	92.5%	95%	+2.5
6.1.4: Increase the percent of team responses that meet timeliness, appropriateness, and effectiveness requirements.(Baseline - 2007: 89%) (Outcome)	FY 2009: 95% (Target Met)	97.5%	98%	+0.5
6.1.5: Increase the number of response teams formed, thus enhancing the Department's capability to rapidly and appropriately respond to medical emergencies and urgent public health needs. (Baseline - 2005: 0) (Outcome)	FY 2009: 41 (Target Exceeded)	36	40	+4
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 2009: 21 (Target Exceeded)	26	36	+10
6.1.7: Cost per Officer to attain or maintain readiness requirements. (Efficiency)	FY 2009: $91.14 (Target Exceeded)	$100	$100	Maintain

Program: **HIV/AIDS IN MINORITY COMMUNITIES**

Long Term Objective: **Long-Term Outcome Goals**

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
7.1.1: Increase the number of ethnic and racial minority individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2008: 83% (Target Not Met)	87.75%	88%	+0.25
7.1.2: Reduce the percentage of AIDS diagnosis within 12 months of HIV diagnosis among racial and ethnic minority communities (Outcome)	FY 2008: 38% (Target Exceeded)	35.25%	34.75%	-0.5
7.1.3: Reduce the rate of new HIV infections among racial and ethnic minorities in the United States (Outcome)	FY 2007: 47.2% (Target Exceeded)	46%	43.7%	-2.3
7.1.4: Increase the number of African American individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2008: 79% (Target Not Met)	88%	89%	+1

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
7.1.5: Increase the number of Hispanic individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2008: 85% (Target Not Met)	90%	91%	+1
7.1.6: Increase the number of Asian/Pacific Island individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2008: 89% (Target Exceeded)	93%	94%	+1
7.1.7: Increase the number of American Indian/Alaskan Native individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2008: 73% (Target Not Met)	80%	81%	+1
7.1.8: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among African American communities (Outcome)	FY 2008: 35% (Target Exceeded)	34%	33%	-1
7.1.9: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Hispanic communities (Outcome)	FY 2008: 41% (Target Not Met but Improved)	38%	37%	-1
7.1.10: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Asian/Pacific Islander communities (Outcome)	FY 2008: 38% (Target Exceeded)	35%	34%	-1
7.1.11: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among American Indian/Alaskan (Outcome)	FY 2008: 38% (Target Met)	36%	35%	-1
7.1.12: Increase the number of individuals who learn their HIV status for the first time through MAI Fund programs (Outcome)	FY 2008: 147,726 (Target Not Met but Improved)	167,662	178,537	+10,875
7.1.13: Maintain the actual cost per MAI Fund HIV testing client below the medical care inflation rate (Efficiency)	FY 2007: $88 (Target Exceeded)	$101.71	$105.3/15	+3.59
7.1.14: Maintain the actual cost per MAI Fund physician and other clinical staff trained below the medical care inflation rate (Efficiency)	N/A	$1,670.78	$1,713.02	+42.24

15/This target is premature and tentative.

Office of Public Health and Science
Summary Table
(Dollars in Thousands)

Program	FY 2009 Appropriation		FY 2010 Appropriation		FY 2011 President's Budget Reqeust	
	FTE	AMOUNT	FTE	AMOUNT	FTE	AMOUNT
GDM Appropriation						
Immediate Office	45	8,820	49	9,495	49	10,685
Office of HIV/AIDS Policy	6	930	6	929	6	1,276
Adolescent Family Life	12	29,778	12	16,658	8	16,658
Office of Disease Prev & Hlth Promo	23	7,232	23	7,200	23	7,929
Pres Council on Physical Fitness & Sports	6	1,228	6	1,225	6	1,235
Office of Minority Health	62	52,956	63	56,000	63	57,980
Office on Women's Health	43	33,746	43	33,746	43	33,746
Office for Human Research Protections	33	6,959	33	6,949	33	7,007
National Vaccine Program Office	17	6,879	17	6,839	17	7,561
Public Health Reports	2	450	2	448	2	452
Commissioned Corps	31	14,813	31	14,813	23	13,513
Office of Adolescent Health	---	---	3	500	4	750
Teen Pregnancy Prevention	---	---	12	110,000	16	129,218
Mandatory Grants to States (TPP)	---	---	---	---	---	50,000
Federal Employee Health and Wellness Initiative	---	---	---	---	---	10,000
Accountability	---	---	---	---	---	103
Subtotal, GDM	**280**	**$163,791**	**300**	**$264,802**	**293**	**$348,113**
GDM Reimbursable:						
Office of Research Integrity	23	[8,909]	24	[9,118]	24	[9,709]
Other	31	---	32	---	32	---
Subtotal, Other GDM	**54**	**$0**	**56**	**$0**	**56**	**$0**
TOTAL	**334**	**$ 163,791**	**356**	**$264,802**	**349**	**$348,113**
PHS Evaluatin Set-Aside;non add						
OPHS		*[4,010]*		*[4,510]*		*[4,510]*
Teen Pregnancy Prevention		*---*		*[4,455]*		*[4,455]*
Subtotal, PHS Evaluation Set-Aside		*[4,010]*		*[8,965]*		*[8,965]*

OPHS
IMMEDIATE OFFICE

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$8,820,000	$0	$9,395,000	$10,685,000	+$1,190,000
FTE	45	0	49	49	0

Authorizing Legislation…………….....…Title III, Section 301 of the Public Health Service Act
FY 2011 Authorization………………..…………………………………………….Indefinite
Allocation Method…………………………………………………………...Direct Federal

Program Description and Accomplishments

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

The Immediate Office directly supports several key HHS priorities, such as obesity prevention, pandemic preparedness, health care reform, and tobacco cessation. The Immediate Office of the ASH ensures a public health perspective on all Secretarial and Presidential priorities. The ASH provides leadership to and oversight of the OPHS policy/program offices as they implement their programs and other HHS and Presidential priorities.

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

OPHS, as part of its responsibility to help employ the HHS Pandemic Influenza Implementation Plan, leads interagency groups focused on antiviral drug use strategies, vaccine prioritization strategies, and surveillance of Influenza A/H5N1 and H1N1.

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

- In mid-2008, the OPHS convened a departmental workgroup on individuals with multiple chronic conditions. This workgroup currently has approximately 30 representatives from nearly all HHS operating divisions participating on a senior level. The first major effort of the workgroup was an inventory of existing HHS programs, activities, and initiatives related to MCC, which was released by the Department in March 2009, and contains over 50 current efforts across HHS. The workgroup is now engaged in determining areas of synergy between existing initiatives as well as discussing the implementation and evaluation of new programs, activities, and initiatives throughout HHS divisions to improve the health status of this population.
- The Surgeon General's Call to Action to Promote Healthy Homes at a press conference on June 9, 2009. The Call to Action looks at the ways housing can affect health; its release will initiate a national dialogue about the importance of healthy homes. The Call to Action also highlights the need for research that links housing conditions with specific health outcomes and highlights the impact of disparate access to safe, healthy, affordable, and accessible homes.
- The HHS Steering Committee for the Prevention of Healthcare-Associated Infections was established in July 2008. The Steering Committee, lead by the Immediate Office of the ASH, was charged with developing a comprehensive strategy to prevent and reduce healthcare-associated infections and issuing a plan which outlines key actions for achieving identified short- and long-term objectives. The plan is also intended to enhance collaboration with external stakeholders to strengthen coordination and impact of national efforts.
- The Office of the Surgeon General created multiple public service announcements and statements in regards to the recent H1N1 influenza virus outbreak. The Acting Surgeon General appeared on television news stations to discuss the virus and provide advice on what the public can do to prevent the spread of the virus, such as washing their hands with soap and water, staying informed through CDC.gov, and encouraging people to follow the instructions of their local public health department.
- ODPHP is drawing on the expertise of a Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 developing the next iteration of *Healthy People*. Public participation will shape *Healthy People 2020*, its purpose, goals, organization, and action plans.
- The U.S. Surgeon General's Family History Initiative's new interoperable and standardized *My Family Health Portrait* tool was release in January 2009. This initiative encourages all Americans to know their family health history, and share it with their clinicians as a prevention screening tool.

Funding History

FY 2006	$8,131,000
FY 2007	$8,165,000
FY 2008	$7,927,000
FY 2009	$8,820,000
FY 2010	$9,495,000

Budget Request

The FY 2011 request is $10,685,000, an increase of $1,190,000 above the FY 2010 Appropriation level. The FY 2011 Request will allow the ASH to maintain and expand its cadre of senior public health staff to implement new programs addressing public health issues such as obesity, chronic disease prevention and communicating information on emerging public health activities. In FY 2011, the ASH will also work on addressing health disparities among special populations.

Under the leadership and coordination of the ASH, HHS will set the standard for reducing obesity by developing a National Strategic Plan. More than one third of the United States, over 72 million Americans, is obese. Health care costs attributable to obesity are approximately $80 billion. This epidemic transcends to children and adolescents as over 17 percent of children ages 2-19 are overweight. Reducing obesity will require concerted action across government, academia, community-based organizations, schools, foundations, and the private sector. To accelerate and leverage progress, the ASH will lead a coordinated and comprehensive national strategy for reducing obesity that is needed and reflects input directly from communities, including evidence-based policy and programmatic strategies for implementation, and establishing goals with measurable interim targets to benchmark progress.

OPHS
NATIONAL VACCINE PROGRAM OFFICE

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$6,879,000	$0	$6,839,000	$7,561,000	+722,000
FTE	17	0	17	17	0

Authorizing Legislation……………………………….Title XXI of the Public Health Service Act
FY 2011 Authorization……..……………………..…………………………………......Expired
Allocation Method……………………..…..…………………………………Direct Federal; Contracts

Program Description and Accomplishments

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

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

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

- *Updating the National Vaccine Plan.* The National Vaccine Plan identifies priority activities to improve the safety and effectiveness of disease prevention through immunization. NVPO is coordinating the revision of the Plan (initially published in 1994) with all relevant agencies and offices in HHS, and with the Departments of Defense and Veterans Affairs, and the U.S.

Agency for International Development. Input is also being obtained from the Institute of Medicine, interested stakeholders, and the general public.

- *Coordination and Enhancement of Immunization Safety.* In April 2008, the Secretary formed a cross-government, Federal Immunization Safety Task Force. The Task Force includes HHS Agencies with assets in immunization safety (NIH, FDA, CDC, HRSA, CMS, IHS) and VA and DoD. The dual goals of this Task Force report are to: 1) enhance federal scientific capacity to detect, understand, and prevent adverse events following immunization; and 2) enhance communications and maintain public confidence in vaccines through sound science, trust and transparency.
- *Pandemic Influenza Preparedness.* NVPO provides scientific direction to HHS pandemic influenza planning and preparedness activities coordinating with the Office of the Assistant Secretary for Preparedness and Response (ASPR), HHS OPDIVS, and other Federal agencies. Key activities include developing national guidance on prioritization of pandemic and pre-pandemic influenza vaccines, guidance on antiviral drug use strategies, and coordination in updating the HHS pandemic influenza preparedness and response plan.
- *National Vaccine Advisory Committee*. NVPO serves as Executive Secretariat for the National Vaccine Advisory Committee (NVAC) which advises and makes vaccine-related recommendations to the Assistant Secretary for Health. NVAC meets at a minimum of three times per year and is funded through the NVPO budget.
- *Strategic Issues in Vaccine Research (SIVR) Program.* NVPO's *Strategic Issues in Vaccine Research* (SIVR) program meets the needs that emerge outside of traditional budget cycles and to initiate and stimulate priority vaccine and immunization-related projects. SIVR has led to significant advances in vaccine safety, development and use while building capacity within HHS and leveraging agency resources to support follow-on activities.

Funding History

FY 2006	$7,004,000
FY 2007	$6,980,000
FY 2008	$6,781,000
FY 2009	$6,879,000
FY 2010	$6,839,000

Budget Request

The FY 2011 request is $7,561,000, an increase of $722,000 above the FY 2010 Appropriation level. The increase provides funds for staff pay increases and enables the continued support of the existing projects such as:

- Coordinate and integrate activities of all Federal agencies involved in vaccine and immunization efforts such as: minimizing gaps that may exist in Federal planning of vaccine and immunization activities; developing and implementing strategies for prevention of human diseases through immunization and prevention of adverse reactions to vaccines;
- Enhance interagency collaboration, so that vaccine and immunization-related activities are carried out in an efficient, consistent, and timely manner. NVPO uses the monthly Flu Risk Management Meeting (FRMM) and weekly Departmental Influenza Conference

- Contribute to pandemic preparedness by finalizing national guidance on the use of medical countermeasures, supporting other vaccine and pandemic preparedness initiatives, and coordinating an update of the HHS Pandemic Influenza Preparedness and Response Plan;
- Complete the Revised National Vaccine Plan;
- Enhance the effectiveness and value of NVAC by supporting their efforts in authoring timely and topical recommendations on critical vaccine policy issues; and
- Assess, evaluate, and fund *Strategic Issues in Vaccine Research* (SIVR) projects. SIVR also will support NVPO goals through the support of public engagement activities to enhance understanding of public values and perspectives on vaccine safety and the vaccination program, improving decision making and program acceptability.

OPHS
OFFICE OF ADOLESCENT HEALTH

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 + / - FY 2010
BA	$0	0	$500.000	$750,000	+$250,000
FTE	0	0	3	4	+1

Authorizing Legislation………………………..Section 1708 of the Public Health Service Act
Allocation Method……………………………. . Direct federal, Competitive Grants, Contracts

Program Description and Accomplishments

The Office of Adolescent Health (OAH) is responsible for coordinating activities of the Department with respect to adolescent health, including coordinating program design and support, evaluation, trend monitoring and analysis, research projects, and training of healthcare professionals. The Office is charged with carrying out demonstration projects to improve adolescent health as well as implementing and disseminating information on adolescent health. OAH will coordinate the efforts of other HHS agencies to reduce the health risk exposure and behaviors among adolescents. OAH will place particular emphasis on the most vulnerable populations, those in low socio-economic areas and areas where adolescents are likely to be exposed to emotional and behavioral stress that can lead to substance abuse. OAH will coordinate with HRSA, SAMHSA, CMS, and CDC to design evidence based approaches to prevent the onset of mental and behavioral disorders.

The Office is also responsible for implementing and administering a new discretionary grant program to support evidence-based teen pregnancy prevention approaches. The OAH will coordinate its efforts with other HHS offices and operating divisions to make competitive grants and contracts to public and private entities to fund medically accurate and age appropriate programs that reduce teenage pregnancy.

Funding History

FY 2010 $500,000

Budget Request

The FY 2011 request is $750,000, an increase of $250,000 above the FY 2010 Appropriation level. Funds will be used to expand the OAH's coordinating role with respect to adolescent health by adding staff that have expertise in dealing with the health problems that emerge during adolescence that have negative impact on the physical and mental well being of adults.

OPHS
OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$7,232,000	$0	$7,200,000	$7,929,000	+$729,000
FTE	23	0	23	23	0

Authorizing Legislation……..……..…………Title XVII, Section 1701 of the PHS Act
FY 2011 Authorization……………………...………………………………….Expired
Allocation Method……………………Direct Federal, Contract, and Cooperative agreement

Program Description and Accomplishments

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

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

Healthy People
ODPHP meets its Congressional mandate to establish health goals for the Nation by leading the development and implementation of *Healthy People* on behalf of the Department. *Healthy People 2010* underpins many of HHS' programs and strategic planning efforts and provides a framework for prevention and wellness programs for a diverse array of stakeholders.

Through measurable, evidence-based objectives, *Healthy People* provides a framework for programs necessary to achieve the vision of a healthier nation. The objectives are designed to drive action and represent an opportunity for individuals to make healthy lifestyle choices; for health professionals to put prevention into practice; for policy makers, communities and businesses to support health-promoting policies in schools, worksites and other settings; and for scientists to pursue new research.

In FY 2009, the charter for the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 was renewed for another two years. The independent, voluntary, 13-member Federal advisory committee is charged with providing to the Secretary advice regarding the process of developing and implementing national health promotion and disease prevention goals and objectives for 2020. In late FY 2009, the Secretary approved the framework for Healthy People 2020, marking the completion of Phase I of the development process. The framework represents the culmination of a 2-year process that drew on input and expertise from both Federal and nonfederal stakeholders. Phase II of the development process includes identification of specific health objectives, their implementation strategies and the creation of a user-centered Web resource. The proposed objectives were released for public comment via the Internet in early FY2010.

In FY 2009, ODPHP and the Office of the Assistant Secretary for Planning and Evaluation completed an assessment of state, local and tribal users of Healthy People. The study examined relevant issues such as: who is using *Healthy People 2010*, how and why they are using it, to what extent respondents view it as contributing to their own disease prevention and health promotion efforts, and what are obstacles to its use. The assessment updates findings from a 2005 assessment of the efficacy of *Healthy People 2010,* provides trend information about awareness and use of *Healthy People 2010,* and assesses the impact of outreach efforts that HHS and its partners undertook after the earlier study. In addition, the findings of this study are informing the development of *Healthy People 2020.*

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

Dietary Guidelines for Americans

ODPHP plays a leadership role in co-coordinating the development, review and promotion of the recommendations from the *Dietary Guidelines for Americans* (DGAs). Published jointly every five years by HHS and the U.S. Department of Agriculture (USDA), the DGAs are the basis of Federal nutrition policy and programs. Based on the latest scientific evidence, the DGAs provide information and advice for choosing a nutritious diet that will meet nutrient requirements, maintain a healthy weight, keep foods safe to avoid food-borne illness, and reduce the risk of chronic disease. ODPHP is and will be coordinating with other HHS offices/agencies and other departments to develop communications, educational information and resources that are research-tested, audience-appropriate, actionable, and consistent with the DGAs.

ODPHP is focusing its resources on nutrition outreach efforts that are based on results of consumer research that provides data on health literacy principles in communicating nutrition

information. Communication of information that is understandable and actionable is critical not only in increasing awareness but also in effecting behavior change related to diet.

The DGAs are informed in part by the Dietary Reference Intakes (DRIs), a system of nutrition recommendations from the Institute of Medicine (IOM) of the US National Academy of Sciences. The DRI system is used by the general public and health professionals in the United States and Canada in the following applications:

- Composition of diets for schools, prisons, hospitals or nursing homes
- Industries developing new food products
- Healthcare policy makers and public health officials

ODPHP continues its leadership role in the development and review of the DRIs by co-sponsoring nutrition-related studies by the Institute of Medicine (IOM). Data from these studies provide critical information to strengthen the science base of disease prevention and health promotion efforts for the Department.

Physical Activity Guidelines for Americans
ODPHP played a leadership role in the Department's development and release of the first-ever Federal comprehensive Physical Activity Guidelines (PAGs), a set of evidence-based recommendations for types and amounts of physical activity for individuals ages 6 years and older to improve health and reduce disease. The Guidelines were released in FY 2009, as coordinated by ODPHP and in collaboration with the President's Council on Physical Fitness and Sports (PCPFS), the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC). In FY 2009, ODPHP focused on outreach by releasing a toolkit containing information for communities, organizations, and other stakeholders to implement recommendations from the PAGs and by coordinating and managing the online Physical Activities Supporters Network, which has over 3,500 members. In addition, ODPHP initiated the policy process which established the PAGs as the basis for consumer information developed by the Department related to physical activity, and ODPHP coordinates the Physical Activity Guidelines – HHS Review Team. This team of physical activity experts from PCPFS, NIH and CDC reviews all consumer materials related to physical activity that are published within HHS to ensure that materials are consistent with the evidence-based messages of the PAGs. ODPHP continues to promote the PAGs through a variety of creative mechanisms, including a PAG widget, PAG blog, and scientific presentations in multiple venues and will continue these efforts in FY 2010 and FY 2011. In addition, ODPHP plans to increase the reach of PAGs by developing consumer information for the Hispanic population as well as populations with limited health literacy.

Disease Prevention and Health Promotion Scholarship
The goal of this initiative is to advance prevention/public health education, research, knowledge and application in health promotion and disease prevention - two basic tenants of prevention and public health - for students, medical residents, practicing physicians, and other health professionals. Funded by ODPHP through a five-year competitive cooperative agreement, the Scholarship Program supports the Luther Terry Fellowship, health policy fellowships, residency rotations for preventive medicine/primary care residents, ODPHP Visiting Scholars Program and Paul Ambrose Health Promotion Student Leadership Symposium; supports opportunities for

outreach to and input from stakeholders on Healthy People and other ODPHP and departmental national initiatives; and facilitates opportunities for other departmental prevention education initiatives. ODPHP has had twelve Luther Terry Fellows since the inception of the program. The ODPHP-APTR Health Policy Fellows Program has provided six health policy fellowships of one-to-two years' duration for public health professionals to support ODPHP teams and initiatives and gain education and experience in health policy development. ODPHP hosts approximately 6 resident physicians and eight Visiting Scholars per year. In addition 40-50 health professionals-in-training participate in the Ambrose Symposium each year.

Health Communication and eHealth
ODPHP is congressionally mandated to provide reliable prevention and wellness information to the public through the National Health Information Center (NHIC). NHIC supports all ODPHP Web sites including Health.gov, Healthy People.gov and healthfinder.gov, the federal government's award-winning prevention and wellness website. In FY 2009, ODPHP more than doubled the number of topics and tools available through the *Quick Guide* including adding new sections for parents and older adults and started the research and development process for a Spanish-language *Quick Guide to Healthy Living* in FY 2009. Healthfinder.gov is also expanding its reach through new media tools such as Twitter, e-Cards, and the ability to syndicate content on partner web sites.

In FY 2009, the NHIC completed the development of an eLearning Prototype to encourage information sharing and learning with and among the professionals and intermediaries served by ODPHP. The goal is to empower professionals and information intermediaries at all levels and across multiple disciplines to work collaboratively and to learn how to communicate with their constituencies more effectively about prevention. ODPHP used a user-centered methodology in developing the eLearning Prototype, which incorporates usability, plain language, and accessibility principles. This Prototype will be Beta tested during 2010 to support priority ODPHP initiatives.

In support of Healthy People 2020, ODPHP collaborated with the CDC and the Office of National Coordinator (ONC) for Health IT to envision how health communication, health literacy and health IT can be integrated into the *Healthy People 2020* framework. This leadership team coordinates the efforts of over 60 experts in health communication and health IT across the Federal government as well as experts in the private sector. This group is currently providing guidance to the Federal Interagency Advisory Group for *Healthy People 2020* on the potential impact of health communication and health IT upon the determinants of health. Leaders at institutions - such as Google, Intel, and Cisco - shared their insights on current and future technological trends, addressing how advances in health IT and health communication can impact and improve health disparities and health literacy.

ODPHP coordinates a broad-based effort in HHS to improve health literacy for all Americans. ODPHP, along with CDC, co-chairs the HHS Health Literacy Workgroup that meets every two months to share information and to identify opportunities for collaboration and coordination. The goal of the workgroup is to encourage the incorporation of health literacy in Department research, program operations, and communication with the public. In FY 2009, science-based

information and promising practices were compiled to produce a National Action Plan on Improving Health Literacy.

Funding History

FY 2006 $7,330,000
FY 2007 $7,305,000
FY 2008 $7,106,000
FY 2009 $7,232,000
FY 2010 $7,200,000

Budget Request

The FY 2011 request is $7,929,000, an increase of $729,000 above the FY 2010 Appropriation level. Funds will support increased pay costs and will maintain the continued development, coordination, and outreach for several activities including *Healthy People 2020*, *Dietary Guidelines for Americans 2010*, *Physical Activity Guidelines for Americans*, health communication and eHealth activities, and training for public health and prevention policy professionals. These programs all focus on preventing disease, improving the health of individuals and communities, reducing and ultimately eliminating health disparities, and promoting effective, sustainable, and consistent public health systems, that is, on achieving the goals of the Office of Public Health and Science.

Healthy People 2020

In FY 2011, an increase of $583,000 will allow ODPHP to complete the development of and launch *Healthy People 2020* through the development of an online version of Healthy People 2020. The new integrated, user-centered Healthy People 2020 web presence will offer: a relational database integrating objectives with evidence-based practices and demographic data, which will make implementation significantly more targeted and actionable; community planning tools designed by and for Healthy People 2020 stakeholders seeking to establish and maintain health promotion and disease prevention programs at all levels; an up-to-date library of best and promising practices to improve outcomes; an online collaborative workspace designed by and for Healthy People 2020 stakeholders, across disciplines and geographic locations, to network, learn and plan together; a suite of social media tools designed to help Healthy People stakeholders take advantage of the latest, most effective communication and ehealth practices.

Outputs and Outcomes

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
1.1: Number of clients served. *(Outcome)*	FY 2007: 88,000 (Target Exceeded)	89,000	99,000	+10,000
Long Term Objective: Communicate strategically by increasing the reach of ODPHP disease prevention and health promotion information and communications				

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
I.a: Awareness of Dietary Guidelines for Americans (measured at least two times between 2005 and 2010) *(Outcome)*	FY 2007: 45% (Target Exceeded)	N/A	N/A	N/A
I.b: Visits to ODPHP-supported websites *(Output)*	FY 2008: 15.029 Million (Target Exceeded)	15.75 Million	16 Million	+0.25
I.c: Consumer Satisfaction with healthfinder.gov, measured every three years at a minimum *(Output)*	FY 2008: 75% (Target Not Met)	80%	N/A	N/A
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 2008: 92% (Target Exceeded)	98%	N/A[1]	N/A
Long Term Objective: Shape prevention policy at the Local, State and National level by establishing and monitoring National disease prevention and health promotion objectives				
II.a: Percentage of States that use the national disease prevention and health promotion objectives in their health planning process *(Outcome)*	FY 2005: 96% (Target Exceeded)	98%	99%	+1
II.b: Increase the percentage of Healthy People 2010 objectives that have met the target or are moving in the right direction *(Outcome)*	FY 2005: 42.2% (Baseline)	60.0%	N/A	N/A
Program Level Funding ($ in millions)		$7.200	$7.929	$.729

[1] This measure will no longer be relevant in FY2011 as all of the HP 2010 Progress reviews will have been completed.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION
Program Data

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request
PREVENTION FRAMEWORK:			
Healthy People, Dietary Guidelines for Americans, Physical Guidelines for Americans	$455,800	$455,800	$1,038,800
PREVENTION COMMUNICATION:			
National Health Information Center	1,658,000	1,658,000	1,658,000
Communication Support	700,000	700,000	700,000
SCIENCE:			
Disease Prevention and Health Promotion Scholarship Program	400,000	400,000	400,000
OPERATING EXPENSES:			
Operating Costs	4,018,200	3,986,200	4,132,200
TOTAL	$7,232,000	$7,200,000	$7,929,000

OPHS
OFFICE OF HIV/AIDS POLICY

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$930,000	$0	$929,000	$1,276,000	+$347,000
FTE	6	0	6	6	0

Authorizing Legislation………..…Title III, Section 301 of the Public Health Service Act
FY 2011 Authorization………………………………………………………...Indefinite
Allocation Method……………………………………………….……..Direct Federal

Program Description and Accomplishments

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

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

OHAP continues to provide leadership for the Minority AIDS Initiative (MAI) programs and activities. OHAP directs and provides administrative support to the MAI Steering Committee for Evaluation and Implementation. OHAP provides leadership to the Department's HIV Executive Coordination and Planning Group (HECPG), which is comprised of principals from all of the HHS agencies with key HIV/AIDS portfolios. Following a program assessment, OHAP began a comprehensive evaluation and assessment of the MAI Fund, a subset of programs and activities under the MAI. OHAP completed and submitted to OMB an inventory of all MAI supported programs and activities. With proposed additional funding for the MAI Fund DHHS will be able to significantly expand HIV testing and education efforts at 10 or more minority serving institutions of higher learning, including HBCU campuses. OHAP will continue its efforts to encourage and support further collaborations and partnership among DHHS agencies and offices.

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

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

In addition, AIDS.gov which is managed by OHAP is now the premier information gateway for Federal domestic HIV/AIDS information and resources. AIDS.gov provides basic HIV/AIDS information and drives traffic to individual agency websites and resources—supporting the Department's HIV prevention, testing, and treatment objectives and improving access to Federal information about HIV/AIDS. AIDS.gov also provides training and information to Federal colleagues, state and local health departments, and AIDS service organizations on using new media in response to HIV/AIDS.

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

Funding History

FY 2006	$932,000
FY 2007	$930,000

FY 2008 $904,000
FY 2009 $930,000
FY 2010 $929,000

Budget Request

The FY 2011 Request Level is $1,276,000, and increase of $347,000 above the FY 2010 Appropriation. The FY 2011 funding request will enable OHAP to continue to serve as the senior advisory agency on HIV/AIDS issues to the Secretary, the Deputy Secretary and the ASH as well as further the development and implementation of the *National AIDS Strategic Plan* as directed by the White House Office on National AIDS Policy.

OPHS
OFFICE FOR HUMAN RESEARCH PROTECTIONS

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$6,959,000	$0	$6,949,000	$7,007,000	+58,000
FTE	33	0	33	33	0

Authorizing Legislation……………………………………..….Title III, Section 301 of the PHS Act
FY 2011 Authorization…………………… ....Indefinite
Allocation Method .... Direct Federal, Contracts, and Other

Program Description and Accomplishments

The Office for Human Research Protections (OHRP) is the lead federal office assuring the integrity of the clinical research enterprise, an enterprise dependent on the willingness of millions of people to volunteer as human research subjects. OHRP's mission is to assure those volunteers, that the federal government is adequately protecting their well-being. OHRP has oversight over more than ten thousand institutions conducting clinical research, both in the U.S. and throughout the world. Any incident in which subjects appear to have been inappropriately harmed can result in a large and immediate drop in the numbers of people volunteering for clinical trials, jeopardizing the research enterprise.

OHRP has been taking the lead in reforming the protection of human research subjects by examining every aspect of the regulations, and to remove bureaucratic requirements that do little or nothing to increase the well-being of research subjects. Through guidance and changes in the regulations, OHRP is making sure that the current system never inappropriately leads to delays in the advancement of medical knowledge.

OHRP is organized into three functional Divisions headed by the Office of the Director (OD). Each Division contributes to these responsibilities in numerous ways. The following narrative provides a brief description of each organizational component and some of OHRP's recent accomplishments and future expectations.

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

- Serves as Executive Secretary of the Secretary's Advisory Committee on Human Research

Protections (SACHRP) and co-chair of Human Subject Research Subcommittee (HSRS) of the National Science and Technology's Committee on Science. In FY 2010, the OD will support up to three SACHRP meetings, approximately four SACHRP subcommittee meetings, as necessary; and lead approximately six meetings of the Human Subjects Research Subcommittee.
- Manages its International Activities Program which provides leadership for HHS in the global effort to improve human research protections through developing policies, procedures and practices for the monitoring and protection of human research participants in studies conducted outside the US, and to enhance the global capacity for protecting human research participants.
- Supports and increases public understanding of the role of human subject protections in advancing biomedical and behavioral knowledge, by providing information and clarification to reporters who disseminate this knowledge to the research community and the general public.

Division of Policy and Assurances (DPA) – DPA is responsible for developing policy and guidance documents related to the HHS regulations for the protection of human subjects (45 CFR part 46). These policy and guidance documents address topics that the research community has indicated warrant further clarification. The central goals of these documents are to help ensure that human research subjects are appropriately protected from harm, and to reduce unnecessary regulatory burden. Critical to meeting these goals is an active partnership with the Food and Drug Administration (FDA), the HHS agencies that conduct or support human subjects research, and the other federal departments and agencies that have adopted the Federal Policy for the Protection of Human Subjects (known as the Common Rule).

DPA organizes and coordinates consultations with experts for certain research involving children, pregnant women, fetuses, neonates and prisoners; and, determines whether proposed research that involves prisoners meets one of the permissible categories as required by the HHS regulations. In addition, DPA administers assurances of compliance with more than 10,000 research institutions and implements a registration system for more than 6,000 institutional review boards (IRB).

Specifically, the Division contributes to the OHRP mission by carrying out the following responsibilities:

- In FY 2009, five final and draft guidance documents were issued to a target audience that includes IRBs and staff, investigators, institutional officials, and funding agencies. Four of the five were final guidance documents, one related to the Genetic Information Nondiscrimination Act and another related to the "engagement" of institutions in human subjects research, which had been long sought out by the research community.
- In FY 2009, DPA developed five FR notices, three related to issuance of OHRP guidance, one ANPRM related to IRB accountability, and a final rule on IRB registration requirements. OHRP's IRB registration final rule was developed in collaboration with FDA who also issued a final IRB registration rule in January 2009. Both rules are very harmonious and rely on the operation of a single HHS IRB registration system that DPA staff operates.
- Coordinates responses to requests for information, technical assistance, and guidance from

- Negotiates Assurances of Compliance with research entities, registers IRBs, and maintains a database of more than 10,000 Assurances of Compliance and more than 6,000 registered IRBs. In FY 2009, DPA staff reviewed and accepted 4,243 new, renewed or updated IRB registrations and approved 4,273 new, renewed or updated Assurances of compliance.
- Reviews and approves certifications for HHS conducted or supported research involving special populations such as children and prisoners. In FY 2009, DPA staff took action on approximately 100 prisoner certification requests and convened one panel of experts to review research involving children.

Division of Compliance Oversight (DCO) – DCO evaluates written substantive indications of non-compliance with HHS regulations—title 45, Part 46, Code of Federal Regulations (45 CFR part 46). DCO conducts inquiries and investigations into alleged non-compliance with the HHS regulations for the protection of human subjects. These activities include conducting and preparing investigative reports, and recommending remedial or corrective action as necessary. DCO also conducts compliance oversight site visits related to the DCO investigations. They include extensive record reviews and numerous interviews with institution staff in order to evaluate specific noncompliance concerns as well as the institution's overall system for protecting human subjects.

Division of Education and Development (DED) –The critical elements of human subjects' protection— informed consent, equitable selection of subjects, research designed to maximize benefits and minimize risks, as well as the development and maintenance of the appropriate administrative infrastructure to support sound and ethical research—are not "taught" in medical school, business school, or other academic programs. DED, fills this critical gap in the furtherance of sound and ethical research by providing technical assistance to institutions engaged in HHS-conducted or sponsored research involving human subjects through developing and maintaining educational guidance materials related to protection of human research subjects. With over 10,700 Federal-wide Assurance (FWA) - holders and 6,000 registered IRBs, DED has an enormous mandate. In a system based largely on trust and the delegation of responsibilities, education of all the stakeholders involved in research involving human subjects is essential. A strong educational foundation is the single most important element in helping to ensure that the safety and welfare of the most precious and valued resource--the human volunteers indispensable to the research enterprise--are protected adequately and appropriately.

- In FY 2009, DED helped organize three OHRP Research Community Forums attended by more than 1,200 people from across the country and abroad. These national conferences provide in-depth and focused human subject protections education across the spectrum of issues, from very basic regulatory education to high-level discussions of advanced topics, and are provided to the regulated community for a fraction of the cost of similar programs provided by non-governmental entities in the field.
- DED staff present at large professional, academic, and association conferences across the country. DED gave approximately 60 presentations in FY 2009, and expects to do the same in FY 2010.
- DED provides hands-on support to institutions quality improvement workshops. Originally piloted to reach about 40-50 individuals working in FWA-holding institutions, this program

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

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

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

Funding History

FY 2006	$6,921,000
FY 2007	$6,897,000
FY 2008	$6,701,000
FY 2009	$6,959,000
FY 2010	$6,949,000

Budget Request

The FY 2011 request is $7,007,000, an increase of $58,000 above the FY 2010 Appropriation level. The request provides funds for pay increases. This will enable OHRP to maintain the same level of activity in previous and continue the support of the existing projects as described above. With this funding, OHRP well recognizes the importance of the two key aspects of its activities to the well-being of the Nation’s clinical research enterprise (i) assuring the integrity of the system for protecting research subjects, and (ii) assuring that that system works in an efficient and effective manner, and does not inappropriately delay or burden the conduct of research.

Outputs and Outcomes

Measure	Most Recent Results	FY 2010 Target	FY 2011 Target	FY2011 +/- FY2010
Support the Secretary's Advisory Committee on Human Research Protections (SACHRP) Committee Meetings Subcommittee Meetings	 FY09: 3 FY09: 4	 3 4	 3 4	 0 0
Lead HSRS meetings	FY09: 6	6	6	0
Policy and guidance documents, and *Federal Register* notices related to OHRP guidance and regulatory actions Guidance documents *Federal Register* notices	 FY09: 5 FY09: 6	 5 6	 6 6	 +1 0
Number of institutions with Federal-wide Assurances review and approved by OHRP	FY09: 4273	4273	4273	0
Number of institutional review boards registered by OHRP	FY09: 4243	4243	4243	0
Number of certifications that OHRP has reviewed and approved for HHS-conducted or supported research involving prisoners	FY09: 100	100	100	0
Protect human subjects from risks caused by regulatory violations through conduct of not-for-cause surveillance evaluations of institutions	FY09: 1	4	4	0
Provide education via sponsored conferences and/or quality assurance workshops to persons involved in human research programs.	FY09: 1200	1300	1300	0
Presentations given by staff to institutions (domestic and international) engaged in HHS conducted or supported research	FY09: 80	85	85	0
Program Level Funding ($ in millions)		**$6,949,000**	**$7,007,000**	**+$58,000**

OPHS
OFFICE OF RESEARCH INTEGRITY

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA*	$8,909,000	---	$9,118,000	$9,709,000	$591,000
FTE	23	---	24	24	---

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

Authorizing Legislation .... Title III, Section 301 and Title IV Section 493 of the PHS Act
FY 2011 Authorization .... Indefinite
Allocation Method .... Direct Federal; Contracts; Grants

Program Description and Accomplishments

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

In recent years, ORI has placed greater emphasis on education, research, evaluation, and prevention activities. In response to these changes, ORI adopted an action plan, approved by the Assistant Secretary for Health (ASH), to increase resources in these areas. Key components of this plan were: 1) the establishment of a research program to study the factors influencing research integrity; 2) an education program on the responsible conduct of research; and 3) fostering ongoing collaborations with ORI's teaching and research partners, including the Association of American Medical Colleges, The Council of Graduate Schools, National Academies, American Association for the Advancement of Science, and other research associations, academic and scientific societies, and numerous individual institutions.

ORI's budget, resources, and programs are relevant directly to the Department's interest in prevention of disease and promotion of health. ORI's overall mission supports the integrity of research and the public confidence in such research. Since clinical trials, human studies, animal studies, and basic research lead to new drugs, devices, and medical interventions, confidence in the science base which leads to such improvements in health is intertwined closely with the beneficial products of the research. ORI also emphasizes prevention in its programs by developing educational resources to support best practices and by supporting intramural and

extramural studies through its research program on the indicators of research integrity and the causes of misconduct. Only through the development of this science base can PHS identify effective and cost efficient means of promoting integrity and preventing misconduct.

ORI's mission to identify and take action in response to research misconduct also provides primary and secondary prevention by removing from research those who commit misconduct and reinforcing the scientific norms of honest scientists who conduct research responsibly.

Each institution (currently more than 5,000) that receive PHS research funding must submit an assurance statement and their policies and procedures for handling allegations of research misconduct, thus demonstrating to their faculty, students, scholars, and staff the importance of honesty in research.

ORI's efforts to prevent misconduct and promote integrity and responsible research practices strengthen the public's trust in researchers, research institutions, and the process of scientific research, essential for the progress of new health care products and treatments which can prevent disease and illness. ORI also supports the public health infrastructure by helping ensure a trustworthy science database, upon which decisions are made and which support public confidence in the use of science-based medical discoveries.

Over the past four years (2006-2009), ORI has accomplished the following:[1]

- Reviewed 800 allegations of misconduct, opened over 80 formal inquiries and investigations, and made 29 findings of research misconduct.
- Reviewed over 100 institutional policies and procedures for regulatory compliance and responded to over 15 incidents of possible retaliation against good faith whistle blowers or non-compliance with regulatory requirements.
- Sponsored or participated in over 50 workshops and conferences with research institutions, scientific societies, and others on research misconduct, the responsible conduct of research, and the promotion of research integrity.
- Engaged in the development of more than 10 educational products in Responsible Conduct in Research (RCR).
- Funded 15 grants to support research on misconduct, education in research integrity, conflicts of interest, and institutional practices that affect the integrity of research.
- Provided on-site or telephonic technical assistance to approximately 150 research institutions in handling allegations of misconduct.
- Received and managed the Annual Report on Possible Research Misconduct for approximately 5000 institutes per year.
- Prepared quarterly newsletters for distribution through postal service and the ORI website
- Website was updated and modified; and was visited more than 100,000 times during the period
- Adopted a sample misconduct policy in 2007 to assist institutions in implementing the new PHS misconduct regulation, 42 CFR Part 93, Subpart E, that requires the accused

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

scientist to provide specific factual evidence to demonstrate his/her innocence.
- Funded 78 awards to 72 societies through a cooperative agreement with Association of American Medical Colleges (AAMC). This resulted in 20 educational products related to research integrity and the responsible conduct of research.
- Funded development of five model RCR programs at leading research universities.
- Created universal objectives and learning topics for the core areas of responsible conduct of research.
- In cooperation with NIH, ORI has funded 49 projects that have resulted in 91 publications in 30 journals.
- Completed two intramural research studies and published the findings in peer reviewed journals.
- Awarded three contracts for research about Research Integrity Officers, mentoring, and researcher's knowledge about research integrity.
- Awarded funds to the National Postdoctoral Association to facilitate the creation of RCR programs specific for post docs.
- Focused 3 conferences for RCR educators and for RCR researchers so that the professionals were enabled to interact and learn from each other.
- ORI staff made presentations at more than 130 conferences to more than 10,000 total attendees
- Increased staff involved in making presentations at conferences.

ORI supports the following OPHS performance measures:

- Increase the number of substantive commitments to prevention on the part of governmental and non-governmental organizations.
- Increase knowledge about disease prevention and health promotion, including effective interventions and research needs.
- Increase the reach and impact of OPHS communications related to strengthening the public health and research infrastructures.
- Increase knowledge about the public health and research infrastructure, including research needs, and improve data collection needed to support public health decisions.

Funding History

FY 2006	$8,172,000
FY 2007	$8,172,000
FY 2008	$8,571,000
FY 2009	$8,909,000
FY 2010	$9,118,000

Budget Request

The FY 2011 Request Level is $9,709,000, an increase of $591,000 above FY 2010 Appropriation level. Funds will maintain existing projects, and will allow for an expanded national education campaign to promote research integrity and quality research. The number of

accessions at ORI of alleged research misconduct has doubled since 1998. The increase is thought to be a direct result of:

- Recent increases in Public Health Service funded research, which inherently increases allegations of research misconduct not just because more research leads to more allegations of research misconduct, but perhaps due to a hasty rush to conduct research while the funds are available.
- Demand for research has never been greater as the nation, indeed the world, face global crises; yet there is a general shortage of U.S. researchers to meet research demand—*per capita* fewer students in the U.S. are choosing research as a career. This shortage of U.S. researchers results in an increasing reliance on researchers from outside the U.S., who may need additional training in their scientific discipline and in conducting research in a culture different from their own.
- Greater accountability requirements and enforcement. In the past, few thought that there was a need for overseeing the integrity of researchers and, without regulatory protection, few were willing to come forward and report an alleged incident of research misconduct for fear of retributions or a lack of faith that an allegation could be proven. A few recent notable cases of research misconduct which were found under DHHS regulations has resulted in more people willing to make allegations of research misconduct. A declining economy which has increased pressures on faculty members and their research support staff members to accept greater administrative and other tasks, decreasing time for research; and the stress of trying to maintain a stream of funding to maintain a research program and staff.
- An increase in global competition for funding and prestige.

In FY 2011, ORI intends to launch a nationwide program that will help educate graduate students, postdoctoral scholars, faculty, and other researchers in the responsible conduct of research. A new RCR curriculum that is updated and expanded will be used. Regional workshops, used effectively in the past and described in such prestigious journals as *Science* and *Nature,* will be a primary means of delivering the new curriculum. The workshops will be facilitated by the ten HHS regional offices, the more than 40 Clinical Translational and Science Centers, and scientific professional and administrative associations. The national campaign also will include distributing research integrity posters, enacting live scenarios that help develop ethical decision making skills, using interactive video scenarios that will enable learners to navigate through ethical dilemmas, and using the ORI web site and social networking technologies to encourage discussion between ORI and the research community about research integrity issues. This national campaign will demonstrate to institutions that the teaching of RCR must be relevant and delivered in a way that engages both scientists and administrators.

OPHS
PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$1,228,000	$0	$1,225,000	$1,235,000	+10,000
FTE	6	0	6	6	0

Authorizing Legislation……………………….……….Title III, Section 301 of the PHS Act
FY 2011 Authorization..Indefinite
Allocation Method...Direct Federal

Program Description and Accomplishments

Established in 1956 by President Eisenhower, the President's Council on Physical Fitness and Sports (PCPFS) is a federal advisory committee of volunteer citizens who advise the President through the Secretary of Health and Human Services about physical activity, fitness, and sports in America. Through its programs and partnerships with the public, private and non-profit sectors, the Council serves as a catalyst to promote health, physical activity, fitness, and enjoyment for people of all ages, backgrounds and abilities through participation in physical activity and sports. The twenty Council members are appointed and serve at the pleasure of the President.

PCPFS creates and cultivates grassroots public and private partnerships and collaborations to raise the public's awareness about the benefits of a physically active and fit lifestyle and provides motivational, easy-to-use, adaptable tools and resources. For example, the *President's Challenge Physical Activity and Fitness Awards* program (*President's Challenge*), started in 1966 with a focus on youth fitness testing, promotes physical activity and fitness recognition for individuals aged 6 and older. PCPFS continues to work with public and private organizations to raise awareness of the *Physical Activity Guidelines* (PAGs) messages, as well as work towards consistency of information in public/private programs and materials.

Funding History

FY 2006	$1,228,000
FY 2007	$1,230,000
FY 2008	$1,195,000
FY 2009	$1,228,000
FY 2010	$1,225,000

Budget Request

The FY 2011 request is $1,235,000, an increase of $10,000 above the FY 2010 Appropriation level. The increase provides funds for staff pay increases and enables the continued support of the existing projects such as:

- Support/promote the Department's initiatives for the coordination and collaboration within departmental components to ensure incorporation of science-based physical activity/fitness strategies and messages in state, and local government programs and information pieces.
- Convene one in-person meeting of the PCPFS to discuss ideas and plans for current and new initiatives and to recognize the Council's Lifetime Achievement and Community Leadership Award winners.
- Continue work with OPM on creating a healthier, more active Federal workforce (*Healthier Feds*).
- Inspire state, local and business leaders to participate in the *National President's Challenge* during May, *National Physical Fitness and Sports Month*.
- As co-lead, with the Centers of Disease Control and Prevention, of the Physical Activity and Fitness Focus Area of *Healthy People 2010*, and soon to be developed *Healthy People 2020.*

OPHS
PUBLIC HEALTH REPORTS

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$450,000	$0	$448,000	$452,000	+4,000
FTE	2	0	2	2	0

Authorizing Legislation…………………Title III, Section 301 of the Public Health Service Act
FY 2011 Authorization………………………………………………………………Indefinite
Allocation Method……..……………..……..Direct Federal; Contract, Cooperative Agreement

Program Description and Accomplishments

The journal *Public Health Reports* (*PHR*), the oldest journal of public health in the U.S., has published continuously since 1878. *PHR* is the public health journal of the U.S. Public Health Service and the Surgeon General, and is produced in collaboration with the Association of Schools of Public Health. *Public Health Reports* brings important research and discussion of key issues to the public health community. Each bi-monthly issue examines subject matter necessary to understand the issues of public health and disease prevention of the Nation.

In addition to the six regular issues, three or more supplemental and/or special issues are published annually. About three to four science-based webcasts are also produced each year. Each issue includes columns such as the *Surgeon General Perspective*, *International Observer*, *Law and the Public's Health*, *Public Health Chronicles*, and *From the Schools of Public Health* that address important national and international public health issues. The *Surgeon General Perspective*, highlights and discusses timely and emerging public health issues identified by the Surgeon General.

The Journal also has a special interest in emphasizing public health history, not only in the *PHR* Public Health Chronicles column but also in supplements and yearly premiums. For example, *Public Health Reports: Historical Collection 1878-2005* is a supplement containing 35 seminal articles with added historical commentary that have appeared over the years. *Vaccination*, is a *PHR* CD that contains a history of vaccine use in America from the 18th century to the present day. This *PHR* end-of-year premium explores the history of this essential public health tool through an audio presentation with historical timelines, photographs, and archived articles. Recently, the entire set of *PHR* journal articles from 1878 has been digitized and is currently available on the internet at:
http://www.pubmedcentral.nih.gov/tocrender.fcgi?journal=333&action=archive .

In order to accomplish its mission, *PHR* works with several different partners, using a variety of allocation methods to distribute funds:

- Contract with Capital Communications Systems Inc. (CCSI) –CCSI provides the design and layout for six regular journal issues per year.
- Professional Services in the form of purchase orders are contracted annually including technical editors, photo journalism, special topic peer-review, and web-cast coordination.
- A grant is awarded annually to the Association of Schools of Public Health to provide support costs related to printing, mailing, subscriptions, and other public health report tasks.

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

Funding History

FY 2006 $463,000
FY 2007 $455,000
FY 2008 $443,000
FY 2009 $450,000
FY 2010 $448,000

Budget Request

The FY 2011 request is $452,000, an increase of $4,000 above the FY 2010 Appropriation level. The increase provides funds to provide useful research and practice information to public health officials and to discuss key public health issues of the day.

Outputs and Outcomes

End-of-year	# of Manuscript Submissions
2005	320
2006	323
2007	416
2008	410
2009 (12/10/09)	424

Key Outcomes	Most Recent Results	FY 2010 Estimate	FY 2011 Estimate	FY 2011 +/- FY 2010
Increase the number of submissions for consideration by Public Health Reports	424 (CY 2009)	450	475	+10%
Publish two or more supplements or special issues to add even more focus to important public health matters	2 (CY2009)	5 or 6	3 or 4	0%
Improve the desirability and outreach of the journal that will increase the frequency that PHR is referenced	3 webcasts (CY2009)	3	3	0%

ASSISTANT SECRETARY FOR LEGISLATION

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Request	FY 2011 +/- FY 2010
BA	$3,430,000	$0	$3,554,000	$3,592,000	+$38,000
FTE	19	0	26	26	0

FY 2011 Authorization ....Indefinite
Allocation Method ....Direct federal

Program Description and Accomplishments

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

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

ASL is organized into six divisions:

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

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

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

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

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

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

Office of the Deputy Assistant Secretary for Legislation for Mandatory Health Programs - Assists in the legislative agenda and liaison for health services and health care financing operating divisions, including the Centers for Medicare and Medicaid Services (CMS) and the Indian Health Service (IHS).

Office of the Deputy Assistant Secretary for Legislation for Human Services - Assists in the legislative agenda and liaison for human services and income security policy, including the Administration for Children and Families (ACF) and the Administration on Aging (AoA).

These three offices develop and work to enact the Department's legislative and administrative agenda; coordinating meetings and communications of the Secretary and other Department officials with Members of Congress; and preparing witnesses and testimony for Congressional hearings. ASL successfully advocates the Administration’s health and human services legislative agenda before the Congress. ASL works to secure the necessary legislative support for the Department’s initiatives and provides guidance on the development and analysis of Departmental legislation and policy.

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

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

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

Funding History

FY 2006	$3,110,000
FY 2007	$3,187,000
FY 2008	$3,379,000
FY 2009	$3,430,000
FY 2010	$3,554,000

Budget Request

The FY 2011 request for ASL is $3,592,000, a net increase of $38,000 above the FY 2010 President's budget level. This increased funding will allow ASL to carry out critical activities to support the President's legislative healthcare and human services agenda that, among others, includes reauthorization of the Temporary Assistance to Needy Families Program and the Older Americans Act.

In FY 2011, ASL will use this increased budget amount to support the President's commitment to strengthen the systems that protect our food and medical products supply, ongoing activities related to the H1N1 virus, the reauthorization of the HRSA health professions programs, the Safe and Stable Families program and others.

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

This budget request will support ASL in facilitating increased communication between the Department and Congress; support ASL's responsibilities to monitor, coordinate and respond to the increasing oversight and accountability activities; and cover funding for increased personnel costs which will enable ASL to continue carrying out mission critical activities to support the President's legislative healthcare and human services agenda.

ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$4,432,000	$0	$4,829,000	$5,314,000	+$485,000
Supporting 2 positions	26	0	28	29	+2

FY 2011 Authorization ....Indefinite
Allocation Method ....Direct federal

Program Description and Accomplishments

The Assistant Secretary for Public Affairs (ASPA) serves as the Department's principal public affairs office, communicating information on the Secretary's initiatives and HHS's mission and activities to the public, and developing strategies to promote increased transparency and accountability. ASPA plays a leading role by:

- Serving the Secretary in advising and preparing public communications and outreach strategy for the Department.
- Providing timely, accurate, consistent, and comprehensive public health information to the public around key public health programs and initiatives identified as priorities such as HIV and AIDS prevention, Tobacco Cessation programs, food safety, obesity, the prevention of healthcare associated infections and other health quality initiatives and the promotion of health information technologies.
- Coordinating public health and medical communications across all levels of government and with international and domestic partners.
- Leading the communications response to government-wide public health emergencies such as the 2009 H1N1 pandemic and the medical and human services response to the 2010 Haiti Earthquake. ASPA coordinates government-wide communications response by planning daily and weekly media briefings with top level Administration officials and the CDC. HHS created materials for key surrogates, coordinating TV and radio booking and helping to design health emergency summits to bring together state, local, and national leaders.
- Coordinating and promoting Open Government policies across HHS, including improved FOIA accountability, increased public access to data and critical consumer messaging.
- Providing public affairs counsel in the HHS policymaking process.
- Acting as the central HHS press office handling media requests, clearing all press releases and interviews, and managing news issues that cut across Agencies; managing electronic clips for the Secretary and senior staff; and compiling a Department-wide report on each day's media affairs.
- Managing, maintaining, and developing the content of the HHS Web site and key HHS managed consumer websites such as flu.gov, foodsafety.gov, and stopmedicarefraud.gov.

- Providing counsel and setting protocols on outreach utilization of New Media and the Web across HHS and HHS Operating Divisions.
- Overseeing the extensive daily public affairs activities that take place throughout the Department, including internal communications across the Department
- Managing communications outreach to key external stakeholders and communities: overseeing translation services for key Departmental materials such as web sites, videos and printed materials.
- Supporting the Secretary's television and radio appearances; managing the HHS broadcast studio, producing and distributing radio and television outreach materials and monitoring television news; and providing HHS photographer.
- Producing speeches, statements, articles, and related material for the Secretary, Deputy Secretary, Chief of Staff, and other top Departmental officials; researching and preparing op-ed pieces, features, articles, and stories for the media.
- Maintaining HHS FOIA/Privacy Act operations and activities by improving openness and transparency through the new Open Government initiative. ASPA has undertaken a departmental wide project to improve FOIA performance, processing efficiency, and using new technologies to highlight key data sets and information resources for consumers. This includes the development of a new website and new protocols for sites like data.gov.

Funding History

FY 2006	$3,931,000
FY 2007	$4,008,000
FY 2008	$4,453,000
FY 2009	$4,432,000
FY 2010	$4,829,000

Budget Request

The FY 2011 request for ASPA is $5,314,000, an increase of $485,000 above the FY 2010 levels. This increase provides funding, in part, for increased staff and the need for resources to support major HHS and government wide communications priorities like Health Care Fraud prevention, food safety, critical flu vaccination and flu prevention messaging, pandemic and bio security preparedness and planning, health information technology, and key health reforms.

This will be done through consumer based cross government websites like flu.gov and foodsafety.gov; PSAs; web casts; satellite tours with top doctors, scientists and departmental specialists; development of New Media tools; and the use of critical Open Government and transparency initiatives and strategies. One area of specific interest and concern will be consumer privacy protections around health reform and electronic medical records.

ASPA will also need to purchase new technologies and outreach tools to communicate changes directly to consumers about new programs and initiatives around health reform, consumer based health quality programs, new services, and benefits in the FY 2011 budget.

In addition, the increase will fund personnel costs to include two additional positions. Personnel costs make up close to 90 percent of ASPA's GDM budget.

Overall the FY 2011 budget request for ASPA will be used to conduct Department-wide public affairs programs; support the rollout of new programs and legislation; increase consumer access and information; enhance transparency and accountability; synchronize Departmental policy and activities with communications; oversee the planning, management and execution of communication activities throughout HHS; and administer Open Government programs, the Freedom of Information Act (FOIA), and Privacy Act programs on behalf of the Department.

ASPA will use funds for the FY 2011 budget to provide citizens with the critical information they need about health and human services programs that are designed to help them achieve economic and health security. ASPA's mission is to ensure to Americans have access to critical public health and human services information in a timely and transparent manner

OFFICE OF THE GENERAL COUNSEL

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget	FY 2011 +/- FY 2010
BA	$37,581,000	$0	$38,692,000	$40,131,000	+1,439
FTE	357	0	361	364	0

FY 2011 Authorization……………………………………………………………Indefinite
Allocation Method………………………………………………………………Direct Federal

Program Description and Accomplishments

OGC supports the development and implementation of the Department's programs by providing legal services to the Secretary of HHS, the Operating Divisions (OPDIVs), and the Staff Divisions (STAFFDIVs). OGC lawyers review proposed legislation and regulations, engage in legislative drafting, and consult and advise on wide-ranging legal issues that emerge from the policies and programs of the Department, Administration, and Congress.

OGC lawyers are heavily involved in litigation before administrative bodies and the federal courts. OGC attorneys independently represent the Secretary in proceedings before administrative bodies such as the Departmental Appeals Board (DAB). In cases before federal courts, OGC works closely with the Department of Justice and offices of United States Attorneys to provide necessary representation.

OGC's litigation caseload has increased dramatically in recent years and that trend is expected to continue. OGC's long-term goal is to continue to consistently provide effective, efficient legal support to the Department. The measures of performance toward this goal are in the quantity of work, and also in the timeliness, accuracy, and clarity of the legal support provided to the Office of the Secretary and program client operations and initiatives

Funding History

FY 2005	$37,413,000
FY 2006	$36,729,000
FY 2007	$37,347,000
FY 2008	$36,617,000
FY 2009	$37,581,000
FY 2010	$38,692,000

Budget Request

The FY 2011 OMBJ request is for $40,131,000, an increase of $1,439,000 over FY 2010 levels. OGC's goal is to support the strategic goals of the Office of the Secretary and the Department by

providing high quality legal services, including sound and timely legal advice and counsel with a team of over 400 attorneys and comprehensive support staff. The budget request for OGC will be used to continue to effectively manage the legal challenges and provide support for the Secretary and Department's initiatives and programs. In addition to the activities financed through the General Departmental Management appropriation, the Office of the General Counsel also provides reimbursable services to HHS components.

In FY 2011, OGC will continue to focus on supporting the Department's highest priorities. Select OGC initiatives and programs are outlined below:

Medicare & Medicaid Services

- *Consumer Choice and Access to Quality Services for Medicare Beneficiaries.* Assist CMS efforts to expand health care coverage options available through the Medicare Advantage program, and continue to address numerous legal issues involving Medicare Advantage Private Fee-for-Service plans.
- *Financial Integrity of Medicare and Medicaid Programs.* Continue to advise CMS with respect to payment system changes, anti-fraud initiatives, and financial integrity of the Medicare and Medicaid programs. Specifically, OGC will work closely with the Health Care Fraud Prevention and Enforcement Action Team (HEAT) members to combat and prevent fraud, waste, and abuse in the Medicare and Medicaid programs. OGC will work to assist the Department of Justice in prosecuting those seeking to defraud the Medicare and Medicaid programs and defending any federal court challenges that are brought as a result of this initiative. OGC will also work with CMS as the recovery audit contractors (RACs) identify Medicare overpayments, including defending these overpayment determinations that are reviewed in federal court.
- *Medicare Advantage and the Part D Benefit.* Medicare Part D benefit and the Medicare Advantage program will continue to generate a significant amount of litigation challenging various aspects of these programs and will generate new litigation as CMS' enforcement/compliance initiatives against these entities increases.
- *Children's Health Insurance Program Reauthorization Act of 2009.* OGC has provided considerable advice to CMS in its development of initial interpretive guidance and will need to provide a substantial amount of advice and guidance as CMS moves to rulemaking to implement significant expansions in CHIP and Medicaid, which will result in expanded coverage of children and pregnant women, as well as increased enrolment of current populations
- *Medicare Secondary Payer Provisions.* Leads efforts to recover conditional payments made under Medicare Secondary Payer (MSP) provisions. This work takes place in many individual and some class action cases filed nationwide. OGC has worked closely with CMS to craft innovative MSP settlements in major products liability cases.

Children, Families, and Aging

- *Improving Head Start Grantee Performance.* Assist ACF in implementing changes to the Head Start Act resulting from legislation reauthorizing the program which was enacted in December 2007. OGC is also assisting with ARRA legislation which doubled the size of

the Early Head Start program and added the largest increase in funding ever made to the Head Start Program. Final regulations are expected to be issued in FY 2010 and OGC will assist ACF in their development and clearance.

Ethics

- *Ethics Redesign Initiative.* Administer the Department's ethics program including public and confidential financial disclosure systems. OGC will focus on completion of ongoing program reviews and implementing enforcement and compliance systems, and reinitiate audits after an appropriate interval to measure improvement.

General Law

- *Employment and Labor Legal Activities.* OGC attorneys defend management decisions with respect to employee misconduct, poor performance or claims of unlawful discrimination before various arbitrators, the MSPB, the EEOC, and the FLRA, and assist DOJ with employment and labor litigation. OGC attorneys also advise management regarding civil service regulations, labor relations and assist in negotiating collective bargaining agreements.
- *TANF Reauthorization.* Assist ACF in answering multiple questions concerning reauthorization of the TANF program in 2010 including providing extensive advice concerning public outreach and Federal Advisory Committee Act (FACA) issues.
- *Oversight of Biomedical and Behavioral Research and Research Misconduct.* Assist the Office for Human Research Protections (OHRP) and the Office of Research Integrity (ORI) in their oversight of HHS-conducted or supported biomedical and behavioral research and research misconduct. OGC also assists NIH in carrying out its own intramural programs to ensure research integrity and appropriate human subject protection in research.
- *Physician Quality Reporting Initiative.* Counsel CMS in the implementation and expansion of the Physician Quality Reporting Initiative (PQRI).
- *President's Health Centers Initiative, and Tort Claims and Tort Litigation.* OGC has issued legal opinions about tort coverage to various clients and has provided assistance to IHS and HRSA in the area of "risk management" activities designed to prevent, respond to, or minimize the effects of any alleged medical malpractice in Federally funded facilities. OGC projects a significant growth in tort claims and tort litigation, especially regarding claims arising from the expansion in the number of HRSA-funded Community Health Centers.
- *William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008.* Work closely with ACF in interpreting provisions of this legislation which reauthorizes the Trafficking Victims Protection program and also transfers new responsibilities for the care and custody of Unaccompanied Alien Children who may be victims of Trafficking from DHS to HHS.
- *Health Information Technology.* Work with CMS on transparency initiatives; work with CMS on the rules effectuating the e-prescribing provisions for the Part D program under the Medicare Modernization Act (MMA); work with ONC on the development of the Nationwide Health Information Network; work with IHS on data-sharing agreements for tribally-operated epidemiology centers; and work with OCR and other Department

components to address privacy and security issues.

Public Health

- *Public Health Emergency Preparedness.* Legal preparedness activities, including advising HHS officials on HHS legal authorities and ability to support state, local and tribal officials in public health emergencies (e.g., quarantine, public health emergency declarations, distribution of medical countermeasures, licensing and liability of health care providers, deployment of HHS personnel, and surge capacity).
- *Pandemic Influenza Preparedness and Response.* Advise relevant HHS agencies in pandemic preparedness and response, including for the current H1N1 influenza pandemic, on issues such as countermeasure procurement, distribution and dispensing, vaccine development and distribution, medical surge capacity, international cooperation, liability protections, injury compensation, emergency declarations, emergency authorization of investigational products, and surveillance.
- *Indian Health Care Improvement Act Reauthorization.* Assist ASL and IHS in providing technical assistance to the Congress (including legislative drafting assistance) on Congressional bills to update IHS program authorities to respond to changing health care needs of the American Indian/Alaska Native population.
- *Indian Self-Determination Act.* OGC reviews hundreds of proposed contracts under this Act, transferring over $2 billion on an annual basis to nearly 300 tribes through these agreements. OGC reviews tribal proposals, advises the federal negotiation team, and ensures agreements are within the agency's statutory authority. OGC also defends IHS in federal and administrative actions challenging Indian Self-Determination Act contracts.
- *Global and Domestic HIV/AIDS and Emerging Infections Programs.* Advise both CDC and HRSA on the numerous legal issues associated with HHS's expanding international programs including those focused on emerging infections and those focused on HIV/AIDS and tuberculosis. OGC will work with key personnel implementing the reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. In addition, OGC will work with the Department of State to provide advice on the development of bilateral agreements with host countries.
- *Strategic National Stockpile.* Advise regarding a number of significant issues involving the purchase, stockpiling, and deployment of vital vaccines, drugs, and other medical supplies, including negotiation of deployment agreements, and the management and contracts administration of current and new contracts.
- *The Pandemic and All-Hazards Preparedness Act (PAHPA), P.L. 190-417.* Advise ASPR on a myriad of issues regarding the return of the NDMS to HHS, employment issues, licensing and credentialing issues, use of Federal property when NDMS teams have not been activated by the Federal government and storage of pharmaceuticals and other equipment.
- *Patient Safety and Quality Improvement Act of 2005 (Medical Malpractice).* Continue to advise and assist AHRQ, OCR, and HHS clients in connection with drafting of regulations and other tasks connected with implementation of the recently enacted patient safety legislation, designed to encourage reporting of medical errors in order to facilitate correction of systemic problems, by ensuring that such reports cannot be used in adversarial proceedings.

DEPARTMENTAL APPEALS BOARD

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget	FY 2011 +/- FY 2010
BA	$9,981,000	$10,548,000	$11,143,000	+$595,000
FTE	66	66	66	--

FY 2011 Authorization……………………………………………………………Indefinite
Allocation Method…………………………………………………………Direct Federal

Program Description and Accomplishments

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

DAB's mission is to provide fast, low-cost, high-quality adjudication and other conflict resolution services in administrative disputes involving HHS, and to maintain efficient and responsive business practices. In general, DAB contributes to the improved management and integrity of HHS programs, and to the quality of health care by:

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

DAB is organized into four Divisions:

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

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

DAB has made measurable progress in the strategic management of human capital by re-engineering its operations and improving its case management techniques. DAB shifts resources across its Divisions as needed to meet changing caseloads and targets mediation services to reduce pending workloads. Performance analyses for each Division are based on FY 2010 data to date, extrapolated to the end of the fiscal year. Workload assumptions are explained in the charts under the Budget Request section.

Board Members – Appellate Division

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

Board jurisdiction affecting Medicare and Medicaid includes:

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

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

Performance analysis: In FY 2009, the Board/Appellate Division closed 139 cases (decisions were issued in 75 of these cases). In FY 2009, 90% of Board decisions had a case age of six months or less, which substantially exceeded the FY 2009 timeliness standard of 86% in Objective 1. This objective 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 2009, Federal courts reviewed 17 Board decisions, and all but two were affirmed. The Board thus maintained its extraordinary record of having no more than 2% of its total decisions overturned by court.

The number of decisions that the Board will issue in FY 2010 and FY 2011 is expected to remain at the FY 2009 level. The Board expects an increase in the number and complexity of appeals filed in FY 2010 and FY 2011. The Appellate Division will maintain its FY 2009 timeliness target of 86% of decisions issued with a net case age of six months or less for FY 2010 and FY 2011. Although the Board exceeded this timeliness target in FY 2009, there may be challenges in FY 2010 and FY 2011, due to several factors. The Board will likely receive more cases that have regulatory deadlines for decisions (such as provider and supplier enrollment or revocation cases and HIPAA civil money penalty cases), which may take priority over other cases ready for decision. In addition, the complexity of cases may result in processing times longer than six months in a significant number of cases. Several decisions issued in the first quarter of FY 2010 involved complex issues and had a net case age of greater than six months. Also, the Board is receiving increasing numbers of National Coverage Determination complaints, and the regulatory appeals procedures for such complaints often cannot be completed within six months.

For FY 2011, the Appellate Division proposes to change 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 will instead measure the percentage of Board decisions in which regulatory deadlines for issuing decisions are met. In FY 2010 and FY 2011, the Appellate Division will likely receive more cases that have regulatory deadlines (such as provider and supplier enrollment or revocation cases and HIPAA civil money penalty cases). But with careful workload planning, the Appellate Division hopes to meet regulatory deadlines in 100% of the cases affected.

Administrative Law Judges – Civil Remedies Division (CRD)

CRD staff support DAB ALJs, who conduct adversarial hearings in proceedings that are critical to HHS healthcare program integrity efforts, as well as quality of care concerns. Hearings in these cases may last a week or more. Cases may raise complex medical or clinical issues. Some cases require presentation of evidence to prove allegations of complicated fraudulent schemes. Cases may also raise legal issues of first impression. For example, appeals of enforcement cases

brought under the Health Insurance Portability and Accountability Act (HIPAA) are likely to raise new issues.

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

Performance analysis: CRD received 776 new appeals and closed 711 appeals in FY 2009. Despite staff losses, CRD met its FY 2009 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 2009 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 2009, CRD had only 39 cases that were open in previous fiscal years.

In FY 2009, staff losses made meeting regulatory deadlines for deciding appeals particularly challenging. One DAB ALJ left to take a Senior ALJ position with SSA; as a result, the number of cases assigned to the remaining ALJs increased by 15% and case processing time increased. In addition, one senior attorney retired and two other staff attorneys were reassigned to help meet statutory deadlines for deciding appeals in another understaffed division. In FY 2008, CRD had six ALJs and ten attorneys; in FY 2009, CRD had five ALJs and seven attorneys. The President's Budget request for FY 2010 will permit CRD to maintain its current staff.

Heightened enforcement and oversight efforts by OIG, CMS, and the HHS Office for Civil Rights (OCR) will result in an increase in the number of appeals in FY 2010 and FY 2011. CRD has experienced a 76% increase in case receipts in the first quarter of FY 2010 over the first quarter of FY 2009. This increase is constituted by mostly provider and supplier enrollment related cases. In addition, more appeals are subject to regulatory deadlines:

- ALJs must decide HHS OIG enforcement, fraud, and exclusion cases within 60 days of the close of the record.
- This 60-day time limit also applies to SSA OIG civil monetary penalty cases, as well as other enforcement cases.
- CMS provider or supplier enrollment appeals must be decided within 180 days of the filing of the case.

CRD expects to meet these statutory and regulatory deadlines for deciding a significant portion of its caseload in FY 2010. However, meeting statutory and regulatory deadlines for FY 2011 will be difficult due to the increase in case receipts. Additionally, it will be increasingly difficult to maintain the low number of aged cases in the other case categories in FY 2011 without the addition of legal staff and one ALJ. However, hiring new staff for FY 2011 does not appear possible under current projections.

Medicare Appeals Council – Medicare Operations Division (MOD)

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

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

Performance analysis: In FY 2009, MOD exceeded its FY 2009 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 160 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. Currently, MOD issues the majority of cases prior to the 90-day deadline. MOD should continue to meet its Objective 6 targets in FY 2010 and FY 2011.

MOD also met its target Objective 7 of issuing 2,050 dispositions in FY 2009, by issuing 2,194 decisions. Although there were slightly fewer dispositions in FY 2009 than in FY 2008, the average number of claims per appeal continued to increase steadily. As a result, the total number of claims resolved increased by 42% from 18,219 in FY 2008 to 21,366 claims in FY 2009. In addition, by the end of FY 2009, MOD eliminated its backlog of older cases.

The HHS Office of Medicare Hearings and Appeals (OMHA) is projecting that MOD will have a significant backlog of appeals arising from CMS Recovery Audit Contractor (RAC) cases in FY 2010 and FY 2011. RAC claims represented 5% of overall MOD claims in FY 2009. Based on OMHA data, MOD projects that it will receive an additional 3,000-4,000 RAC claims in FY 2010, and 4,000-5,000 RAC claims in FY 2011.

The majority of cases that MOD handles must be decided within a 90-day statutory deadline. At its current staffing and workload levels, MOD has successfully managed its caseload within this timeframe and with the assistance of three new attorneys hired at the end of FY 2009 will continue to do so, despite the new RAC work.

MOD has 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 number and complexity of the cases have, resulting in an increase from 22,000 pages of document certification for Federal court appeals in FY 2007 to 197,000 pages in FY 2008 and 243,653 in FY 2009. This trend will continue into FY 2010 and FY 2011. 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 2009, MOD sought extensions of time for filing court records, hired a contract paralegal, detailed administrative staff from other DAB Divisions and occasionally reassigned attorneys to assist with court document preparation. MOD plans to hire one new administrative staff member in FY 2010 to meet the Federal court filing requirements.

Alternative Dispute Resolution (ADR) Division

Under the Administrative Dispute Resolution Act, each Federal agency must appoint a dispute resolution specialist and must engage in certain activities to resolve disputes by informal methods, such as mediation, that are alternatives to adjudication or litigation. Using ADR techniques saves costs and improves program management by reducing conflict and preserving relationships that serve program goals (*e.g.*, between program offices and grantees, or among program staff). Using ADR also furthers compliance with President Obama's directive of January 24, 2009, entitled "Memorandum to the Heads of Executive Department's and Agencies on Transparency and Open Government." The President called on the Executive Branch to: (1) provide increased opportunities for the public to participate in policymaking; and (2) use innovative tools, methods and systems to cooperate with other Federal Departments and agencies, across all levels of government, and with non-profits, businesses and the private sector.

The DAB Chair is the Dispute Resolution Specialist for HHS and oversees ADR activities under the HHS policy issued under the Act. ADR Division staff provide mediation services in DAB cases, provide or arrange for mediation services in other HHS cases (including workplace disputes and claims of employment discrimination filed under the HHS Equal Employment Opportunity program), and provide training and information on ADR techniques (including negotiated rulemaking – a collaborative process for developing regulations with interested stakeholders).

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

Performance analysis: In FY 2009, the ADR Division met its performance goals 5.1 and 5.2 by conducting 11 conflict resolution seminars and providing ADR services in 75 HHS cases. This was consistent with FY 2008 results and less than the new FY 2010 and FY 2011 targets of 15 seminars and 80 cases. The increase for FY 2010 and 2011 is projected because a staff member who began in FY 2009 will be fully trained in FY 2010, and because the Division anticipates some efficiency resulting from using DAB's new videoconferencing capacity whenever possible for mediations which would otherwise require travel. In FY 2009, the ADR Division successfully undertook several initiatives, such as: training a cadre of Indian Health Service collateral duty mediators located in IHS' Northwest and Southwest Area Field Offices who will be available for mediating EEO cases in those locations; training FDA emerging leaders (FDA Fellows Program participants) in conflict management techniques; using videoconferencing technology for ADR training of Regional personnel in Detroit and San Francisco; supplementing small ADR staff with free law school interns; initiating review of HHS Interim ADR Policy to assure support for new Presidential directive on Transparency and Open Government; and providing technical assistance to CMS regarding a proposed comprehensive workplace ADR Program. In FY 2010 and FY 2011, the ADR Division will undertake various initiatives including: encouraging parties to use videoconferencing for mediations which would otherwise require travel; benchmarking ADR operations against other ADR programs, including the Office of the Ombudsman, National Institutes of Health; completing review of HHS Interim ADR Policy to assure support for President Obama's directive on Transparency and Open Government; and convening focus groups of Sharing Neutrals Program (SN) participating agencies to develop ideas for continuous improvement of SN operations; and developing mediation skills enhancement programs for SN mediators.

Funding History

FY 2007	$9,600,000
FY 2008	$9,641,000
FY 2009	$9,981,000
FY 2010	$10,548,000

Budget Request

DAB's FY 2011 request is $11,143,000, an increase of $595,000 over the FY 2010 EWnacted level. This funding level is essential if DAB is to be able to cover its increasing Medicare and other workloads (especially the RAC initiative), increasing fixed costs (such as Rent and utilities), and e-Government needs and requirements -- and to avoid the potential fiscal and legal consequences of not meeting statutory and regulatory deadlines for hearings and appeals, and for submitting certified administrative records in cases appealed to Federal court.

Board Members – Appellate Division

Chart A shows total historical and projected caseload data for this Division. FY 2009 data is based on actual case receipts, and FY 2010 and 2011 data is based on certain assumptions, including:

- Nationwide Federal pay raise of 1% in January 2011 and non-pay inflation factor of 1% for FY 2011;
- Increases in provider/supplier enrollment cases and HIPAA appeals; and
- Higher levels of appeals in discretionary grant cases due to increased number of grants awarded with stimulus funds.

Chart A
APPELLATE DIVISION CASES

	FY 2009	FY 2010	FY 2011
Open/start of FY	88	79	83
Received	130	150	160
Decisions	75	75	75
Total Closed	139	146	150
Open/end of FY	79	83	93

Administrative Law Judges – Civil Remedies Division

Chart B shows total historical and projected caseload data for this Division. FY 2009 data is based on actual case receipts and was modified from prior budget charts to reflect more recent data, including new information from HHS agencies. FY 2010 and 2011 data is based on certain assumptions, including:

- Nationwide Federal pay raise of 1% in January 2011 and non-pay inflation factor of 1% for FY 2011;
- No new resources for this Division during FY 2010 or FY 2011;
- A continued upward trend in certain case types, due to heightened enforcement and oversight efforts by HHS OIG, CMS, and OCR, which includes increased receipts of provider/supplier enrollment appeals; and
- Meeting new regulatory processing deadlines in FY 2010 with no increase in staff.

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Chart B
CIVIL REMEDIES DIVISION CASES

	FY 2009	FY 2010	FY 2011
Open/start of FY	338	391	679
Received	776	1188	1200
Decisions	171	195	200
Total Closed	711	860	860
Open/end of FY	395	719	1059

Medicare Appeals Council – Medicare Operations Division

Chart C contains case data for this Division, based on actual numbers for FY 2009 and trends in case receipts at lower levels of appeals. DAB reports data about those cases requiring individual determinations, while noting the associated individual claims (a single case may represent hundreds of Medicare claims and more than one Medicare contractor denial).

Assumptions on which the data are based include:

- Nationwide Federal pay raise of 1% in January 2011 and non-pay inflation factor of 1% for FY 2011;
- Increased receipts cases in FY 2010 and FY 2011, as OMHA's disposition rate increases, which includes increases in appeals originating with Recovery Audit Contractors; and
- Hiring administrative staff in FY 2010 to handle increased court record preparation.

Chart C
MEDICARE OPERATIONS DIVISION CASES

	FY 2009	FY 2010	FY 2011
Open/start of FY	776	531	281
Received	1,949	2, 100	2,400
Cases Closed (claims closed)	2,194 (21,366 claims)	2,350 (25,000 claims)	2,500 (27,000 claims)
Open/end of FY	531	281	181

Alternative Dispute Resolution Division

In FY 2010 and FY 2011, ADR will strive to meet the following goals:

- Provide 15 ADR conflict resolution seminars for HHS to enhance ADR capacity at HHS, such that ADR is used whenever appropriate in disputes involving HHS;
- Use ADR in 80 HHS cases to increase cost savings, decrease contentiousness, and enhance party satisfaction in case resolution;
- Leverage limited resources for HHS cases and advance interagency ADR goals through efficient management of the OPM award-winning Sharing Neutrals Program;
- Collaborate with other Federal Departments and agencies to advance joint ADR goals; and
- Review HHS' ADR policy to assure that it is current and supports President Obama's Memorandum to the Heads of Executive Department's and Agencies on Transparency and Open Government.

Outcome/Outputs Table

Measure	Most recent result - FY 2009	FY 2010 Target	FY 2011 Target	FY 2010 +/- FY 2009
1.1: Percentage of Board decisions with net case age of six months or less.	86%	86%	86%	Maintain
2.1: Number of Board decisions reversed or remanded on appeals to Federal court as a percentage of all Board decisions issued.	2%	2%	2%	Maintain

The Appellate Division proposes the following revision to Objective 3

2.1: Percentage of Board decisions meeting applicable statutory and regulatory deadlines for issuance of decisions.	100%	100%	100%	Maintain

Measure	Most recent result – FY 2009	FY 2010 Target	FY 2011 Target	FY 2010 +/- FY 2009
3.1: Percentage of decisions issued within 60 days of the close of the record in HHS OIG enforcement, fraud and exclusion cases.	100%	100%	100%	Maintain
3.2: Percentage of decisions issued within 60 days of the close of the record in SSA OIG CMP cases and other SSA OIG enforcement cases.	N/A	100%	100%	Maintain
3.3: Percentage of decisions issued with 180 days of filing of provider or supplier enrollment appeal.	N/A	100%	100%	Maintain
4.1: Number of cases open at end of Fiscal Year that was opened in previous Fiscal Years.	≥2008	≥2009	≥2009	Maintain
5.1: Number of conflict resolution seminars conducted for HHS employees.	11 Sessions	15 sessions	15 sessions	Maintain
5.2: Number of DAB cases (those logged into ADR Division database) requesting facilitative ADR interventions prior to more directive adjudicative processes.	75	80	80	Maintain

Measure	Most Recent Result – FY 2009	FY 2010 Target	FY 2011 Target	FY 2010 +/- FY 2009
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.	147 Days	155 Days	155 days	Maintain
7.1: Number of dispositions. Counting method changed in FY 05 (see narrative below); FY 04 comparable results are 2183 cases.	2,194	2,350	2,500	Maintain

OFFICE ON DISABILITY

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$805,000	$0	$864,000	$976,000	+$112,000
FTE	4	0	7	7	0

FY 2011 Authorization…………………………………………………..Indefinite
Allocation Method…………………………………………………….Direct Federal

Program Description and Accomplishments

The Office on Disability (OD) supports initiatives funded by this budget 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. The Office on Disability also has new strategic goals/objectives under each of the three themes described above that will support our initiatives. These strategic goals also support Presidential and Secretarial priorities in health care and community living. The Office on Disability's discretionary budget covers operational and personnel costs. Our personnel are involved in coordinating efforts across HHS, which is dependent upon other agencies budgets.

Community Living Initiative
On the 10th year anniversary of the Supreme Court Olmstead v. L.C. Decision June 22, 1999, President Obama announced the Year of Community Living. In this case, the court held that the unjustified institutional isolation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act. Secretary Sebelius formed a Coordinating Council to guide the Department's work on this initiative. The Office on Disability leads the Coordinating Council which is comprised by the heads of the following Federal partners: Administration on Aging, Center for Medicare & Medicaid Services, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, Administration for Children and Families, Office for Civil Rights, and Assistant Secretary for Planning and Evaluation.

Working groups have been established to carry out the overall goals of the Coordinating Council and enable the council to focus on a variety of issues at one time. These working groups identify potential areas of work and expansion of activities, and decide priorities for the Community Living Initiative.

Services Working Group - Coordinates and oversees the progress of existing programs benefiting people with disabilities and seniors; identifies gaps in health and support services and develops and implements quality improvement strategies. This group

developed an evaluation of a Federal *housing first approach* that provides housing services and comprehensive support services to people with severe and persistent mental illness.

Housing Working Group - Explores ways to expand and adapt housing programs to meet the needs of people with disabilities and seniors. This effort is also part of the HHS-HUD collaboration that Secretaries Donovan and Sebelius formed in August of 2009. This initiative originated from the Office on Disability and OD has the lead This group developed a number of proposals to coordinate housing and human services.

Workforce/Caregiving Working Group - Develops possible solutions to the challenges raised by the increasing demand for community-based services. This group began to focus on recruitment, retention and training issues associated with providing high-quality community-based long-term care.

Data and Quality Working Group - Evaluates available data sources including the emerging Nationwide Health Information Architecture; identifies information gaps, and develops strategies to fulfill these gaps and ensure data collection is enhanced to facilitate the development of community-based long-term care quality indicators. This effort will be coordinated with the Office on Disability initiative on Comparative Effectiveness Research (CER). This group began to compile information on available datasets federally and privately sponsored to identify gaps and propose enhancements that will facilitate the development of community-based quality improvement interventions.

Communications Strategy Working Group - Develops continuous communication strategies to inform federal, state, and local networks about the initiative and its progress. This group planned a series of stakeholder's dialogues across the country, the first of which is scheduled for February 2010 in San Diego, California.

Coordination and Integration of Health Care and Related Services and Supports
The Office on Disability coordinates and oversees the progress of existing health care programs and related services benefiting people with disabilities and which may prove to be a catalyst for integration of these programs and services. The Office on Disability works with CMS and other Federal agencies across and outside HHS to identify gaps in health and support services available to people with disabilities, develop and implement quality improvement strategies to integrate these services, and to advance health outcomes for this population.

Creating Sustainable Housing for Vulnerable Populations
HUD Secretary Donovan and HHS Secretary Sebelius jointly convened three working groups to identify ways to better link HUD's housing resources with HHS's health and human service resources. The three working groups focus on: (1) Homelessness, (2) Community living (persons with disabilities, aging), and (3) Livable communities (macro level housing and community planning, design and health). The Office on Disability leads working group 2, which serves both the Community Living Initiative and the HHS-HUD partnership. In its role, the office is charged with overseeing the three following

major tasks: a) Providing or targeting Public Housing Authorities (PHAs) and appropriate housing stakeholder groups with information designed to develop a better understanding of how certain HHS programs operate; b) Providing expert knowledge to health and human services agencies and key stakeholders on federally funded housing programs; c) Identifying and promoting best practices in which federally-funded housing resources are coordinated with health and human services programs to better serve people with disabilities and seniors.

Emergency Preparedness and Response
A) H1N1 - The Office on Disability, in conjunction with CDC, crafted a series of educational messages targeting employers, direct care workforce, and people with disabilities to increase awareness and educate these audiences on the multiple aspects of H1N1 (clinical, diagnosis, prevention including immunization, people at higher risk, treatment), and how to prepare and respond to a potential outbreak. The Office on Disability also coordinated with the White House's Office of Public Engagement a series of H1N1 outreach calls to educate disability and other communities on H1N1.

B) States Preparedness Plans and People with Disabilities - The Office on Disability worked with States to ensure people with disabilities are included in States Preparedness and Response Plans. To date, 40 States have included in their plans guidelines to help meet the needs of this population.

Workforce Expansion: Elevating the Status of HHS Employees w/ Disabilities Committee
The Office on Disability is working with ASA and the HHS Employees with Disabilities Committee to identify the current number and the specific needs of employees with disabilities across HHS; barriers precluding HHS from increasing its workforce by hiring people with disabilities; opportunities to recruiting, hiring, and retaining people with disabilities; skills and abilities in need across HHS that could be fulfilled by individuals with disabilities. A letter establishing a goal of increasing the number of persons with disabilities in the HHS workforce to 2% of the overall workforce has been signed by Secretary Sebelius.

Section 508 Compliance
The Office on Disability is coordinating a 508-section compliance review across HHS.

Autism
The Office on Disability is represented on the Interagency Autism Coordinating Committee (IACC) to plan and develop a research agenda that supports health services research.

Funding History

FY 2006	$643,000
FY 2007	$739,000
FY 2008	$779,000
FY 2009	$805,000
FY 2010	$864,399

Overview of Budget Request

The Office on Disability (OD) FY 2011 request figure is $976,000 and reflects an increase of $112,000 over the FY 2010 appropriation level. This increase is needed to cover mandatory costs of annualization of the January 2011 pay raise and the anticipated FY 2011 pay raise. In FY 2011, the Office on Disability will continue to oversee the Department's implementation and coordination of disability programs, policies, and federal intergovernmental efforts related to the health and well-being of Americans with disabilities, including the Secretary's Community Living Coordinating Council, the President's Health Reform Initiative and Comparative Effectiveness Research. The budget request for the Office on Disability will be used to continue to effectively manage and provide cost effective support to the Secretary and Department's disability initiatives and programs.

OFFICE OF GLOBAL HEALTH AFFAIRS

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 + / - FY 2010
BA*	$6,451,000	$0	$6,424,000	$6,452,000	+28,000
FTE	24	0	24	24	0

*$2.5 million in funds formerly Health Diplomacy Initiative

FY 2011 Authorization……………………………………………………………Indefinite
Allocation Method……………………………………..………………………Direct Federal

Program Description and Accomplishments

The Office of Global Health Affairs (OGHA) coordinates global health and human services policies within the Department and represents HHS to Federal departments and agencies, foreign governments, international organizations, non-governmental organizations and the private sector. OGHA provides policy and staffing support to the Secretary, Deputy Secretary and other HHS leaders in the areas of global health and family issues, policy advice, leadership and coordination of international health and social matters across HHS, including those major global health initiatives that reach across the Government and involve other U.S. Federal agencies and multilateral organizations.

The issues in which OGHA is involved on behalf of the Department range from infectious diseases, to chronic diseases, health security, post-conflict health assistance, and health and sustainable development. More specifically, OGHA:

- Coordinates U.S. Government inter-agency processes related to Presidential and Secretarial initiatives, multilateral organizations, and HHS bilateral cooperation with specific countries
- *Presidential Initiatives:* Leads and coordinates HHS participation in the implementation of the President's Global Health Initiative, as well as existing commitments to The Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the President's Malaria Initiative.
  - *Emergency Plan:* OGHA provides staff and policy support to the Secretary, to HHS technical agencies, to the Office of the Global AIDS Coordinator for the development and implementation of the Emergency Plan.
  - *Global Fund:* Working closely with the Office of the Global AIDS Coordinator, OGHA continues to be strongly involved in all aspects of U.S. involvement with the GFATM. Based in Geneva, the GFATM is an independent non-profit organization created in 2002 to disburse money to public-private partnerships in developing countries to support prevention, treatment and care programs for these three major global diseases. HHS provides approximately one-third of the annual

U.S. contribution. OGHA staff serves on various international working groups to provide input into the operations of the GFATM and U.S. Government interagency core groups to determine U.S. policy towards the fund.

- *Multilateral cooperation:* Participates in policy development, governance, and reform efforts, including priority-setting, related to multilateral health organizations, and provides expert advice through the inter-agency process related to the Group of Eight (G8), Asia Pacific Economic Cooperation, and others.
- *Bilateral cooperation:* Promotes key bilateral (country-to-country) relationships in the health sector with countries in all geographic regions of the world. For example:
  - *Mexico:* Strengthens cooperation with Mexico through the U.S.-Mexico Binational Commission, and provides policy and staff support for the Secretary as Commissioner for the United States section of the U.S.-Mexico Border Health Commission (USMBHC). OGHA coordinates the HHS efforts in support of the President's Security and Prosperity Partnership with Canada and Mexico.
- Infectious diseases and health security: OGHA coordinates policy development on issues surrounding emerging and re-emerging infectious diseases, including preparation for and response to naturally occurring or intentional infectious disease threats, through appropriate international mechanisms and international relationships.
- Inter-agency partnerships: Partners on global health and human services with other U.S. Government agencies and represents HHS on relevant inter-agency policy coordination committees.
- Health attachés: Supports HHS International Health Attaché positions in the U.S. Mission to International Organizations in Switzerland, India, Vietnam, South Africa, and China.

OGHA received the Afghanistan Health Initiative (AHI) program in FY 2004 and continued management and oversight of the program in FY 2009 and FY 2010. HHS proposes transfer of AHI to CDC in FY 2011.

OGHA administered the initial year of the Health Diplomacy Initiative FY 2009 and provided assistance and policy coordination in FY 2009 and will continue in FY 2010. OGHA will continue to provide strategic leadership and policy coordination for health diplomacy in FY 2011. HHS proposes transferring on-the-ground training and service functions to CDC in FY 2011.

<u>Funding History</u>

FY 2006	$9,690,000
FY 2007	$3,763,000
FY 2008	$3,951,000
FY 2009	$6,451,000*
FY 2010	$6,424,000*

*$2.5 million in funds formerly reflected in the Health Diplomacy Initiative which has moved to CDC.

Budget Request

The FY 2011 request for OGHA is $6,452,000; an increase of $28,000 above the FY 2010 enacted level. This request will be used to support the above activities, including increased post costs for Health Attachés abroad; increased support for HHS engagement multilaterally with the World Health Organization (WHO); increased OGHA support for the Global Health Security Action Group (Ministerial Initiative); and the Secretary's role globally on a bilateral and multilateral level as the Health Minister of the United States of America.
OGHA's activities have expanded significantly over recent times. Public health and science have been at the center of a number of global policy dialogues, especially within multilateral venues – at the United Nations and its councils and specialized agencies, and at the G-8 Summit conferences. OGHA remains the Department's focal point for the development and coordination of international policy.

In FY 2011, OGHA activities will increase in support of the President's Global Health initiative. Funding of $2,000,000 will be provided directly to CDC for continued implementation of Global Health Initiative programs on which it has been collaborating with OGHA, to support policy coordination, technical support, management, administration, integration, and development of global health strategy within HHS and government-wide.

In addition to providing broad support, OGHA has specific functions in the following areas:

- Provide policy guidance, coordination, and advocacy related to refugee health and humanitarian issues such as trafficking persons;
- Supports current International HHS Health Attaché positions at the U.S. Missions in Geneva, and the U.S. Embassies in New Delhi, Pretoria, Hanoi, and Beijing;
- Managing core bilateral program positions in OGHA, including those associated with cooperation with Canada, Mexico, India, China, Vietnam, Afghanistan, Egypt, Russia, and South Africa;
- Managing core OGHA functions associated with HHS involvement in international multilateral health organizations; and
- Providing policy and related program cooperation with USAID and several of its missions.

United States-Mexico Border Health Commission (USMBHC)
Funding is included in the FY 2011 request to continue the work of the USMBHC, which was established bi-nationally in 2000 and provides international leadership to optimize health and quality of life along the United States–México border. USMBHC was established by Public Law 103-400. The goals of the Commission include institutionalizing a domestic focus on border health which can transcend political changes, and creating an effective bi-national venue to address public health issues and problems which affect U.S.-Mexico border populations in a sustainable and comprehensive way.

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-sector approaches. OGHA is the Secretary's focal point of coordination for the USMBHC; and the HHS Secretary serves as the Commissioner for the U.S. Section of the USMBHC.

The USMBHC (1) promotes sustainable partnerships which engage international, federal, state and local public health entities in support of annual initiatives around critical border health priorities that for 2010 will focus on tuberculosis, obesity and diabetes and infectious disease as impacted by public health emergencies; (2) leads the development of a comprehensive border health research agenda that will inform policy makers, researchers and entities which fund research where research gaps, needs and opportunities lay; (3) hosts the annual National Infant Immunization Week/Vaccination Week of the Americas (NIIW/VWA) that promotes the benefits of infant immunization in a regional and bi-national approach unmatched by any region anywhere in either country and the annual Border Bi-national Health Week events along the entire U.S.-México border, which bring together local communities for health screenings, health education interventions and other unique training and education forums.

The Law outlined a number of duties for the USMBHC, including assisting in the coordination and implementation of the efforts of public and private entities to prevent and resolve health problems; assisting in the coordination and implementation of efforts of public and private entities to educate such populations concerning such health problems; to conduct or support investigations, research or studies designed to identify, study, and monitor, on an ongoing basis, health problems that affect the border area; conduct or support a bi-national, public-private effort to establish a comprehensive and coordinated system, which uses advanced technologies for health related data collection and monitoring of health problems; and provide financial, technical or administrative assistance to public/private entities who act to prevent or resolve such problems or who educate populations concerning such health problems.

The Commission will continue to serve as a catalyst for border health issues, identify measurable and sustainable bi-national solutions through the engagement of public and private stakeholders at the international, federal, state, and local levels; and provide international leadership to optimize health and quality of life along the United States–México border.

Metrics Table
United States-México Border Health Commission (USMBHC)

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target
1.1: Reduce the percent of indirect spending on border health activities	FY 2008: 7% FY 2009: 7%	6%	6%
1.2: The percentage of Health Border 2010 population level health outcome objectives with baseline data achieved.	FY 2008: N/A (2010 Outcome)	50%	N/A
1.3: The incidence of tuberculosis cases per 100,000 inhabitants on the U.S. side of border.	FY 2008: N/A (2010 Outcome)	5	N/A
1.4: The incidence of HIV cases per 100,000 inhabitants on the U.S. side of border.	FY 2008: N/A (2010 Outcome)	4.2	N/A
1.5: The diabetes death rate on the United States side of the border (number of deaths per 100,000 inhabitants).	FY 2008: N/A (2010 Outcome)	5	N/A
1.6: United States-Mexico Border Health Commission (BHC): Border Binational Health Week (BBHW) celebrated on both sides of the U.S. Mexico Border	FY 2008: 20,576 FY 2009: 12,000 (Target not met, but improved)	13,000	13,000
1.7: Cumulative number of health related organizations that have adopted population-level health outcome objective of the BHC – Healthy Border 2010 Strategy into their planning, programming or funding process. (New Measure – 2008)	FY 2008: 57% FY 2009: 75% (Target not met, new objective)	90%	90%
Program Level Funding ($ in millions)	**N/A**	**N/A**	**N/A**

OFFICE OF INTERGOVERNMENTAL AFFAIRS

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$6,244,000	$0	$6,099,000	$6,438,000	+$339,000
FTE	24	0	33	33	0

FY 2011 Authorization…………………………………………………………Indefinite
Allocation Method……………………………………………………………Direct Federal

Program Description and Accomplishment

The Office of Intergovernmental Affairs FY 2011 Budget request is $6,438,000, an increase of $339,000 over the FY 2010 President's Budget request.

The Office of Intergovernmental Affairs (IGA) serves the Secretary as the primary link between the U.S. Department of Health and Human Services (HHS) and state, local, and tribal governments. The mission of the Office of Intergovernmental Affairs is to facilitate communication regarding HHS initiatives as they relate to state, local, and tribal governments. IGA serves the dual role of representing the state and tribal perspective in the federal policymaking process as well as clarifying the federal perspective to state, and tribal representatives.

The IGA is composed of a headquarters team that works on policy matters within HHS Operating Divisions and serves as liaison with state and local governments and related public policy groups. In addition to the Headquarters team, IGA has ten regional offices which include the Secretary's Regional Directors, Executive Officer, and an IGA Specialist who is responsible for public affairs and media activities. Within the IGA Office of Tribal Affairs, IGA coordinates and manages tribal and native policy issues, assists tribes in navigating through HHS programs and services, and coordinates the Secretary's policy development for Tribes and national Native organizations.

IGA also provides executive direction for the Secretary's Intradepartmental Council on Native American Affairs (ICNAA). The ICNAA is an internal council that brings together all HHS Operating Divisions and Staff Divisions to help frame HHS policy and initiatives on American Indians, Alaska Natives, and Native Americans.

The mission and functions of the IGA is to:

- Advise HHS on state, local, and tribal issues:
    - advise Departmental officials on state, local, and tribal perspectives regarding HHS policies and programs.
    - facilitate the coordination and implementation of Administration and Secretarial initiatives at the headquarters, regional, state, tribal, local and community levels.
    - formulate and recommend Department policies on the delivery of services to states, territories and communities.
    - ensure that HHS services are consistent in approach on state, local, and tribal levels of government.
- Facilitate communication between HHS and state, local, and tribal governments.
    - serve as the Departmental liaison to state, local, and tribal governments and the organizations that represent them.
    - represent the Secretary and Deputy Secretary in communications with intergovernmental officials of other Federal agencies, officials of state, tribal and local governments, and non-governmental organizations, including national advocacy groups and national associations that represent state, local, and tribal governments.
- Coordinate the HHS Regional Offices.
    - direct the Regional Directors (RDs) and their offices in their role in planning, development and implementation of Departmental policy.
    - serve as point of contact between the SRRs and the Regional Offices.

IGA tracks HHS region-specific, Federal and State legislative actions, and serves as a surrogate for the Secretary and Deputy Secretary in the regions, informing State, local and tribal officials, the media and public of the Administration's and Department's program initiatives and priorities. IGA provides Departmental leadership in the field in several areas, including all top Secretarial priorities and initiatives. IGA also represents the Secretary and the Deputy Secretary in contacts with officials from other Federal agencies, the White House, State, local, and tribal governments, their representative organizations, and other outside parties. IGA solicits a full range of viewpoints from stakeholders, including State, local and tribal officials, district Congressional staffs, business coalitions, interest groups, advocacy groups, the media and other regional constituents to be shared with headquarters and the Office of the Secretary.

<u>Funding History</u>

FY 2006	$5,931,000
FY 2007	$5,762,000
FY 2008	$5,978,000
FY 2009	$6,244,000
FY 2010	$6,099,000

FY 2011 Budget Request

The FY 2011 request for IGA is $6,438,000, an increase of $339,000 over the FY 2010 enacted level. This will partially cover increased personnel costs such as the annualization of the January 2010 pay raise, and the anticipated January 2011 pay raise. The budget request for IGA will be used to coordinate a range of outreach activities and facilitate cross-cutting initiatives in the field. IGA develops close relationships with, and is the Secretary's representative to governors, State legislators, mayors, tribal leaders, other elected and appointed officials, and their constituencies.

In 2011, IGA will work extensively to convene multi-stakeholder forums with state, local and tribal governments to advance and support health reform activities across the country. IGA will continue to build on their participation in the White House Regional Forums on health reform which were held in Michigan, Vermont, Iowa, North Carolina and California to discuss what must be done to change our health care system. IGA also responds with outreach and communication with key external groups, such as business advocacy groups, healthcare organizations and other private sector entities impacted by Departmental Initiatives.

OPHS
FEDERAL EMPLOYEE HEALTH AND WELLNESS INITIATIVE

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$0	$0	$0	$10,000,000	+$10,000,000
FTE	0	0	0	0	0

FY 2011 Authorizing Legislation……………………………………………………….
Allocation Method…………………………………………………………..Direct Federal, Contracts

Program Description and Accomplishments

On May 12, 2009, President Obama met with CEOs from several major corporations to discuss their initiatives to improve employee health and reduce health care costs through worksite wellness and other initiatives. As a result of this meeting, an interagency planning group consisting of the Office of Personnel Management, the Office of Management and Budget, the National Economic Council, and HHS was established to explore the development of the Federal Employee Worksite Health and Wellness Initiative. A five-part initiative has been proposed by the agencies, including:

Activities by the President and agency heads to create a culture of wellness for Federal employees;
The development of prototype health and wellness programs at three locations to serve as models for comprehensive worksite wellness programs to be rolled out across Federal worksites;
Improving nutrition and fitness facilities in Federal facilities by expanding farmer's markets, altering cafeteria contracts to support more nutritional options, and improving access to a variety of fitness opportunities;
Modernization of the Federal Employee Health Benefit Program to ensure consistency with the President's health reform goals, including prevention, wellness, and cost reduction; and,
Rigorously evaluating the programs to document the effectiveness of the initiative.

The target audience for this effort is all Federal employees. Ultimately, the results of the Initiative may influence wellness practices throughout the American workforce.

Budget Request

The FY 2011 request is $10,000,000 to operate and evaluate three Federal Employee Worksite Health and Wellness Initiative prototypes. The interagency planning group has agreed to develop two prototypes at three sites:

Prototype A: Two sites will be staffed primarily by nurses and nurse practitioners and will provide comprehensive wellness, urgent care, and occupational health services. It will emulate many of the successful private sector programs and represent a significant advancement over the wellness programs offered in most Federal agencies; and,
Prototype B: One site will have the same set of primary prevention services as Prototype A plus the addition of services overseen by a full time physician, or physician assistants who will be able to provide additional clinical preventive screenings, diagnoses, and treatment interventions with close communication with any existing primary care providers the employee may have.

Both of these prototypes, as well as other aspects of this initiative, will be rigorously evaluated. All aspects of the wellness pilots shall be reviewed, including the effectiveness and efficiency of health and wellness interventions, operations, programs, finances, costs (health, workmen's compensation, and disability), benefits, outreach, absenteeism, employee morale, and other outcomes including the impact of improved health on productivity.

A common evaluation plan, protocol, and metric will be devised for use in all wellness pilots. However, unique pilot characteristics and attributes will be considered and incorporated as required into the actual evaluation activities for each pilot. Evaluation procedures will be developed, formally documented, and followed during the evaluations. The evaluation design should include before and after comparisons as well as control or comparison groups and locations.

The evaluation is meant to have formative and summative components. Interim reports providing preliminary findings and assessments of operational aspects of the pilots will be required.

A single evaluation team will be used to evaluate all wellness pilots and comparison groups.

OPHS
HEALTHCARE-ASSOCIATED INFECTIONS

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$5,000,000	$0	$5,000,000	$5,000,000	$0
FTE	0	0	0	0	0

Authorizing Legislation……………..……Title III, Section 301 of the Public Health Service Act
FY 2011Authorization...……………………..……………………………………Indefinite
Allocation Method…...…………………………………...……..………………Direct Federal

Program Description and Accomplishments

Healthcare-associated infections (HAIs) are infections that patients acquire while receiving treatment for medical or surgical conditions. HAIs are among the top ten leading causes of preventable death in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths in 2002. The financial burden attributable to these infections is staggering. HAIs resulted in an estimated $28 billion to $33 billion in excess healthcare costs each year.

In FY 2008, HHS began a Department-wide effort to address HAIs by establishing the senior-level Steering Committee for the Prevention of Healthcare-Associated Infections in order to improve and expand prevention efforts. The Steering Committee, chaired by the Deputy Assistant Secretary for Healthcare Research and Quality, is charged with developing and implementing the HHS Action Plan to Prevent HAIs. The Plan established national five-year goals and outlined key actions for enhancing and coordinating HHS activities and outlined opportunities for collaboration with external partners.

In FY 2009, OPHS is expanding the work of the Steering Committee by coordinating implementation of the Action Plan, monitoring progress in achieving the national goals outlined in the Action Plan, and leading the next tier's efforts. The Steering Committee also coordinates the use of HAI-related American Recovery and Reinvestment Act (ARRA) funds provided to the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), and Centers for Medicare and Medicaid Services (CMS).

In late FY 2009, OPHS began development and implementation of a three-year national media campaign to raise awareness of the importance of addressing HAIs with a variety of audiences. The campaign focuses on consumers and healthcare providers in hospital settings as well as medical, dental, nursing students and practicing clinicians with a computer-based interactive training. The campaign aims to impact the norms around preventing HAIs by elevating

prevention behaviors and will empower consumers to take a more active role in their healthcare and motivate providers to recognize the important role they can play in reducing national rates. The campaign includes national public service announcements in both Spanish and English, a consumer and provider checklist, out-of-home advertisements, and a stakeholder/partnership plan to help disseminate campaign information and to identify strategic partnerships.

OPHS has also supported a variety of inter-agency projects linked to the Action Plan, including:

- establishment of a framework for prioritizing specific HAI prevention recommendations that are based on a rigorous systematic assessment of the scientific evidence to support their effectiveness. The framework for prioritization will be based on examination of the (1) evidence for effectiveness; (2) magnitude of health impact that can be derived from adherence to recommendations; and (3) balance of costs and benefits arising from implementation of recommendations;
- establishment of a framework for evaluating the Action Plan and its implementation; development of a set of core measures and targets to assess the nation's progress in reducing and preventing HAIs; and establishment of a mechanism to continuously refine the measures and targets in response to new scientific discoveries and improved measurement systems; and
- implementation of a research proposal to validate the use of low-cost sensor technology for monitoring adherence to recommended hand hygiene practices in a variety of healthcare settings and to test the impact of data feedback on hand hygiene practice improvement.

In FY 2010, the Steering Committee began its next tier efforts to reduce and prevent HAIs in ambulatory surgical and hemodialysis centers. The Steering Committee plans to continue to implement the current Action Plan focused on infections occurring in hospitals and develop strategies focusing on these other two care settings in FY 2010.

Funding History

FY 2006	$0
FY 2007	$0
FY 2008	$0
FY 2009	$5,000,000
FY 2010	$5,000,000

Budget Request

The FY 2011 request is $5,000,000, the same as FY 2010 Appropriation level. FY 2011 Request enables the continued support of the existing projects as described above, specifically continuation and expansion of the national media campaign. The continued funding will also be used to expand the use of social media tools and develop a single comprehensive website for HAI information, as well as evaluate the media campaign and original Action Plan and assess whether it is achieving its intended goals.

OPHS also plans to use the continued funding to support a coordinated information systems strategy at the Department. Various HAI surveillance and reporting systems exist across HHS, but a need has been defined for better coordination of the systems. OPHS plans to support the

development and implementation of information systems projects designed to support a standards-based solution for integrating data collection across specific HHS data systems with the intent of using interoperability standards to reduce "siloed" Departmental data systems and reduce the data collection and reporting burden on healthcare facilities.

The Steering Committee seeks to build effective partnerships for HAI prevention at the regional, state, and local levels, as well as support the development and implementation of state-level HAI prevention plans. In FY 2011, the Steering Committee will begin its third tier efforts focused on reducing infections in long-term care facilities. The Steering Committee will also have the responsibility for monitoring the Department's progress in reducing and preventing HAI.

SECRETARIAL INITIATIVES AND FLEXIBILITY

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$0	$0	$1,250,000	$2,500,000	+$1,250,000
FTE	0	0	0	0	0

FY 2011 Authorization: ………………………………………….. Indefinite
Allocation method: ……………………………………………… Direct Federal; Contracts

Program Description and Accomplishments

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

Budget Request

The FY 2011 request for Secretarial Initiatives and Flexibility is $2,500,000, an increase of $1,250,000 over the FY 2010 Appropriation. As the Administration's priorities continue to emerge, the budget request will allow the Secretary to be prepared to support OS component offices as they respond to new legislative requirements and implement programs to address new and existing critical health issues. The budget request will allow the Secretary to provide necessary support as HHS Operating Divisions (OPDIV) and Staff Divisions (STAFFDIV) establish programs and initiatives in support of the Administration's mission and goals.

HHS has been proactively seeking ways to respond to health issues that have emerged as a result of our current economic climate. As a result, the OPDIVs and STAFFDIVs have implemented programs and initiatives intended to respond to the critical health needs of the public. The budget request will allow the Secretary to establish and support priorities aligned with OPDIV

and STAFFDIV activities, enabling the Secretary to provide necessary and expected leadership. These supportive activities will also enable the Secretary to ensure appropriate accountability and transparency, emphasizing Administrative priorities.

Accountability in HHS

Throughout this document are targeted funding increases totaling $3,798,000 requested for individual Staff Divisions to improve Departmental Accountability functions and activities. These funds will ensure that key offices have the necessary resources to support risk mitigation efforts for ongoing HHS activities. This request reflects an increased need for additional resources to support those offices which are responsible for creating and implementing guidance, policies, and controls crucial to the effective management of HHS programs. Growth of HHS programs has resulted in increased demands on these offices. As a result, OS intends to be responsive by providing oversight to programs critical to the safety and well being of the American public. As OS responds to the Administration's priorities to employ rigorous standards of accountability and transparency throughout the Federal government, this funding will allow responsible offices to: enhance oversight of and policy guidance for acquisitions; strengthen legal review and oversight; improve financial reporting and financial controls; and implement robust budgetary oversight execution controls and performance tracking. In support of these efforts, this request includes salaries and expenses to employ the necessary staff with the distinctive skill-sets required to execute these functions. Details supporting the budget request can be found in the individual FY 2011 budget requests of each affected office as follows:

Staff Division	Purpose	Amount Requested*
Assistant Secretary for Public Affairs	Improve transparency via improved communications	$543,000
Assistant Secretary for Financial Resources	Improve risk mitigation in contracts administration by expanding oversight and accountability; improve financial reporting and financial controls, implement more robust budgetary execution controls and performance tracking; improve grants management and operations oversight, and eliminate improper payments	$1,205,000
Assistant Secretary for Administration	Strengthen human capital management	$317,000
Office of the General Counsel	For legal analysis and counseling throughout the acquisition process to reduce legal risk on procurement actions	$1,019,000
Departmental Appeals Board	Maintain its current staff to handle appeals caseload	$611,000
Office of Public Health & Science	Improve internal controls through A-123 audit support	$103,000

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

OPHS
TEEN PREGNANCY PREVENTION

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
Discretionary	---	---	$110,000,000	$129,218,000	+$19,218,000
Mandatory	---	---	---	50,000,000	+50,000,000
Evaluation funds (non-add)	---	---	*[4.445]*	*[4.445]*	---
FTE	---	---	12	16	+4

Authorizing Legislation……………………………..….Omnibus Appropriation Act, FY 2011
Allocation Method…………………………… Direct Federal, Competitive Grants, Contracts

Program Description and Accomplishments

The Teen Pregnancy Prevention (TPP) program is a new discretionary grant program to support evidence-based teen pregnancy prevention approaches and is under the direction of the Office of Adolescent Health (OAH). This funding will be used to make competitive grants and contracts to public and private entities to fund medically accurate and age appropriate programs that reduce teen pregnancy and for the Federal costs associated with administration and evaluation. OAH will coordinate its efforts with other HHS offices and Operating Divisions.

The TPP program addresses rising teen pregnancy rates by supporting evidence-based models to reduce the risks of pregnancy. These funds will support both the replication of evidence-based models and demonstration programs to identify new effective approaches.

Funding History

FY 2010 $110,000,000

Budget Request

The FY 2011 request is $129,218,000, an increase of $19,218,000 above the FY 2010 Appropriation level. The discretionary TPP initiative directs most funds towards programs that have been shown to be effective, but also provides room for innovation to identify new approaches. This budget will support both types of projects. First, $85 million will be used to fund a wide range of evidence-based programs that replicate teen pregnancy prevention programs which have proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors (Tier I).

An additional $28 million will be used for research and demonstration (R&D) grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy (Tier II). These R&D programs must not necessarily have to have a rigorous evaluation demonstrating effectiveness, but must show promise and potential. The models which grantees propose to use will be subject to rigorous evaluation and, if shown to be effective, grantees may be eligible under the $85 million designated for evidence-based programs. Funds will also be used for training and technical assistance, evaluation, outreach and additional program support.

The budget also seeks authorization for a new $50 million mandatory TPP program of grants to States, tribes, and territories.

As part of the Administration's government-wide initiative to strengthen program evaluation, the request also includes $4,000,000 for a Federal evaluation of the projects funded under the discretionary TPP program. This study is one of 23 evaluation proposals specifically approved by the Office of Management and Budget (OMB) for FY 2011 to strengthen the quality and rigor of Federal program evaluation. To ensure that the study is well designed and implemented, OAH will work with the HHS Assistant Secretary for Planning and Evaluation (ASPE), evaluation experts at OMB, and the Council of Economic Advisers during the planning, design, and implementation of the study. OAH is committed to promoting strong, independent evaluation that can inform policy and program management decisions and will post the status and findings of this and other important evaluations publicly available online.

In FY 2011, through a contract, OAH will work to develop appropriate program performance measures for the TPP program and other OAH activities, as well as design a system for collecting annual performance data.

Teenage Pregnancy Prevention Program Data

ACTIVITY	FY 2010 APPROPRIATION	FY 2011 REQUEST LEVEL
RESOURCE DATA		
Mandatory Grants to States	---	$50,000,000
Teen Pregnancy Prevention Grants (discretionary)		
Tier I – Replication Projects	$75,000,000	$85,000,000
Tier II – Research and Demonstration Projects	$25,000,000	$28,000,000
Total, TPP Grants	$100,000,000	$113,000,000
Training and Technical Assistance, Outreach, and other program support*	$10,000,000	$12,218,000
Evaluation	---	$4,000,000
Total Resources	$110,000,000	$179,218,000
PROGRAM DATA		
Number of Teen Pregnancy Prevention Grants		
Discretionary Grants		
New starts	275	35
Continuations		275
Contracts	9	10
Mandatory Grants to States		50

*Program support – includes funding for space, equipment, information technology, grants panel review costs, conference fees, program monitoring, travel, printing, staff salaries and benefits, and associated operating costs.

OPHS
ADOLESCENT FAMILY LIFE

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$29,778,000	$0	$16,658,000	$16,658,000	$0
FTE	12	0	12	8	-4

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

Program Description and Accomplishments

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

In FY 2010, Congress did not appropriate funds for AFL Prevention demonstration grants. In FY 2011, it is anticipated that only AFL Care demonstration grants will be supported. In FY 2009, the AFL program supported two types of demonstration programs:

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

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

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

The AFL program supports the HHS Strategic Plan, Goal 3: Promote the economic and social well-being of individuals, families and communities; Objective 3.2 - Protect the safety and foster

the well-being of children and youth. AFL has three measures directly related to care projects: (2.2.1) "Maintain the incidence of clients in AFL Care demonstration projects who do not have a repeat pregnancy," (2.2.2) "Increase infant immunization among clients in AFL Care demonstration projects," (2.2.3) "Increase the educational attainment of clients in AFL Care demonstration projects." AFL measures the caliber of evaluations for both care and prevention projects through a measure that seeks to "Improve the quality of the Title XX independent evaluations." The program's efficiency measure seeks to sustain the cost to encounter ratio for both prevention and care programs.

In FY 2009, AFL initiated a national evaluation of the AFL program and will continue this effort for the next two years. The purpose of this evaluation is to conduct an independent cross-site evaluation of the AFL demonstration program to describe its implementation and to evaluate its impact on desired outcomes. During FY 2009, baseline and one wave of follow-up data collection was conducted with AFL prevention grantees. Long term outcome objectives 1 and 2, with associated measures, will be assessed through this process (see "AFL Outcome Table"). Note that after FY 2009, long-term objective 1 will no longer be measured due to discontinuation of funding.

Funding History

FY 2006	$30,256,000
FY 2007	$30,229,000
FY 2008	$29,778,000
FY 2009	$29,778,000
FY 2010	$16,658,000

Budget Request

The FY 2011 request is $16,658,000, the same level of funding as the FY 2010 Appropriation level. The FY 2011 request provides funds for staff pay increases and enables the program to continue to support AFL Care demonstration projects and research.

Outputs and Outcomes

Measure	Most Recent Result (FY 2008)	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Long-Term Objective 1: Encourage adolescents to postpone sexual activity by developing and testing abstinence interventions.				
1.1 Increase communication among parents and adolescents on topics relating to puberty, pregnancy, abstinence, alcohol, and/or drugs.	43%	N/A	N/A	N/A
1.2 Increase adolescents' understanding of the positive health and emotional benefits of abstaining from premarital sexual activity.	57.5%	N/A	N/A	N/A
Long-Term Objective 2: : Ameliorate the effects of too-early-childbearing by developing and testing interventions with pregnant and parenting teens				
2.1Maintain the incidence of clients in AFL Care demonstration projects who do not have a repeat pregnancy.	90%	92%	92%	Maintain
2.2 Increase infant immunization among clients in AFL Care demonstration projects.	65%	82%	84%	+2%
2.3 Increase the educational attainment of clients in AFL Care demonstration projects.	79%	80%	81%	+1%
Long-Term Objective 3: Identify interventions that have demonstrated their effectiveness to: 1) promote premarital abstinence for adolescents and 2) ameliorate the consequences of adolescent pregnancy and childbearing.				
3.1 Improve the quality of the Title XX independent evaluations (prevention/care)	48.5%/ 55.5%	N/A / 58.8%	N/A / 63%	N/A / +4.2%
Long-Term Objective 4: Improve the efficiency of the AFL program.				
4.1 Sustain the cost to encounter ratio in Title XX prevention and care demonstration projects (prevention/care)	$25/ $72	N/A / $110	N/A / $110	Maintain
Program Level Funding ($ in millions)	$29.778	$16.658	$16.658	Maintain

ADOLESCENT FAMILY LIFE
Program Data

Activity	FY 2009 Actual		FY 2010 President's Budget Request		FY 2011 Request Level	
PROGRAM FUNDING	No.	Amount	No.	Amount	No.	Amount
Care Demonstration Grants						
Continuations	31	$10,999,022	17	$6,306,264	16	$7,315,098
New	0	0	9	4,692,758	6	3,683,924
Subtotal, Care	31	$10,999,022	26	$10,999,022	22	$10,999,022
Prevention Demonstration Grants						
Continuations	35	$13,120,000	0	$0	0	0
New	0	0	0	0	0	0
Subtotal, Prevention	35	$13,120,000	0	$0	0	0
Total, Demonstration Grants	66	$24,119,022	26	$10,999,022	22	$10,999,022
Research						
Continuations	4	$488,787	1	$500,000	4	$600,000
New	1	511,213	4	600,000	2	500,000
Subtotal, Research	5	$1,000,000	5	$1,100,000	6	$1,100,000
Demonstration related technical assistance and support activities		1,499,446		1,140,000		1,140,000
Research IAAs & Related Activities		640,418		640,418		640,418
Support Costs		2,421,871		2,778,560		2,778,560
TOTAL		**$29,778,000**		**$16,658,000**		**$16,658,000**
CLIENTS SERVED*						
Title XX Care Demonstrations.........	31	5,149	26	3,500	22	4,000**
Title XX Prevention Demonstrations................................	35	27,665	0	0	0	0
TOTAL...	66	32,814	26	3,500	22	4,000

*Number of clients estimated by average 200 per year per care program.
**In FY 2011, the estimated number of Care client served is slightly increased since first year grants will be devoted to start-up activities. The number of Care clients served will increase in 2012.

OPHS
OFFICE OF MINORITY HEALTH

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$52,956,000	$0	$56,000,000	$57,980,000	+1,980,000
FTE	62	0	63	63	0

Authorizing Legislation…………………………..…Title XVII, Section 1707 of the PHS Act
FY 2011 Authorization………. ....Expired
Allocation Method .... Direct Federal; Competitive Grant/Cooperative Agreement; & Contract

Program Description and Accomplishments

The Office of Minority Health (OMH) was created in 1986 as one of the most significant outcomes of the 1985 *Secretary's Task Force Report on Black and Minority Health.* OMH was subsequently established in statute by the Disadvantaged Minority Health Improvement Act of 1990 (PL 101-527), and reauthorized under the Health Professions Education Partnerships Act of 1998 (PL 105-392).

OMH's mission is to improve the health of racial and ethnic minority populations through the development of policies and programs that help eliminate disparities. Policy and program activities focus on improving the health status and health outcomes for African Americans, Hispanic Americans, American Indians/Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders. The poor health outcomes for racial and ethnic minorities are reflected in the health status and health care disparities that are apparent when comparing health indicators for minorities against those of the rest of the U.S. population.

In many respects, racial and ethnic minority populations continue to be under-served by the U.S. health care system. The 2008 National Healthcare Disparities Report (NHDR) which is mandated by Congress found that for African Americans, Asians, American Indians/Alaska Natives, Hispanics, and poor people, at least 60 percent of measures of quality care are not improving (stayed the same or worsened). The Report also found that while reducing disparities in access to care is an important step to improving overall quality: (1) for African Americans and Asians, 60 percent of the core measures used to track access remained unchanged or got worse; and (2) for Hispanics, 80 percent of the core access measures remained unchanged or got worse[1]. In fact, some of the largest gaps remain:

[1]2008 National Healthcare Disparities Report, page 2. Agency for Healthcare Research and Quality.

- The proportion of new AIDS cases was 9.4 times as high for African Americans as for Caucasians.[2]
- While the rate of hospitalizations for lower extremity amputations improved overall, the gap between African Americans and Caucasians increased (5.7 admissions per 1,000 population with diagnosed diabetes compared to 2.5 admissions per 1,000).
- Asian American/Pacific Islander and Vietnamese American women especially tend to have much lower rates of cervical cancer screening than other groups.[3]
- About 1 in 4 American Indian or Alaska Native adults (23.8 percent) were poor compared with 1 in 5 African American adults (20.9 percent), 1 in 8 Asian adults (12.7 percent) and 1 in 11 Caucasian adults (9.0 percent).
- Hispanics had 63 percent more pediatric asthma hospitalizations.[4]
- About one-third of poor and near-poor Hispanic or Latino women experienced an unmet medical need due to cost.[5]
- African American children have a 260 percent higher emergency department visit rate, a 250 percent higher hospitalization rate, and a 500 percent higher death rate from asthma, as compared with Caucasian children.[6]

The primary recipients of OMH grant funds include state offices of minority health, community- and faith-based organizations, tribes and tribal organizations, and institutions of higher education. OMH makes approximately 149 grant awards per year which directly focus on prevention and health promotion (e.g., culture of wellness, healthy choices, and medical screenings), risk reduction, healthier lifestyle choices, utilization of quality health care services, and barriers to health care for racial and ethnic minorities. They also facilitate development, implementation, and/or improvement of state and tribal government policies and programs to: (1) improve collaboration and reduce redundancy; (2) increase availability and utilization of all forms of data and information; and, (3) improve access to, and availability of, quality health care for racial and ethnic minorities.

OMH developed the *National Partnership for Action to End Health Disparities* (NPA) to guide and strengthen future actions at the community, state, tribal, regional, and national levels.

The NPA has five objectives around which national strategies have been formed:

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[2] 2008 National Healthcare Disparities Report, page 51. Agency for Healthcare Research and Quality.

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

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

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

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

- Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes;
- Strengthen and broaden leadership for addressing health disparities at all levels;
- Improve health and health care outcomes for racial and ethnic minorities and underserved populations and communities;
- Enhance cultural and linguistic competency; and
- Improve coordination and use of research and outcome evaluations.

Significant activities and programs in OMH share one or more of these NPA objectives. OMH is working with its key stakeholders to prioritize and implement national strategies and actions. Key national NPA partners include the Association of State and Territorial Health Officials, National Committee for Quality Assurance, National Association of State Offices of Minority Health, National Conference of State Legislatures, and the National Business Group on Health.

African American and American Indian/Alaska Native infant mortality rates are among the highest in the nation. Despite existing efforts, there is insufficient awareness of what individuals and families can do to prevent infant mortality. OMH launched *A Healthy Baby Begins with You* campaign to address prevention of infant mortality and promotion of preconception care in African American communities. More than 60 events have been conducted with state and city health departments, Healthy Start programs, and national organizations including CityMatCH, the March of Dimes and the Association of Maternal and Child Health Programs. The campaign's national spokesperson is Tonya Lewis Lee, author, producer, and wife of filmmaker Spike Lee.

Hepatitis B virus (HBV) disproportionately affects Asian Americans, and Native Hawaiians, and Other Pacific Islanders. In December 2008, OMH released, in partnership with the Centers for Disease Control and key stakeholders, *National Goals and Strategies to Address Chronic Hepatitis B in Asian American, Native Hawaiian, and Other Pacific Islander Populations*. Elements include increasing national awareness of the disproportionate impact of HBV; engaging stakeholders in national and community level action; and, expanding the infrastructure needed to reduce the risk of chronic HBV infection and its long-term complications.

The mission of the Center for Linguistic and Cultural Competence in Health Care (CLCCHC) is to enhance the ability of the health care system to deliver effective, culturally and linguistically appropriate health care services to ethnically and racially diverse populations. Through CLCCHC, OMH has supported the development of the Culturally and Linguistically Appropriate Services Standards (CLAS) in health care, cultural competency E-learning modules for physicians and registered nurses that are fully accredited for continuing medical and nursing education, web-based Health Care Services Language Implementation Guide Tool to facilitate health care access to language minority populations, and, "CLAS-ACT" (Culturally and Linguistically Appropriate Services and Clinical Trials) as a tool for increasing the participation of minorities in clinical trials.

In FY 2009, 71,754 continuing medical education credits and certificates of participation were awarded to participants of the physician modules and 35,250 continuing education credits were awarded to registered nurses. In addition, specific activities of the Center for Emergency

Preparedness for Underserved Communities (CEPUC), includes the National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities and the Cultural Competency e-learning training program for disaster personnel.

Youth Empowerment Program represents pilot projects which target the identification of programmatic and policy gaps needed to improve outcomes for minority boys. This program addresses community-based interventions for reducing risky behaviors among targeted minority youth. These demonstration grants require a multi-partner approach involving institutions of higher education, primary and secondary schools, community organizations and institutions, and the community at-large. Each grantee must involve at least three formal partnerships, one of which must be with a primary or secondary school. A youth center must be established to provide services to the cohort, grades 3 through 10, from the target population to participate in each of the 3 years of the project.

The Office of Minority Health Resource Center supports a national health information infrastructure, critical health disparities awareness programs, cross-departmental collaborations, and the web presence for OMH. The Resource Center will continue its collaborations with state health departments, state offices of minority health, and focus on personal and community behavior related to health and the issues faced by community organizations. Its capacity development efforts target small and new service organizations that improve outreach and testing for HIV, tuberculosis, and sexually transmitted infections in the US Pacific Jurisdictions; strengthen community-based outreach; improve data collection and analysis on HIV infection in African immigrant communities; increase mentoring and training for Latino community leaders working on HIV/AIDS; and strengthen community-based and tribal work on HIV/AIDS.

The National Umbrella Cooperative Agreement Program is a strategic approach to increasing the diversity of the health-related work force, improving quality of care, and improving evaluation procedures and the collection and analysis of data for targeted minority populations. The use of the cooperative agreement funding mechanism facilitates the ability of HHS to partner with other Federal agencies in working with national organizations to carry out a broad range of public health projects to reduce health disparities among racial and ethnic minorities.

The purpose of National Minority Male Health Project (NMMHP) is to promote healthy lifestyles among minority males through a comprehensive program of research, service, and education. The outcomes of the NMMHP will be used to develop other national efforts to address health disparities among racial and ethnic minority males. $Funded projects address a range of issues related to health disparities for minority males, engagement of minority males in health care, and improvement in education outcomes.

The American Indian and Alaska Native Health Research Advisory Council (HRAC*)* was established to provide a venue for consulting directly with Tribes about health research priorities and to collaborate on approaches to effectively address their health issues and needs. As an advisory body to HHS, the HRAC is comprised of elected Tribal officials and serves three primary functions: obtain input from Tribal leaders on health research priorities and needs for their communities; provide a forum through which HHS operating and staff divisions can better communicate and coordinate AI/AN health research activities; and provide a conduit for

disseminating information to Tribes about research findings from studies focusing on the health of AI/AN populations.

Funding History

FY 2006	$56,338,000
FY 2007	$53,455,000
FY 2008	$49,118,000
FY 2009	$52,956,000
FY 2010	$56,000,000

Budget Request

The FY 2011 request is $57,980,000, a net increase of $1,980,000 above the FY 2010 Appropriation level. The FY 2011 budget request will support the following projects:

The request includes $2,000,000 to support a new Department strategic plan on tobacco cessation. OPHS will lead, in coordination with OMH, the Office on Women's Health (OWH) and other partners, activities to reduce tobacco use among vulnerable populations. Activities include the *Tobacco Cessation among Minority Populations and Low Socioeconomic Women* (TCMW) program. This program will increase patient awareness about the dangers of tobacco and will provide access to culturally and linguistically relevant evidence-based cessation strategies to reduce smoking among minorities and low socioeconomic women.

State Partnership Program. $7,100,000 (an increase of $500,000) to support grants to state and U.S. affiliated Pacific Basin Jurisdictions (territories) departments of health, thereby strengthening state and territorial policies related to racial and ethnic health disparities; develop or adopt state and territory-wide collaborative plans for eliminating health disparities; and facilitate implementation of innovative programs that reduce disparities in health across the state/territory. OMH also is working with the Association of State and Territorial Health Officials and the National Association of State Offices of Minority Health to strengthen and increase state-based strategic planning and partnerships.

American Indian and Alaska Native (AI/AN) Partnership Program. This program provides support to tribal epidemiology centers to work with their respective tribal leaders to better access data, engage in data development activities, and/or use a broad array of data to facilitate evidence-based health care decision-making and address health disparities planning; develop non-traditional alliances and partnerships to improve coordination/alignment of health and human services and access to quality care for their communities; and improve the diversity of the tribal healthcare, public health, and research workforce. A request of $2,000,000 ($400,000 above the FY 2010 appropriation) to requested to support the program.

Community Partnership to Eliminate Health Disparities Demonstration Grant Program (CPEHD). The request includes $7,000,000, an increase of $1,000, to will support the second year of projects funded for a three-year period. The CPEHD program promotes the utilization of community partnerships with locally grounded, grassroots organizations to develop and/or

implement promising practices and model programs targeting minority communities that focus on: health education promotion; disease risk reduction and increased access to and utilization of preventive health care; and treatment services. These projects coordinate integrated community-based educational screening and outreach services and provide linkages for access and treatment to minorities in high-risk, low-income communities.

Bilingual/Bicultural Demonstration Grants Program. The FY 2011 request of $1,600,000, an increase of $400,000, will addresses the health status of limited English proficient minority populations by reducing barriers and increasing access to quality health care, increasing the diversity of the healthcare workforce, and disseminating outcomes related to culturally and linguistically appropriate services and training.

HIV/AIDS Cooperative Agreement Program. This program addresses critical gaps in HIV/AIDS prevention through effectiveness of partnership arrangements that include national minority-serving organizations, institutions of higher education (particularly those with a history of serving minority populations, such as Historically Black Colleges and Universities, Hispanic Serving Institutions, Tribal Colleges and Universities), and organizations with access to minority populations with increasing rates of HIV/AIDS. The request includes $1,600,000, an increase of $500,000, to support this initiative.

Comparative Health Disparities Demonstration program. The request for the Comparative Health Disparities demonstration program is $2,700,000, an increase of $700,000. Funds are intended to develop evidence about health care reform strategies that have the greatest likelihood for improving outcomes for minority communities. Racial and ethnic minorities experience rates of morbidity and mortality from chronic diseases, challenges to accessing quality healthcare, and rates of uninsured that are two or three times larger than the White population. They also are underrepresented in the health care workforce, more likely to live in communities with limited or poor healthcare resources, and face language and cultural barriers to care.

Outputs and Outcomes

Measure	FY 2009 Preliminary	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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%)	N/A (interim FY 2007 data indicate 66.4%)	68.6%	68.6%	---
Increased knowledge and understanding of the nature and extent of racial and ethnic health disparities in the general population (1999 Baseline: 47.5%)	52.5 preliminary (exceeded target of 51.8%)	52.8%	53.8%	+1.0%
Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support (2006 Baseline: 18,960-reset in 2009 to 7312)	7312 (Reset)	7531	7757	+226
Program Level Funding ($ in millions)	$52.956	$56.000	$57.980	+$1.980

Grant Awards

	FY 2009 Omnibus	FY 2010 Pres Budget	FY 2011 MAX
Number of Awards	120	149	157
Average Award	$198,483	$200,168	$201,443
Range of Awards	$130,000-$900,000	$125,000-$1,000,000	$125,000-$1,000,000

Program Data Chart

Activity	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request
OMH Resource Center	$3,000,000	$3,700,000	$3,700,000
Logistical Support Contract	1,300,000	1,400,000	1,400,000
Center for Linguistic and Cultural Competency in Health Care	1,600,000	1,600,000	1,600,000
Evaluation	300,000	700,000	800,000
Tobacco Cessation	0	0	2,000,000
Other Contracts & IAAs	3,898,630	4,879,000	4,879,000
Subtotal, Contracts	10,098,630	12,279,000	14,379,000
Male Health	900,000	1,000,000	1,000,000
HIV/AIDS Coop Agreements	800,000	1,000,000	1,500,000
Umbrella Cooperative Agreements	3,834,000	2,725,000	2,725,000
Subtotal, Coop Agreements	5,534,000	4,725,000	5,225,000
Bilingual/Bicultural Demonstrations	2,300,000	1,200,000	1,600,000
Health Disparities Program:			
State Partnership Grants	5,100,000	6,600,000	7,100,000
American Indian/Alaska Native Partnership Grants	1,200,000	1,600,000	2,000,000
Community Partnership Grants	5,700,000	6,000,000	7,000,000
Comparative Demonstrations	0	2,000,000	2,700,000
Youth Empowerment Program	3,900,000	3,500,000	3,500,000
Conference Support Program	400,000	200,000	350,000
Subtotal, Demonstration Projects	18,600,000	21,100,000	24,250,000
Health Disparities – Mississippi	5,283,000	4,000,000	0
Specified Project – Lupus	1,000,000	0	0
Operating Expenses	12,440,370	13,896,000	14,126,000
TOTAL	**$52,956,000**	**$56,000,000**	**$57,980,000**

OPHS
OFFICE ON WOMEN'S HEALTH

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$33,746,000	$0	$33,746,000	$33,746,000	$0
FTE	43	0	43	43	0

Authorizing Legislation…………………………………..Title III, Section 301 of the PHS Act
FY 2011 Authorization...Indefinite
Allocation Methods…………………………….....Direct Federal; Competitive grants; Contracts

Program Description and Accomplishments

The Office on Women's Health (OWH) was established in 1991 to improve the health of American women and girls by advancing and coordinating a comprehensive women's health agenda throughout HHS. The program has four goals: 1) Develop and impact national women's health policy; 2) Develop, adapt, and evaluate and/or replicate model programs on women's health; 3) Educate, influence and collaborate with health organizations, health care professionals, and the public; and 4) Increase OWH's capacity to achieve maximum operational performance and objective documentation of accomplishments.

OWH provides departmental leadership on women's health, while developing partnership opportunities across agencies and with the private sector. OWH promotes health equity for women and girls through sex/gender-specific approaches and fulfills this mission through competitive contracts and grants to an array of community, academic and other organizations at the national and community levels. National educational campaigns provide information about the important steps women can take to improve and maintain their health. This approach maximizes efficiency and minimizes costs. OWH has experienced success in all of its program goals.

During FY 2008, OWH drafted a Strategic Plan for FY 2010 - FY 2015, which became effective in October 2008. Under this new plan, OWH began funding evidence-based interventions to acknowledge women's health areas that were not addressed at the national level by any other public or private entity. These programs focus on disparities in women's health, in which minority status, disabilities, geography, family history, low socioeconomic status (SES), chronic conditions, and infectious diseases are contributing risk factors.

OWH assumed leadership and management of the Chronic Fatigue Syndrome Advisory Committee (CFSAC) in FY 2009. Research has shown that CFS is three to four times more common in women compared to men, a rate similar to that of autoimmune conditions like multiple sclerosis and lupus. CFSAC's focus is on children and women with CFS, as well as

ongoing research issues with CDC and NIH. The 2009 meeting was the first meeting that was accessible via videocast. The videocast increased access for individuals with CFS who could not travel to the meeting and also allowed for on demand access after the meeting. The CFSAC met again October 29-30, 2009 and included presentations from departmental *ex-officio* members who offered a status report on CFS-related activities. This webcast attracted almost 1,000 viewers on the first day alone; the highlight being a presentation on the recent funding of xenotropic murine leukemia virus-related virus (XMRV) associated with CFS.

FY 2008 Appropriations Language directed OWH to fund the Institute of Medicine to conduct a study of progress in women's health research. Details of the study, the committee membership, and related materials can be found at http://www.iom.edu/CMS/3793/61343.aspx. Results are expected in early 2010.

Impact National Health Policy as it relates to Women and Girls

The HHS Coordinating Committee on Women's Health (CCWH) was established in the early 1980's to advise the Assistant Secretary for Health on current and planned activities across HHS that safeguard and improve the physical and mental health of women and girls. The CCWH members include senior-level representatives from the National Institutes of Health (NIH), Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), and other agencies and offices.

In July 2009, the CCWH convened *A Summit for Action: The Health of Women and Girls Beyond 2010*. The Summit included approximately one hundred leaders from across the United States, including its territories. Summit attendees — including policy, practice, research, community, and advocacy experts — worked together to lay the groundwork for a comprehensive, compelling and forward-driven action agenda to improve the health of women and girls. This effort will also support a well-integrated systems approach, in concert with the tenets of Healthy People 2020. The CCWH has created an action agenda for transmission to the Secretary that will be developed into a National Action Agenda by spring 2010. Development of the Action Agenda will be the focus of the CCWH meetings through spring 2010.

Model Programs on Women's and Girls' Health

Model Programs on Women's Health focus on developing and replicating innovative programs in women's health. The OWH model program, *Advancing System Improvements to Support Targets for Healthy People 2010* (ASIST 2010), will complete the third year of its three year funding period in FY 2010. The program funds gender-focused, public health systems approaches that adapt evidence-based strategies for use in diverse populations and geographic areas to promote behavior change that lead to improvements in health outcomes for patients with chronic diseases and prevention of these diseases. Grantees are implementing system and policy changes to expand and improve delivery systems and to support program sustainability. Examples of policy changes achieved thus far include getting insurance companies to reduce the premiums of diabetic and hypertensive patients who get their disease under control and getting insurance companies to agree to reimburse for case management supervised by nurse

practitioners. A national evaluation of the ASIST 2010 program is underway to assess the effectiveness of gender-focused, public health systems approach on service delivery and behavioral change.

In FY 2010, OWH will continue an assessment of its former multidisciplinary models of women's health programs in an effort to identify the characteristics of programs that have sustained themselves after federal funding has expired. The assessment will generate examples of acceptable sustained federal programs and guidelines for sustaining a federal program that may be included in future grant/contract announcements.

One model program planned for FY 2010 is a multi-agency program to reduce smoking rates in young, low socioeconomic status (SES) women, 40 percent of whom are now smoking. These women will be reached at three levels: clinical interventions during pregnancy and one year after delivering a child, quit lines with free incentives, and media campaigns.

In FY 2010, OWH will convene an interactive HIV/AIDS Gender Forum that supports the exchange of concepts and best practices in serving women. The Gender Forum will focus on ensuring that public health initiatives, programs, prevention and care services demonstrate competency in serving women.

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

Education and Collaboration on Women's and Girls' Health

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

OWH maintains www.womenshealth.gov, which provides health information and referrals to consumers of health care services, health professionals, researchers, educators, and students. From January 1 – November 30, 2009, there were 14,613,743 user sessions to womenshealth.gov. Additionally, for this same period there were over 26,594 phone calls to the National Women's Health Information Center, with 4,934 of them being specific to breastfeeding.

OWH's www.girlshealth.gov website is the #1 Google return when searching on "girls health." The site motivates girls ages 10-16 to choose healthy behaviors by providing information on fitness, nutrition, stress management, relationships with friends and family, peer pressure, suicide, drugs, and self-esteem. The www.girlshealth.gov website had 1,114,483 user sessions during calendar year 2008.

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

other retailers. In the year since it was released, 3,059 books have been sold, placing it in the top 17% of book sales nationally.

Two key programs focus on girl's health and are the backbone of OWH efforts. The *BodyWorks* toolkit for the prevention of obesity focuses on the family as the most important environment to prevent obesity in girls and the rest of the family. The toolkit helps parents and caregivers of young adolescent girls and boys (ages 9-13) improve family eating and activity habits. Evaluation of the program was completed in early FY 2009. Preliminary responses of trainers and families have been enthusiastic; currently there are over 2,600 trainers and 1,500 families throughout the country who have participated in the program. The Spanish version of the *BodyWorks* toolkit was released in the summer of 2009. There are 122 Spanish speaking trainers with at least 38 families throughout the country have participated in the program. In addition, OWH awarded a contract to develop culturally appropriate materials for low literacy and economically disadvantaged parents to enhance their communication on important life skills with their teen daughters.

In 1999, the Department of Health and Human Services' Office on Women's Health, the Centers for Disease Control and Prevention, and the National Osteoporosis Foundation began work on a national bone health campaign to increase calcium consumption and physical activity in girls ages 9-12. *Powerful Bones. Powerful Girls!,* launched in 2001. Recently, the project has been rebranded and renamed as *Best Bones Forever!* (BBF). The BBF campaign was launched on September 2, 2009 and has re-developed a fun and educational website for girls (www.bestbonesforever.gov); collateral pieces for girls and parents; a website for parents (www.bestbonesforever.gov/parents); and three freely distributed promotional power-points for girls, parents, and community partners/organizations. The new campaign uses social marketing approaches focusing on friendship with the supporting message, "Grow strong together, stay strong forever." In FY 2010, OWH will be implementing new social media outreach, exhibiting at various conferences/meetings, tracking the pilot sites, and ongoing upkeep and writing for the campaign websites.

In FY 2009, contractors were awarded funds to conduct an environmental scan (investigation, research, and analysis) of current girls/adolescent health initiatives, programs, and campaigns that exist across the country, and provide comprehensive guidance and programmatic recommendations to OWH for the developing, coordinating, launching, monitoring and evaluating a federally-authorized, and supported National Girl-Adolescent Health and Wellness Initiative. The environmental scan will cover girls and adolescents/teens until 18 years of age living in the United States.

OWH contributes to, and expects to continue, several nationwide women's heart health initiatives. As a founding sponsor (with the National Institutes of Health's National Heart, Lung, and Blood Institute) of the *Heart Truth Campaign*, OWH is disseminating health professional educational modules on the science behind the campaign's messages. OWH also supports the *Heart Truth Champions* program in several cities to deliver educational messages. In addition, OWH supports the *Sister to Sister Everyone Has a Heart* Foundation's annual *Women's Heart Day Campaign* every February.

In FY 2009, OWH collaborated with HRSA to continue the four-year *National Business Case for Breastfeeding Campaign* to encourage businesses to offer lactation support for mothers who return to work. The goal of the program is to increase support to sustain breastfeeding for six months by women who return to work. The *Business Case for Breastfeeding Kit* is available in hard copy though the HRSA Resource Center and on line at the breastfeeding webpage at www.womenshealth.gov/breastfeeding. OWH is partnering with CDC and the Surgeon General's office to update the blueprint for action on breastfeeding. This new document will reflect the latest science related to breastfeeding.

On March 31, 2009, OWH and the Advertising Council launched the first ever *National Lupus Awareness Campaign*. This campaign is dedicated to increasing awareness of lupus to improve early diagnosis and treatment among those who are at increased risk for this disease. The campaign, targeted toward young minority women who are most affected by lupus, will provide them and their family members with information to help them take action if they have symptoms. The campaign includes TV and radio public service announcements (PSAs), a website (www.couldihavelupus.gov), bulletin boards and other media tools. The campaign will also generate long overdue public attention for lupus and raise recognition of the disease as a significant national public health problem.

OWH manages the Quick Health Data Online which is a dynamic and comprehensive database system that provides state and county level data for women and men from all 50 states, the District of Columbia, and the US territories. Database elements include demographics, mortality, access to care, reproductive health, infectious and chronic disease, maternal health, mental health and violence and abuse. OWH modified and expanded this data warehouse in FY 2009 and updates the data annually. User sessions average 8,000 per month.

OWH sponsors the annual National Women's Health Week campaign. For 2009, more than 1200 events and outreach activities occurred all across the U.S. and its territories. More than 140 governors', mayoral, tribal, and congressional proclamations were issued. OWH also conducted the WOMAN (*Women and girls Out Moving Across the Nation*) Challenge, resulting in over 42,000 women signing up to increase their physical activity to recommended levels. The Deputy Assistant Secretary for Women's Health's radio interviews generated millions of audience impressions. National Women's Checkup Day is the day after Mother's Day when OWH encourages women to schedule preventive checkups they often postpone. Hundreds of providers and organizations offered free or reduced rate screenings on the 2009 Checkup Day.

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

Funding History

FY 2006	$28,205,000
FY 2007	$28,219,000
FY 2008	$31,033,000
FY 2009	$33,746,000
FY 2010	$33,746,000

Budget Request

The FY 2011 request is $33,746,000, the same level of funding as the FY 2010 Appropriation level. In FY 2011, OWH plans to update the Women's Mental Health Initiative's span to include a specific publication for military and veteran women. Assessment and evaluation of the *Action Steps to Improving Women's Mental Health* and consumer companion booklet, *Women's Mental Health: What It Means to You* will continue. Likewise, a Spanish adaptation of the consumer booklet will begin in FY 2010.

Programs being considered for implementation in FY 2010 and carrying forward into FY 2011 under the "program opportunity fund" allocation include (but are not limited to) targeted community-based awareness/education efforts on female genital cutting, for immigrants from high-prevalence countries; broadening the Women and Mental Health Initiative's span to include specific materials on depression, trauma, and other unique mental health challenges for women; gender-focused enhancements of health system reform initiatives; and leadership programs for adolescent girls, and for women and girls living at the US-Mexico border.

Additionally, the National Breastfeeding Initiative program will continue through FY 2010. The goal of the program is to increase support to sustain breastfeeding for six months by women who return to work. OWH has been working with CDC staff to develop a three-year national media PSA campaign to increase the percentage of women who are aware of the eight warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911. It is likely that TV, radio, new media, airport ads, and print media will be used to disseminate this message nationally. This campaign will continue through FY 2011.

Outputs and Outcomes

Measure	Most Recent Results	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Long-Term Objective 1: Increase the percentage of women-specific Healthy People 2010 objectives and sub-objectives that have met their target or are moving in the right direction				
1.1 Increase the percentage of women-specific *Healthy People 2010* objectives and sub-objectives that have met their target or are moving in the right direction.	69.5% (exceeded target, 67.5% - FY 2007)	74.0% (245/338)	N/A	N/A
1.1 Increase the percentage of women-specific *Healthy People 2020* objectives and sub-objectives that have met their target or are moving in the right direction. (Updated)	*Healthy People 2020* baseline derived in 2010	N/A	Baseline	N/A
Long-Term Objective 2: Increase heart attack awareness in women				
2.1 Increase the percentage of women who are aware of the eight early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911. (baseline: FY05 54.5%)	65.8% (exceeded target)	70%	72.5%	+2.5
Long-Term Objective 3: Expand the number of users of OWH communication				
3.1 Number of users of OWH communication resources (e.g., NWHIC, womenshealth.gov website; and girlshealth.gov website).	31.6m sessions (exceeded target)	32.0m sessions	33.0m sessions	1.0m sessions
Long-Term Objective 4: Increase the number of people that participate in OWH-funded programs per million dollars spent annually				
4.1 Number of girls ages 9-17 and women ages 18-85+ that participate in OWH-funded programs (e.g. information sessions, websites, and outreach) per million dollars spent annually	1,191,580 (exceeded target)	1,321,838	1,427,667	+105,829
Program Level Funding ($ in millions)		$33.746	$33.746	---

OFFICE ON WOMEN'S HEALTH
Program Data

Activity	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request
ASIST 2010	4,932,059	0	0
Sustainability of Federal Programs	150,000	0	0
Adolescent Health & Osteoporosis	3,150,000	3,150,000	3,150,000
Cardiovascular Disease Programs	1,302,393	1,250,000	1,250,000
Workplace Breastfeeding	415,000	415,000	415,000
Quick Health Data	411,000	450,000	450,000
Mental Health	100,000	0	0
Regional Women's Master Contract	1,206,376	1,500,000	1,500,000
HHS Women's Health Advisory Committee	0	0	250,000
HIV/AIDS–Minority Communities	1,955,000	1,300,000	1,300,000
Program Opportunity Fund (see narrative)	0	8,606,000	8,269,000
Lupus	1,392,228	0	0
Minority Women's Health	200,000	200,000	200,000
Violence Against Women	2,325,000	625,000	625,000
Nat'l Women's Hlth Info Center	3,200,000	3,200,000	3,200,000
Print Materials (incl mini calendars)	1,000,000	1,000,000	1,000,000
Communications Outreach	300,000	300,000	300,000
National Women's Health Week	250,000	250,000	250,000
Co-sponsorships (incls IAAs & others)	500,000	500,000	500,000
Meeting Logistics Contract	1,200,000	1,000,000	1,000,000
Operating Expenses	9,756,944	10,000,000	10,087,000
TOTAL	**$33,746,000**	**$33,746,000**	**$33,746,000**

OPHS
HIV/AIDS IN MINORITY COMMUNITIES

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$51,891,000	$0	$53,891,000	$53,891,000	$0
FTE	0	0	0	0	0

Authorizing Legislation ....Title III, Section 301 of the PHS Act
FY 2011 Authorization ....Indefinite
Allocation Methods..Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

In 1999, the Congressional Black Caucus initiated a partnership with the Department of Health and Human Services (HHS) to significantly increase the national response to the HIV/AIDS epidemic in racial and ethnic minority communities since they are disproportionately impacted by this epidemic. The partnership identified the following issues as priorities:

- developing more effective prevention education interventions;
- increasing access to HIV counseling and testing services; and
- ensuring that comprehensive and quality health care and drug abuse treatment services are available in these communities.

Since FY 1999, Congress has appropriated $50 million or more each year to support the Minority AIDS Initiative (MAI). Utilizing these funds, significant steps have been taken to respond to this unfolding crisis through capacity enhancements to mount a community-based response, delivering prevention and treatment services, and providing guided and informed technical assistance and research. A sustained commitment to these goals will ensure a durable response with a flexible resource pool that can be quickly targeted to respond to newly emerging problems and to capitalize on lessons learned. Since most minority communities have disproportionately high rates of HIV/AIDS infection, these targeted investments have been successful in identifying and addressing key barriers to allowing the Department's programs to effectively reach and serve minority communities.

Funds received by the Office of the Secretary for the MAI are disbursed to the Public Health Service agencies in HHS, such as the Centers for Disease Control and Prevention (CDC); Health Resources and Services Administration (HRSA); Substance Abuse and Mental Health Services Administration (SAMHSA); and Indian Health Service (IHS), on a competitive basis. Project proposals are subject to three levels of review, including peer review by fellow agency representatives who comprise the MAI Steering Committee; secondary review committee of

senior OPHS staff led by the Director of the Office of HIV/AIDS Policy (OHAP); and final review team comprised of the Assistant Secretary for Health (ASH) and a few of his key advisors. Following approval from the ASH, agencies then award the funds through grants, cooperative agreements, and/or contracts to support hundreds of organizations and entities across the country.

Following are examples of activities that have been supported with MAI funds.

Outreach and Partnership Building
An integral part of OPHS' national prevention strategy is to educate, motivate and mobilize local and national minority leaders in the fight against HIV/AIDS. The goal is to leverage the credibility and influence of community leaders, and to place resources (information and technical) in the hands of those who know and can reach vulnerable racial and ethnic communities. This strategy also hopes to improve health outcomes in general for these populations, while promoting HIV testing and early medical treatment for those who are HIV-infected. Several efforts are underway which have facilitated the creation of new partnerships and initiatives. At the national level, dialogues with the YWCA and the National Medical Association have resulted in these organizations adopting HIV awareness, education and/or prevention activities which target their employees, clients and members.

Concurrently, the HHS Regional Health Administrators have reached hundreds of community- and faith-based groups and leaders in first-time engagements with HHS on HIV/AIDS awareness and education. Some of these groups have now become advocates of HIV prevention education, while others have stepped forward to become providers of HIV/AIDS services. Grants for outreach and partnership activities are awarded to not-for-profit community- and faith-based organizations, local health departments and clinics, health care providers, and universities and colleges, including Historically Black Colleges and Universities (HBCUs), Hispanic Serving Colleges and Universities (HSCUs), and Tribal Colleges and Universities (TCUs), research institutions, local government agencies, tribal government and for-profit organizations and companies. With the awarding of these grants, many influential and well-positioned entities educate and mobilize local communities through a variety of venues and mediums to engage the HIV epidemic. From sponsoring health fairs to town hall meetings and prayer breakfasts, local leaders become federal partners. Similarly, through the use of their own internal publications, training, listservs and e-mail blasts, community leaders provide additional media for outreach.

Technical Assistance and Training Activities
MAI funds are being used to expand technical assistance and capacity building activities for organizations serving racial and ethnic minorities disproportionately impacted by HIV/AIDS. Grants are awarded to not-for-profit community- and faith-based organizations, local health departments and clinics, health care providers, and universities and colleges, including HBCUs, HSCUs, and TCUs, research institutions, local government agencies, tribal government and for-profit organizations and companies.

Training centers from the HRSA, SAMHSA, CDC, and Office of Population Affairs (OPA) have continued a formal partnership to collaborate among these providers. These collaborative efforts have significantly reduced duplication of efforts, and have fostered more rigorous and

comprehensive training both across and within the areas of HIV/AIDS prevention, care and treatment. Currently, training centers in the HHS regions are developing curricular and training modules that reflect the many advances in preventing and treating HIV, as well as aiding HHS in activities which promote and support the Department's policies.

Prevention

With a focus on at-risk and high-risk ethnic and racial minority populations, CDC, SAMHSA, IHS, and several OPHS offices receiving MAI funds continue to make HIV testing central to their prevention efforts. Routine HIV testing and rapid HIV testing have been consistently integrated in the kinds of programs and activities developed over the last few years to reach youth, ex-offenders, rural and frontier populations, immigrants, college students, MSM, and substance abusers.

In general, grants to fuel prevention work have been awarded to not-for-profit community-based and faith-based organizations, local health departments and clinics, health care providers, and universities and colleges, including HBCUs, HSCUs, and TCUs, research institutions, local government agencies, tribal government and for-profit organizations and companies. Multi-ethnic evidence based behavioral interventions remain essential to the MAI prevention efforts. The Office of Minority Health's Pacific Project and African Immigrant Project are just two examples of that expanded prevention effort.

Assessment and Evaluation

In 2007, the MAI Fund underwent a program assessment in which OHAP coordinated the data and responses and was responsible for its completion. As a result, OHAP developed and has begun to implement an improvement plan for the MAI Fund. The plan consists of improving four performance objectives and one management objective. Specifically, the improvement plan consists of: (1) establishment of baselines and ambitious targets for long-term performance measures; (2) development of a comprehensive evaluation plan for MAI Fund activities; (3) development of a formal process to document the use of performance information in managing the MAI Fund and making funding allocation decisions; (4) establishment of procedures that get grantees to commit to measures and report on performance related to the program's goals; and (5) arrangement for the inventory of programs with related missions or activities and document their complimentary relationship to the activities of the MAI Fund.

By working with the MAI Steering Committee, OHAP has integrated or will soon integrate the entire set of improvement objectives outlined in the Improvement Plan. All process or procedural fixes are now in place and the establishment of baselines and ambitious targets are complete. An eighteen month evaluation of the MAI Fund began in the fall of 2008 and will conclude in FY 2010. Performance measures have been included as one of the variables to consider when assessing the merit of new proposals, and most agencies have quickly aligned their proposals to our efforts to increase testing and knowledge of HIV status; decrease new HIV infections; delay the onset of an AIDS diagnosis; decrease AIDS mortality; and improve the cost efficiency of both HIV testing and the training of clinical staff.

MAI Accomplishments in FY 2008 and FY 2009

Through the National HIV Testing Mobilization Campaign we have provided outreach to over 5 million Americans through direct contact and social marketing activities. Memorandums of Agreement have been established with 7 national HIV/AIDS organizations across a broad spectrum of HIV/AIDS demographics to expand HIV testing. The legacy document on the Campaign has been completed "Lessons Learned to Inform Future Social marketing Efforts. Also completed this year is the "HIV/AIDS: Building Capacity to Better Serve Your Community" *A Guide to Strengthening HIV/AIDS Services*. This primer will be produced in hard copy at a very limited number, but will also be posted on the OHAP Webpage and the document will be down loadable

Through the MAI, a number of projects are designed to promote increased access to, continuity of, and quality of care, including: expanded recruitment and training of clinical staff; refining referral and linkage strategies; development of chronic care initiatives; promotion of telemedicine; and exploration of additional retention and patient navigation programs.

Through the AIDS.gov portal and the use of new media tools we have significantly broadened the outreach capacities of all of the HHS agencies and offices with HIV portfolios. MAI-funded projects have increasingly integrated new media tools and strategies in their activities.

OHAP developed and completed the MAI Inventory of programs and activities that have been funded over the past three years. This comprehensive inventory captures program, budget, award distribution information for all activities supported under the MAI. The inventory will also be presented to HHS leadership as a possible means to catalog HIV/AIDS activities in support the President's National AIDS Strategic Plan.

<u>Funding History</u>

FY 2006	$ 51,855,000
FY 2007	$ 51,891,000
FY 2008	$ 50,984,000
FY 2009	$ 51,891,000
FY 2010	$ 53,891,000

<u>Budget Request</u>

The FY 2011 Request Level is $53,891,000, same as the FY 2010 enacted level. The FY 2011 request will allow funds to be disbursed to agencies for new and continuing projects in the following areas:

Capacity Development in Rural and Moderate Incidence Areas

One of the keys to having an impact on this epidemic is to provide sustainable capacity development in rural and moderate incidence areas where an HIV/AIDS infrastructure may be weak or non-existent. Given these infrastructure challenges, it is incumbent upon federal agencies to think creatively about what will work and how best to move these areas forward.

The MAI Fund in FY 2011 represents an important opportunity to provide indigenous organizations within these communities the capacity development around service delivery and the management of HIV/AIDS. During times of tightened resources but an unwavering epidemic, our sustainable and proactive efforts are needed. From the rural South to tribal country to some small cities in the Midwest and southwest, there are places where carefully targeted resources from the MAI Fund could have significant impact on the epidemic.

Technical Assistance and Training Activities
Innovations in technology and new media or new perspectives on the use of old media, has broadened our understanding of how the federal government can provide invaluable technical assistance and training to organizations and other entities. From podcasts to text messaging to PSAs, there is a new and exciting way the MAI Fund can provide the tools to our local partners to assist them to carry awareness and prevention messages to their constituents, encourage HIV testing or refer for treatment and care. With our recognized challenges to reach youth and other populations detached from traditional public health campaigns and messages, it's important we use every tool we have in our arsenal to make a dent in this epidemic. Creative use of the MAI Fund in FY 2009 and beyond can be the vanguard of such efforts.

Prevention
In 2010, these funds will be used to continue our expansion of HIV testing opportunities as the cornerstone of prevention and our efforts to find the more than 250,000 individuals who are positive but do not know their status. Part of our prevention efforts must also involve getting those who test positive in care and returning to care those that have left. There remains strong evidence that those individuals who know their positive status are more likely to take steps to modify unsafe behaviors. Finally, prevention cannot lose sight of the majority of Americans who are negative and the segment of those who are at great risk. Whether it is high risk youth, women, or minorities, our prevention efforts must continue to evolve and stay relevant and appropriate. The MAI Fund provides the funding vehicle for agencies to be innovative and to test new approaches on a short-term basis.

Outreach and Partnership Building
In FY 2010, these funds will be used to continue our outreach and partnerships with non-traditional and under-served community-based and faith-based entities. While certain focus will be on those communities and populations that are disproportionately impacted by HIV/AIDS, we will continue to try to stay ahead of the epidemic and target resources to those emerging communities that have lower incidence levels but are ripe for a much larger problem. Outreach to youth and those individuals over 50 will play an increasingly important role as the rates of infection rise among both segments. Within our partnerships we will explore new ways to communicate and forge relationships through the use of innovative technology and new media.

HIV/AIDS IN MINORITY COMMUNITIES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
7.1.1: Increase the number of ethnic and racial minority individuals surviving 3 years after a diagnosis of AIDS *(Outcome)*	FY 2008: 83% (Target Not Met)	87.75%	88%	+0.25
7.1.2: Reduce the percentage of AIDS diagnosis within 12 months of HIV diagnosis among racial and ethnic minority communities *(Outcome)*	FY 2008: 38% (Target Exceeded)	35.25%	34.75%	-0.5
7.1.3: Reduce the rate of new HIV infections among racial and ethnic minorities in the United States *(Outcome)*	FY 2007: 47.2% (Target Exceeded)	46%	43.7%	-2.3
7.1.4: Increase the number of African American individuals surviving 3 years after a diagnosis of AIDS *(Outcome)*	FY 2008: 79% (Target Not Met)	88%	89%	+1
7.1.5: Increase the number of Hispanic individuals surviving 3 years after a diagnosis of AIDS *(Outcome)*	FY 2008: 85% (Target Not Met)	90%	91%	+1
7.1.6: Increase the number of Asian/Pacific Island individuals surviving 3 years after a diagnosis of AIDS *(Outcome)*	FY 2008: 89% (Target Exceeded)	93%	94%	+1
7.1.7: Increase the number of American Indian/Alaskan Native individuals surviving 3 years after a diagnosis of AIDS *(Outcome)*	FY 2008: 73% (Target Not Met)	80%	81%	+1
7.1.8: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among African American communities *(Outcome)*	FY 2008: 35% (Target Exceeded)	34%	33%	-1
7.1.9: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Hispanic communities *(Outcome)*	FY 2008: 41% (Target Not Met but Improved)	38%	37%	-1
7.1.10: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Asian/Pacific Islander communities	FY 2008: 38% (Target Exceeded)	35%	34%	-1

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
7.1.11 Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among American Indian/Alaskan	FY 2008: 38% (Target Met)	36%	35%	-1
7.1.12 Increase the number of individuals who learn their HIV status for the first time through MAI Fund programs	FY 2008: 147,726 (Target not Met but Improved)	167,662	178,537	+10,875
7.1.13 Maintain the actual cost per MAI Fund HIV testing client below the medical care inflation rate	FY 2007: $88 (Target Exceeded)	$101.71	$105.30	+3.59
7.1.14 Maintain the actual cost per MAI Fund physician and other clinical staff trained below the medical inflation rate	FY 2006: 795.70 (Target Exceeded)	$1,670.78	$1,713.02	+42.24
Program Level Funding ($ in millions)	$51.891	$53.891	$53.891	+$2.0

Measures based upon overall surveillance data related to HIV testing.

HIV/AIDS IN MINORITY COMMUNITIES
FUNDING ALLOCATION
(Dollars in thousands)

Agency	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09
CDC	$15,641	$15,641	$10,500	$9,850	$8,500	$8,745	$7,875	2,740
SAMHSA	12,000	12,000	11,000	11,345	9,500	$10,235	8,735	9,600
HRSA	6,200	5,600	6,900	8,205	8,637	$8,641	7,190	6,348
NIH	—	—	—	—	—	——	——	—
IHS	1,450	1,450	1,500	2,096	1,963	1,913	2,300	3,210
OS	14,700	13,363	18,554	19,661	22,090	21,192	23,723	21,465
OPHS:								
OHAP	3,200	1,863	2,914	2,956	6,335	3,932	2,523	3,958
OMH	7,900	7,900	8,000	7,650	7,000	6,760	8,800	8,900
OPA	3,000	3,000	6,000	6,000	6,100	6,500	7,100	8,070
OWH	600	600	1,640	3,055	2,655	4,000	4,000	6,125
RHA	—	—	—	—	—	——	1,300	1,780
Eval Set-aside	—	1,021	1,090	1,258	1,165	1,165	1,160	1,160
TOTAL	$49,991	$49,075	$49,544	$52,415	$51,855	$51,891	$50,984	$51,891

FY 2010 and 2011 - allocation to be determined. Review of FY 2010 proposals currently underway; decisions to be reached early Spring.

OPHS
COMMISSIONED CORPS INITIATIVES

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010 Appropriation
BA	$14,813,000	$0	$14,381,000	$13,513,000	-$1,3004,000
FTE	31	0	31	23	-8

Authorizing Legislation….Title III, Section 301 & Title XXVIII, Section 206 of PHS Act
FY2011Authorization….…………………..……………………………….....Indefinite
Allocation Method…………….…….……………………......….Direct Federal; Contracts

Program Description and Accomplishments

This request provides funding to support components of the Office of the Surgeon General (OSG) and continue support efforts. Offices supported by this activity include the Office of Force Readiness and Deployment, Office of Reserve Affairs, and the Office of Science and Communication. The Immediate Office of the Surgeon General and the Office of Commissioned Corps Operations are not supported by this funding.

Readiness and Response: The Office of Force Readiness and Deployment (OFRD), a division in the OSG, was established in 2003 to manage the Commissioned Corps Readiness and Response Program.

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

- public health and medical emergencies,
- urgent public health needs and challenges, and
- National Special Security Events.

US Public Health Service Commissioned Corps (Corps) officers are deployable assets and must meet requirements for physical fitness, height and weight standards, immunizations, basic life support certification, and the completion of training related to emergency response and humanitarian assistance. OFRD executes this program by ensuring individual Corps officers are trained for deployment; that the Corps deploys the appropriate team(s) and/or individual(s); and that once deployed, they function in a timely and effective manner.

Active duty commissioned officers are assigned to one of three Tiers. Tier 1 and Tier 2 consist of preconfigured response teams. Tier 3 consists of active duty officers not assigned to response teams. The tiers are further distinguished by the rapidity with which responses can be mounted: Tier 1 response teams deploy within 12 hours of notification;

Tier 2 response teams do so within 36 hours of notification, and; Tier 3 officers deploy within 72 hours of notification.

All the members of the above teams as well as all Tier 3 officers are comprised of active duty commissioned officers assigned to agencies of the US government, within and external to the Department of Health and Human Services. Thus, their response duties are in addition to their day-to-day agency-specific duties. The following is a summary of the Corps' current Tiered response system:

Assets	Tier	# Currently Available	Officers per Team	Arrival On Scene	Deployment Duration
Rapid Deployment Forces	1	5	125	<24 Hours	15-30 days
National Incident Support Teams	1	5	72	<24 Hours	15-30 days
Regional Incident Support Teams	1	11	12-30	<24 Hours	1-3 days
Applied Public Health Teams	2	5	47	<48 hours	15 days
Mental Health Teams	2	5	26	<48 Hours	15 days
Services Access Teams	2	5	10	<48 Hours	15 days
PHS Capitol Area Provider Teams	2	5	5	<48 Hours	1-3 days
Remaining Active Duty Corps Officers	3	----	~4,400	<72 hours	15 days

In addition to the use of this tiered approach for responding to public health emergencies, OFRD deploys pre-positioned teams of officers and individuals for National Special Security Events and high-profile mass gatherings, such as the annual State of the Union Address.

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

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

- Active Duty Officers are provided both didactic and field training by OFRD to achieve and maintain compliance with force readiness standards as well as to increase operational capability.

Infrastructure and Management: To protect the health and safety of the American people, the Commissioned Corps is modernizing into a force that is ready to respond rapidly to the most dramatic public health challenges and health care crises that can result from natural disasters (including infectious disease epidemics), technological catastrophes, terrorist attacks, and other extraordinary needs. In its day-to-day role, the Corps will remain an essential national resource within HHS to meet mission critical requirements and to address health care needs in isolated, hardship, hazardous, and other hard-to-fill positions.

The Commissioned Corps Force Management System (CCFMS) employs reengineered business processes, new data, and an integrated information technology solution. Better human resources (HR) information empowers HHS and the Corps to fulfill core public health missions and enables centralized force management for the first time. The CCFMS utilizes the United States Coast Guard's Direct Access HR Solution for Uniformed Personnel, a PeopleSoft-based program. Once fully implemented, Corps adoption of Direct Access should save HHS a minimum of $1 million in IT costs each year for the foreseeable future.

Officer HR data has been transferred to Direct Access, which was released to Corps officers on June 1, 2009. HHS and the Corps incorporated a comprehensive list of public health skill sets into Direct Access to enable leadership to match officers with positions and deployments. Direct Access collects validated, searchable information that previous systems had not captured in the past.

Officers are using Direct Access to proactively maintain compliance with Readiness standards for public health response, search for jobs, and capture multiple licenses and certifications, education, and security clearance information. Integration of HR data allows HHS to better utilize the skill sets of the Corps to improve accessibility of health care, respond to natural and manmade disasters, and foster scientific research and development in the United States.

For the first time, agencies and other public health entities will be able to post jobs for Corps officers in Direct Access and can search for officers meeting the job criteria. The collection and characterization of searchable, standardized, descriptive billet (officer positions) information is underway and will be completed by the end of the 2010. It will serve as the basis for Corps force management based upon public health needs.

Budget Request

The FY 2011 request is $13,513,000, a decrease of $1,300,000 below the FY 2010 Appropriation level. This reduction is due to the completion of one time projects such as

PHS Officer Advanced Course and Pilot Class and portions of the Direct Access project. Continued support will be provided to the following activities:

- Deployment Readiness Training ($4.0 million) – Training will continue to be both didactic and field-based in FY 2011. Field-based training will encompass exercises in austere settings designed to familiarize teams and individual officers with deployment and operational scenarios consistent with the National Planning Scenarios and to enhance the resilience of all participants. Field based training in FY 2011 will also build upon the development of domestic medical readiness training exercises that will provide training as well deliver services to underserved communities.
- Inactive Reserve Officer Training ($.150 million) - Basic officer training will be provided to 15-25 inactive reserve officers in order to insure a trained surge capacity to respond to public health and other emergencies as well as supplement agency needs.
- Direct Access ($2.6 million) - Direct Access functionality will be further developed focusing on the adaptation of current data and applications to the PeopleSoft 9.0 environment. In addition, the Corps will continue to develop systems and import data to support increased functionality within Direct Access.
- Recruitment Support ($1.0 million) – Recruitment and advertising campaigns will be created that are known to be effective at reaching target audiences, that include health professionals. The funds will be used to purchase advertising space in print materials, printed and electronic marketing brochures, and for attendance at conferences and other professional events at which potential recruits will be in attendance.
- Operating Costs and Salaries and Benefits ($5.763million) – Funds support personnel for the day-to-day operations to manage the billets system, processing assignments, training, licensure and certification validation, force management, and other activities. Funds also support overhead, rent and other operating costs.

Outputs and Outcomes

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY11 +/- FY10
6.1.1: Increase the percentage of Officers that meet Corps readiness requirements, thus expanding the capability of the individual Officer. (Baseline – 2004: 50%) *(Outcome)*	FY 2009: 94.37% (Target Exceeded)	95%	96%	+1.0%
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 2009: 79.37% (Target Exceeded)	82.5%	85%	+2.5%
6.1.3: Increase the percent of individual responses that meet timeliness, appropriateness, and effectiveness requirements.(Baseline - 2007: 77%) *(Outcome)*	FY 2008: 93% (Target Exceeded)	93%	95%	+2.0%
6.1.4: Increase the percent of team responses that meet timeliness, appropriateness, and effectiveness requirements.(Baseline - 2007: 89%) *(Outcome)*	FY 2008: 95% (Target Met)	97.5%	98%	+1.5%
6.1.5: Increase the number of response teams formed, thus enhancing the Department's capability to rapidly and appropriately respond to medical emergencies and urgent public health needs. (Baseline - 2005: 0) *(Outcome)*	FY 2009: 41 (Target Exceeded)	46	48	+2
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 2009: 21 (Target Exceeded)	26	36	+10

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY11 +/- FY10
6.1.7: Cost per Officer to attain or maintain readiness requirements. *(Efficiency)*	FY 2009: $91.14 (Target Exceeded)	$100	$90	$90
Program Funding Level ($ in millions)	NA	$14.813	$13.513	-$1.3

OPHS
EMBRYO ADOPTION AWARENESS CAMPAIGN

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$4,200,000	$0	$4,200,000	$4,200,000	$0
FTE	0	0	0	0	0

Authorizing Legislation…………..………………Public Health Service Act, Section 1704
FY 2011 Authorization……………..…………………………………….……Indefinite
Allocation Method……………………..………………………..Competitive Grants, Contract

Program Description and Accomplishments

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

The program focuses on educating couples with available frozen embryos who may choose to donate them. The program also functions to inform infertile couples about the availability of embryos for donation/adoption. Information and educational activities are specifically directed at potential donors and recipients, as well as professionals (e.g., physicians, IVF clinic personnel, attorneys, and/or social workers) involved with the process of embryo donation and/or adoption.

With the passage of P.L. 107-116 (the FY 2002 Departments of Labor, Health and Human Services, Education and Related Agencies Appropriations Act), Congress authorized the Department to launch a public awareness campaign about the existence of frozen embryos available for adoption. In FY 2009, Congress increased funding for the program from the FY 2008 level of $3.93 to $4.20 million. Congress continued to include authority allowing funds to be used for medical and administrative services related to embryo adoption, stating, "*That funds provided in this Act for embryo adoption activities may be used to provide to individuals adopting embryos, through grants and other mechanisms, medical and administrative services deemed necessary for such adoption: Provided further, That such services shall be provided consistent with 42 CFR 59.5 (a) (4).*" This language was also attached to the FY 2010 appropriations for the program.

The core focus of the program is on information and education activities that contribute to increasing public awareness and understanding of embryo donation and adoption. A key challenge is to help couples with the decision-making process necessary to release frozen embryos for adoption. Funded projects have used both traditional and cutting-edge public information techniques to reach the general public as well as professionals. Outreach to professionals is based on the concept that the understanding they acquire will be transmitted to their clients and hence to the general public. These projects have equipped professionals with the knowledge, skills and abilities necessary to provide useful information to their clients.

The program supports the Department's Strategic Goal 3, which seeks to protect life, family, and human dignity by promoting the economic and social well-being of individuals, families, and communities; enhancing the safety and well-being of children, youth, and other vulnerable populations; and strengthening communities.

Funding History

FY 2006 $1,979,000
FY 2007 $1,980,000
FY 2008 $3,930,000
FY 2009 $4,200,000
FY 2010 $4,200,000

Budget Request

The FY 2011 request is $4,200,000, the same level of funding as the FY 2010 Appropriation level, which enables the continued support of the existing and new grants.

Embryo Adoption Awareness	**FY 2008**	**FY 2009**	**FY 2010 (est.)**	**FY 2011 (est.)**
Total Number of Awards	8	8	8	4
Average Award	$396,000	$460,000	$460,000	$475,000
Range of Awards	$328,000-$500,000	$367,000-$500,000	$367,000-$500,000	$450,000-$500,000

ACQUISITION REFORM

Resources and Budget Request Summary:

As part of a government-wide initiative to advance contracting reform, HHS is requesting $7,000,000 within the General Departmental Management account to improve the capability, capacity and effectiveness of HHS's acquisition workforce. This is a new request.

The Federal acquisition workforce includes contract specialists, program and project managers, and contracting officer technical representatives (COTRs). This funding is requested in order to mitigate the risks associated with gaps in the capacity and capability of the acquisition workforce government-wide, and improve the effectiveness of that workforce, in order to maximize value in Federal contracting. The Office of the Assistant Secretary for Financial Resources (ASFR) will lead this initiative.

The requested resources will be used to:

- increase the capacity of the acquisition workforce in the contracting functional area, plus any necessary changes for program managers and COTRs;
- increase the capability of the acquisition workforce by investing in training to close identified gaps in such areas as project management, negotiations, requirements development, contract management and other key topics; and
- increase the effectiveness of the acquisition workforce by investing in improvements to systems that support the contracting function.

Background:

Successful acquisition outcomes are the direct result of having the appropriate personnel with the requisite skills managing various aspects of the acquisition process. Between FY 2000 and FY 2008, acquisition spending by civilian agencies increased by 56% (in inflation-adjusted dollars), while the number of contract specialists grew by only 24%. This increased workload has left less time for effective planning and contract administration, which can then lead to diminished acquisition outcomes. This lack of capacity and capability in the acquisition workforce will also result in tradeoffs during the acquisition lifecycle, which may reduce the chance of successful outcomes while increasing costs and impacting schedule.

In his March 4, 2009, memorandum on Government Contracting, the President mandated that all Federal agencies improve their acquisition practices and performance by maximizing competition and value, minimizing risk, and reviewing the ability of the acquisition workforce to develop, manage, and oversee acquisitions appropriately. Subsequent guidance from the Office of Management and Budget (including the memorandum *Improving Government Acquisition,* issued July 29, 2009, and the memorandum *Acquisition Workforce Development Strategic Plan for Civilian Agencies, FY 2010-2014*, issued October 27, 2009) directed agencies to strengthen the acquisition workforce and increase the civilian agency workforce, to more effectively manage acquisition performance.

The $7,000,000 request would be a meaningful expansion over the investments started by HHS in FY 2010, and would enable the Department to make further improvements. Such improvements would best be managed as part of a multi-year staged effort, with additional resources in future fiscal years.

HHS will invest the Acquisition Reform funds in the following actions (in priority order), to implement HHS' Acquisition Workforce Development Strategic Plan:

- Building or expanding HHS's acquisition workforce through intern, rotational, and mentor programs to increase the capacity of the workforce and support succession planning (e.g., recruit, hire, and retain HHS' acquisition workforce).

- Developing a centralized training fund to enhance the capabilities of the acquisition workforce and close competency gaps (e.g., train HHS' acquisition workforce).

- Developing or refining HHS's systems to track acquisition workforce metrics (e.g., educational/certification data), project future acquisition workforce needs, and conduct data-driven analysis to support HHS acquisition workforce planning activities (e.g., measure HHS' acquisition workforce).

- Strengthening and expanding HHS' acquisition management resources, programs and strategies to improve acquisition planning and oversight (e.g., improve HHS' acquisition outcomes).

PHS EVALUATION SET-ASIDE

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget	FY 2011 +/- FY 2010
ASPE	$41,243,000	$41,243,000	$41,243,000	$0
Health Reform Activities	$1,000,000	$12,500,000	$12,500,000	$0
OPHS	$4,010,000	$4,510,000	$4,510,000	$0
OPHS (Teen Pregnancy Prevention)	$0	$4,455,000	$4,455,000	$0
ASFR	$503,000	$1,503,000	$1,503,000	$0
Caroline Pryce Walker Conquer Childhood Cancer Act	$0	$1,000,000	$1,000,000	$0
FTE	133	136	136	0

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

Program Description and Accomplishments

HHS' Public Health Service (PHS) Evaluation Set-Aside program is authorized by section 241 of the U.S. Public Health Service Act. Projects supported by PHS Evaluation funds serve decision-makers in both the public and private sectors of public health research, education, and practice communities, by providing valuable information regarding how well HHS programs and services are working. Systematic collection of information on program performance, this program has a significant impact on the improvement of activities and services provided by HHS.

The FY 2011 request for the PHS Evaluation Set-Aside in GDM includes funding for programs in three offices: The Assistant Secretary for Planning and Evaluation (ASPE), the Office of Public Health and Science (OPHS), and the Assistant Secretary for Resources and Technology (ASRT). Descriptions of these offices' PHS Evaluation programs follows.

Assistant Secretary for Planning and Evaluation

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

new programs, and providing direction for HHS-wide strategic, evaluation, legislative, and policy planning.

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

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

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

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

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

ASPE Budget Request

The FY 2011 request for ASPE is $53,743,000 (excluding the Children's Health Insurance Program discussed below). The FY 2011 funding level will allow ASPE to continue a variety of independent policy research and evaluation activities across the spectrum of the HHS's programs, with particular attention to crosscutting initiatives.

$8,603 of the FY 2011 ASPE account will be used to support Department-wide enterprise information technology and ongoing government-wide e-governement initiatives.
The ASPE account helps to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

ASPE's Research and Evaluation program, funded under section 241 of the U.S. Public Health Service Act, has a significant impact on the improvement of HHS policies, programs, and services. Set-aside funds are used to conduct research and evaluation studies; collect data; and estimate the costs, benefits and impacts of policies and programs under consideration by HHS or the Congress. ASPE's work directly supports the HHS mission and achievement of the Strategic Goals. In FY 2011 ASPE will conduct the following activities in support of HHS's four Strategic Goals.

Goal 1: Improve the safety, quality, affordability, and accessibility of health care, including behavioral health care and long-term care. Priority projects for FY 2011 under this goal include health care reform initiatives, promoting health information technology; modernizing Medicaid; and strengthening and improving Medicare.

Goal 2: Prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats. Priority projects for FY 2011 under this goal include improving food and medical product safety, promoting emergency preparedness, response, and recovery planning efforts; preventing chronic disease and promoting healthy behaviors; and reducing health disparities.

Goal 3: Promote the economic and social well-being of individuals, families, and communities. Priority projects for FY 2011 under this goal include protecting the safety and fostering the well-being of children and youth; addressing the needs of vulnerable populations; encouraging the development of strong, healthy, and supportive communities; and promoting economic independence and social well-being of individuals and families.

Goal 4: Advance scientific and biomedical research and development related to health and human services. Priority projects for FY 2011 under this goal include conducting research and evaluation efforts and translating them into practice, especially in the areas of food, drug, and medical product safety, and personalized health care.

ASPE Grant Awards Table:

Description	FY 2009	FY 2010	FY 2011
Number of Awards	5	5	5
Average Award	$545,000	$565,000	$565,000
Range of Awards	$350,000 - $750,000	$350,000 - $850,000	$350,000-$850,000

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

ASPE's academic research center grants provide funding for five research institutes with funding levels ranging from $350,000 per year to $750,000 per year as of FY 2009. The national poverty center conducts a broad program of policy research to describe and analyze national, regional, and state environment (e.g., economics, demographics) and policies affecting the poor, particularly those families with children who are poor or at-risk of being poor. In addition, ASPE supports three smaller research centers that maintain a more focused agenda on expanding our understanding of the causes, consequences, and effects of poverty in local geographic areas, especially in states or regional areas of high concentrations of poverty. The national center on family and marriage research works to improve our understanding of how family structure and function affect the health and well-being of children, adults, families, and communities. All of the centers develop and mentor social science researchers whose work focuses on these issues.

Health Reform Activities

HHS' Supporting Role for Policy Development and Advancement: As the lead health agency, HHS will play a central role in health reform activities. Key activities include the following which may shift depending on the timing of legislation and the needs of the Secretary, Executive Office of the President, and the Congress.

- Modeling to estimate costs and savings of health reform. The Office will contract with organizations to support micro-simulation models to estimate the effects of different components and sets of policies being considered in developing health reform plans. In FY 2011, the Office will also assess the need for additional modeling capacity to estimate the impact of potential health policy changes.

- Studies to aid in development and implementation of reform. HHS's current role in producing studies will be expanded to meet multiple, concurrent requests for analyses from the Secretary, the Executive Office of the President, and the Congress.

- Internal policy development and technical assistance projects. HHS will also continue to serve as a source of information and data to other parts of the Federal government. Reviews, data analysis, and options papers will be developed as needed to support all aspects of health reform.

Engaging the public and supporting Outreach and Transparency. The President is committed to making health reform inclusive. This involves outreach to the public in the form of community discussions, web-based listening sessions, surveys, events, and other means of soliciting input and guidance. HHS will continue to support these forums and other events to meet the President's commitment to an open and inclusive process. HHS will also continue to support staff whose roles are best fulfilled by being assigned to the White House Office of Health Reform.

Office of Public Health and Science

The Office of Public Health and Science (OPHS) exhibits an essential role in the Public Health Evaluation Set-Aside program at HHS. Within OPHS, the Immediate Office of the Assistant Secretary for Health (ASH) coordinates the Evaluation Set-Aside program. Studies supported by these Set-Aside funds serve decision makers in federal, state, and local government; and the private sector of the public health research, education, and practice communities by providing valuable information about how well programs and services are working. Projects that were approved for 2009 evaluation funds are listed below by HHS Strategic Goal:

Effectiveness of Programs and Strategies

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – *Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.*

- National Blood Collection and Utilization Survey (NBCUS), a bi-annual industry-wide survey of 3,000 blood collection facilities and blood centers. Data collection of more than 325 data elements are analyzed to determine the current trends in blood safety and availability, cellular therapies, and tissue transplantation. The survey is used to evaluate policy and program effectiveness and is essential to the Advisory Committee on Blood Safety and Availability in assessing past and future recommendations.

- Health and Diet Survey – Dietary Guidelines Supplement 2009 – Evaluation of activities designed to inform the American public about the 2005 Dietary Guidelines of Americans. The baseline survey was conducted in December 2004 and follow-up surveys were conducted in December 2005 and in December 2007. This information will be used to assess the impact of current HHS-wide nutrition communication and education efforts and aid in planning future activities.

- Evaluation of HIV Prevention Programs for Young Women Attending Minority Institutions - In 2003, the OWH through the Minority AIDS Initiative initiated the

HIV Prevention for Young Women Attending Minority Institutions program. This program is an innovative approach to HIV prevention for young women and will help to reduce the risk and spread of HIV among women in the U.S. This evaluation should provide OWH with an understanding of effective gender-specific interventions, both process and outcome. This is the final year of this project.

Strategic Goal 3: Human Services – *Promote the economic and social well-being of individuals, families, and communities.*

- Evaluating Title XX Adolescent Family Life Program - The purpose of this project is to conduct a cross-site evaluation of the AFL demonstration program to both describe its implementation and to evaluate its impact on desired outcomes, completing a long-term effort, on the part of OPA, to plan and conduct such an evaluation. This project presents a unique opportunity to evaluate the effectiveness of a multi-site funding program to prevent adolescent premarital sexual activity and to improve the outcomes for pregnant and parenting adolescents and their children. This is the fourth and final stage of this project. Note that after FY 2009, the long-term objective relating to prevention projects will no longer be measured due to discontinuation of funding.

Environmental Assessments

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – *Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.*

- Community Assessment of Rosebud Sioux Tribe Suicide Prevention Initiatives – Evaluation of prevention strategies and tribal policies on reservation communities, such as Rosebud Sioux, which has epidemic levels of suicide. This project will assess the extent to which recent suicide prevention initiatives have influenced community awareness and perceptions of suicide risk, and access to services, in local communities. This formative evaluation will be the first community-based approach aimed at providing tribal officials with feedback on measurable progress toward the reduction of suicide.

Improving Program Management

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.

- Evaluation of the Integration of Preparedness Indicators throughout Healthy People 2020 – This project will evaluate proposed public health preparedness indicators for Healthy People 2020. The Mid-Atlantic Public Health Preparedness Coalition will serve as a technical consultant on choosing an appropriate set of preparedness indicators. This project will evaluate the utility at state and local levels for program

development and strategic planning for statewide preparedness and response. It will also evaluate the utility of these indicators for assessing state and local preparedness.

- Quick Guide to Healthy Living – Spanish – The Office of Disease Prevention and Health Promotion (ODPHP) seeks to conduct formative research, and develop and evaluate a comparable version of healthfinder.gov's Quick Guide to Healthy Living, including a mobile phone application for Spanish speakers with limited health literacy. ODPHP is congressionally mandated to connect the public and professionals to important health information. Over 30 million U.S. residents speak Spanish in the home. This would expand the reach to Spanish-speaking communities on these important OPDHP initiatives.

- Building a Healthier Heartland (BHH) – BHH will evaluate, further develop and enhance a multi-stakeholder community collaboration that can amplify a consistent health message across four key community channels (Business, Schools, Organizations, Government) and model it around chronic disease risk factors (poor nutrition, physical inactivity, tobacco use). Programs would focus on such actions/issues as: Coalition Building, Measurement, Education, Messaging, Policy Change, and Social Networking. BHH strives to develop a coalition of local and national stakeholders working to strengthen partners' efforts to promote the health of Kansas City Metropolitan Area residents and employees. The goals of BHH are to improve nutrition, increase physical activity, and reduce exposure to tobacco and secondhand smoke.

Supporting an Evaluation Infrastructure

Strategic Goal 4: Scientific Research and Development - *Advance scientific and biomedical research and development related to health and human services.*

- Developing, Implementing, and Evaluating a Web-Based Performance Information Management System (PIMS). This project, led by OMH, will implement Phase II, and is intended to primarily support implementation, further integration, and evaluation of the effectiveness of system components, including use of performance and evaluation tools and resources by broader audiences in the longer term. The purpose of PIMS is to improve the Office's ability to demonstrate meaningful results in return for the public's investment in OMH-funded programs. The result of this initiative will enable OMH and its partners within OPHS, HHS, and across the Nation to more effectively and efficiently produce and demonstrate more meaningful progress towards the health of racial/ethnic minorities and reduction of racial/ethnic health disparities.

- Improving Medication Assisted Substance Abuse Treatment in the U.S. Caribbean Jurisdictions – Puerto Rico and the Virgin Islands requested assistance from SAMHSA to provide technical assistance for improving their drug treatment programs. SAMHSA has gathered partners from a variety of federal programs to serve as an advisory group to seek broader assistance. There is significant substance abuse treatment need (health gap) within the territories, which this project seeks to

provide strategies to ameliorate. The goals of the project are to develop a long term strategy for capacity and infrastructure development with specific actionable goals, map deliverables for SAMHSA and other Federal partners, and establish reasonable performance metrics for system improvement.

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.

- Development of Health Indicators for the Nation – Evaluation of the current and past Healthy People objectives and implementation activities that will help ensure that the next generation of objectives – Healthy People 2020 – represents national health priorities, reflects extensive stakeholder input, and is relevant to a wide variety of users. The project will reach beyond the traditional public health sector to engage stakeholders from other areas not directly connected with health. This input will be gathered, evaluated, and synthesized.

Teen Pregnancy Prevention

The FY 2011 request is $4,455,000 million Public Health Service (PHS) Act evaluation funds "to carry out evaluations (including longitudinal evaluations) of teen pregnancy prevention approaches." Most of the PHS evaluation funds support the Evaluation of Adolescent Pregnancy Prevention Approaches (PPA) study currently being conducted by the Administration for Children and Families and this support will continue through the end of the contract in FY 2013. Additional evaluations will be designed and implemented with the remaining funds. To ensure the study is well designed and implemented, OAH will partner with the Assistant Secretary for Planning and Evaluation (ASPE), evaluation experts at OMB and the Council of Economic Advisers during the planning, design, and implementation of the study. OAH is committed to promoting strong, independent evaluation that can inform policy and program management decisions and will post the status and findings of this and other important evaluations publicly available online.

In FY 2011, through a contract, the Office will work to develop appropriate program performance measures for the TPP program and other OAH activities as well as design a system for collecting annual performance data.

Assistant Secretary for Financial Resources

The FY 2011 request for the Office of the Assistant Secretary for Financial Resources (ASFR) is $1,503,000, the same as the FY 2010 enacted level. The FY 2011 request will be used to maintain program evaluation activities within the ASFR Office of Budget. These funds will cover staff focused on monitoring and assessing program evaluation activities in the PHS agencies and in the preparation of Performance and Accountability Report-related materials. Funds will also go towards the continued development and operation of an electronic performance tracking system for HHS programs, similar to

systems used by a number of other Federal agencies.

Funding History

Fiscal Year	Amount	FTE
2006	$39,552,000	53
2007	$39,552,000	49
2008	$46,756,000	14
2009	$46,756,000	131
2010	$65,211,000	144

Budget Request

The total FY 2011 request for GDM's PHS Evaluation program is $65,211,000, the same as the FY 2010 enacted level. Beginning in FY 2008, these PHS Evaluation amounts reflect the transfer of funding for ASPE from the GDM appropriation; all funding for ASPE operations is now centralized in PHS Evaluation funds.

The FY 2011 request for **ASPE** is $41,243,000, the same as the FY 2010 enacted level. This funding level will allow ASPE to continue a variety of independent policy research and evaluation activities across the spectrum of the Department's programs, with particular attention to specific crosscutting initiatives, the breadth and depth of which are described in this submission.

The FY 2011 request for **Health Reform Activities** is $12,500,000, the same as the FY 2010 Enacted level. This level will allow HHS to play a central role in designing and implementing health reform as described above. The funds will primarily support the Office of the Assistant Secretary for Planning and Evaluation. Funds may also be used to support activities required of the Office of Public Health and Science, including the Office of Minority Health and Office on Women's Health and the Office on Disability.

The FY 2011 request for **OPHS** is $4,510,000, the same as the FY 2010 Enacted level. This level will allow OPHS to allocate the same level of funds to its program offices to continue conducting evaluation projects.

The FY 2011 request for **OPHS Teen Pregnancy Prevention** is $4,455,000, the same as the FY 2010 Enacted level. This level will allow OPHS to carry out evaluations (including longitudinal evaluations) of teen pregnancy prevention approaches.

The FY 2011 request for **ASFR** is $1,503,000, the same as the FY 2010 Enacted level. This level will allow ASRT to fund increasing program evaluation activities within the ASRT Office of Budget. These funds will go towards the continued development and operation of an electronic performance tracking system for HHS programs, similar to systems used by a number of other Federal agencies.

The FY 2011 request for **Caroline Pryce Walker Conquer Childhood Cancer Act** is $1,000,000, the same as the FY 2010 Enacted level.

OTHER FUNDING SOURCES

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriations	FY 2011 President's Budget Request	FY 2011 + / - FY 2010
FMAP BA	$0	$5,000,000	$0	$0	$0
CHIPRA BA	$15,000,000	$0	0	0	0

Authorizing Legislation ....Unauthorized

Program Description and Accomplishments

Federal Medical Assistance Percentage Implementation Funding (FMAP)
This funding is to implement section 5001- Temporary Increase of the Federal Medical Assistance Percentage (FMAP) for Medicaid, Foster Care, and Adoption Assistance. Section 5001 of the Recovery Act provided an increase in the States' FMAPs during a 9-calendar quarter recession adjustment period beginning October 1, 2008 and ending December 31, 2010. The Recovery Act provided $5 million to HHS for implementation of the increased FMAP provision. The Secretary allocated funds to the Centers for Medicare & Medicaid Services, Administration for Children and Families, and Office of the Assistant Secretary for Planning and Evaluation for quarterly provision implementation for FY 2009, FY 2010, and FY 2011.

Evaluation of Express Lane Eligibility Option under CHIP
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 created a new option for States to rely on an Express Lane agency finding when determining eligibility for medical assistance, through September 30, 2013. Each State must annually provide an eligibility error rate on children enrolled in Medicaid or CHIP using these findings. If a State's error rate exceeds three percent, corrective actions will be undertaken and continued noncompliance may lead to a reduction in payments. The Secretary must conduct an effectiveness evaluation of this option and report to Congress by the end of FY 2012. The Assistant Secretary for Planning and Evaluation will be conducting this evaluation.

Updated Federal Evaluation of CHIP
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 requires the Secretary to conduct a new evaluation of ten States with approved child health plans under the Children's Health Insurance Program (CHIP). In FY 2010, HHS will review results of the initial CHIP evaluation conducted in 2000, consult stakeholder groups concerning design of the current study, and identify an entity to perform the evaluation work. Throughout FY 2010 and FY 2011, HHS will conduct an evaluation of enrollment processes, services, performance measure outcomes, and prepare a Report to Congress meeting the December 31, 2011 statutory deadline.

Funding History

FY 2008 $0
FY 2009 $15,000,000
FY 2010 $0

Budget Request

There is no FY2011 funding request for this activity.

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT
(Excluding Service and Supply Fund)

	FY 2009 Enacted			FY 2010 Enacted			**FY 2011** Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Immediate Office of the Secretary.......	66	0	66	69	0	69	69	0	69
Administration....................................	115	1	116	117	1	118	117	1	118
Financial Resources............................	170	1	171	175	1	176	178	1	179
Health, OPHS.....................................	251	83	334	278	78	356	271	78	349
Legislation..	19	0	19	26	0	26	26	0	26
Public Affairs......................................	26	0	26	28	0	28	29	0	29
General Counsel..................................	356	3	359	358	3	361	361	3	364
Departmental Appeals Board..............	66	0	66	66	0	66	66	0	66
Disability..	4	0	4	7	0	7	7	0	7
Global Health Affairs...........................	18	6	24	22	2	24	22	2	24
Intergovernmental Affairs...................	23	1	24	32	1	33	32	1	33
Planning and Evaluation......................	130	3	133	133	3	136	133	3	136
Center for Faith-Based and Neighborhood Partnerships..............	6	0	6	7	0	7	7	0	7
Presidential Commission for Bioethical Issues...............................	10	0	10	10	0	10	10	0	10
Total, GDM	1,260	98	**1,358**	1,328	89	**1,417**	1,328	89	**1,417**

Average GS Grade	
2007...	GS-12/2
2008...	GS-12/4
2009...	GS-12/3
2010...	GS-12/4
2011...	GS-12/4

DETAIL OF POSITIONS

	FY 2009 Enacted	FY 2010 Enacted	FY 2011 Estimate
Executive Level I	1	1	1
Executive Level II	1	1	1
Executive Level III	0	0	0
Executive Level IV	9	9	9
Executive Level V	0	0	0
Subtotal	11	11	11
Total – Executive Level Salaries	$1,752,500	$1,779,000	$1,814,000
SES Subtotal	94	99	99
Total – ES Salaries	$13,855,000	$14,783,000	$15,079,000
GS-15	175	183	183
GS-14	260	271	271
GS-13	293	305	305
GS-12	250	261	261
GS-11	95	99	99
GS-10	6	7	7
GS-09	99	103	103
GS-08	35	37	37
GS-07	41	43	43
GS-06	8	9	9
GS-05	13	13	13
GS-04	1	1	1
GS-03	0	0	0
GS-02	0	0	0
GS-01	0	0	0
Subtotal	1,276	1,332	1,332
Commissioned Corps	98	89	89
Ungraded	84	85	85
Total positions	1,563	1,616	1,616
Total FTE usage, end of year	1,358	1,417	1,417
Average ES salary	$147,394	$149,323	$152,310
Average GS grade	GS-12/3	GS-12/4	GS-12/4
Average GS salary	$77,973	$82,359	$84,006
Average Special Pay (Commissioned Corps)	$79,755	$80,049	$83,936

SIGNIFICANT ITEMS IN APPROPRIATIONS COMMITTEE REPORTS

FY 2009 House Appropriations Committee Report Language (House Report 111-220)

Item
Healthcare-Associated Infections (HAIs) – The Committee notes that the shortage of primary care health professionals may lead to medical errors that can contribute to healthcare associate infections, as health workers may be more prone to making medical errors due to extended and often unregulated work hours and increased fatigue. The Committee also notes the importance of developing standardized protocols and training programs directed a primary care health professionals and health care administrators. The Committee, therefore, encourages the Secretary to consider and incorporate strategies to increase the size of the primary care workforce and to address recommendations from the Government Accountability Office regarding physician and medical work hours within the HAI Action Plan in order to increase capacity to detect, prevent, and reduce healthcare-associated infections. (p. 185/186)

Action Taken or to be taken
The Steering Committee for the Prevention of Healthcare-Associated Infections at the Department of Health and Human Services (HHS), which developed the *HHS Action Plan to Prevent Healthcare-Associated Infections*, agrees that the shortage of primary care health professionals and clinician fatigue and stress are important issues. In addition, the HHS Steering Committee recognizes that the reduction of healthcare-associated infections involves multiple factors and may require a multi-faceted approach.

The HHS Steering Committee is examining options to better address personnel issues as it relates to the prevention and reduction of healthcare-associated infections and shares the Committee's concerns about limited infection control personnel and training. Strategies for augmenting the infection control training of healthcare professionals, including identifying optimal training methods, and providing appropriate incentives to enhance the training provided to health professional students are being discussed.

Also, the HHS Steering Committee is seeking ways to further integrate healthcare-associated infection reduction efforts with the Health Resources and Services Administration (HRSA) within HHS. HRSA has broad resources to affect the distribution of the primary care workforce and integration of interdisciplinary training.

Item
HIV/AIDS Epidemic - The conferees expect the Office of the Secretary to support activities that are targeted to address the growing HIV/AIDS epidemic and its disproportionate impact upon communities of color, including African Americans, Latinos, Native Americans, Asian Americans, Native Hawaiians, and Pacific Islanders, at no less that the fiscal year 2009 funding level as proposed by the House. The Senate did not include a similar provision.

Action Taken or to be Taken
OMH supports HIV/AIDS programs, some of which are funded by the Minority HIV/AIDS Initiative (MAI). These programs include:

The Collaborative Technical Assistance and Capacity Development (CTA/CD) grant program, which is designed to develop and improve the coordination and continuum of HIV prevention, treatment and support services provided by organizations closely interfaced with targeted minority populations impacted by HIV/AIDS.

Curbing HIV/AIDS Transmissions among High Risk Youth and Adolescents by Utilizing Peer-to-Peer Interaction Using New Application Technologies (CHAT), is a partnership with the Office of HIV/AIDS Policy, Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration to support ongoing HIV/AIDS prevention, education and testing initiatives aimed at youth who are currently in alternative education settings, juvenile detention facilities, and alternative living arrangements ordered by the courts.

HIV/AIDS Health Improvement for Re-entering Ex-offenders Initiative (HIRE) is an OMH partnership with the Office of HIV/AIDS Policy, Substance Abuse and Mental Health Services Administration, Centers for Medicare and Medicaid Services, Administration for Children and Families, Health Resources and Services Administration, Indian Health Service, and the Department of Justice that seeks to improve the HIV/AIDS health outcomes of ex-offenders re-entering the mainstream population. OMH, utilizing case management strategies, will target the reentry population with special focus on substance abusers, MSM, and individuals impacted by mental health disorders.

SPECIAL REQUIREMENTS

FY 2011 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

GDM Allocation Statement:
$484,528 of the **FY 2011** GDM account, not including OPHS, will be used to support Department-wide enterprise information technology and government-wide E-Government initiatives. The GDM account helps to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$44,532** is allocated to developmental government-wide E-Government initiatives for **FY 2011**. This amount supports these government-wide E-Government initiatives as follows:

FY 2011 Developmental E-Gov Initiatives*	
Line of Business – Geospatial One-Stop	$433
Line of Business - Human Resources	$3,151
Line of Business - Financial	$8,980
Line of Business - Budget Formulation and Execution	$6,048
Disaster Assistance Improvement Plan	$25,920
FY 2011 Developmental E-Gov Initiatives Total	**$44,532**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Geospatial: Promotes coordination and alignment of geospatial data collection and maintenance among all levels of government: provides one-stop web access to geospatial information through development of a portal; encourages collaborative planning for future investments in geospatial data; expands partnerships that help leverage investments and reduce duplication; and, facilitates partnerships and collaborative approaches in the sharing and stewardship of data. Up-to-date accessible information helps leverage resources and support programs: economic development, environmental quality, and homeland security. HHS registers its geospatial data, making it available from the single access point.

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and

data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

In addition, **$82,289** is allocated to ongoing government-wide E-Government initiatives for **FY 2011**. This amount supports these government-wide E-Government initiatives as follows:

FY 2011 Ongoing E-Gov Initiatives*	
E-Rule Making	$34,413
Integrated Acquisition Environment	$47,876
FY 2011 Ongoing E-Gov Initiatives Total	**$82,289**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

FY 2011 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

Allocation Statement:
OPHS will use **$175,591** of its **FY 2011** budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. OPHS helps to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Developmental
Of the amount specified above, **$4,632** is allocated to a developmental government-wide E-Government initiative for **FY 2011**. This amount supports the government-wide E-Government initiatives as follows:

FY 2011 Developmental E-Gov Initiatives*	
Line of Business – Grants Management	$4,632
FY 2011 Developmental E-Gov Initiatives Total	**$4,632**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from this initiative are:

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally,
NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Ongoing Initiatives
In addition, **$117,731** is allocated to an ongoing government-wide E-Government initiatives for **FY 2011**. This amount supports the government-wide E-Government initiatives as follows:

FY 2011 Ongoing E-Gov Initiatives*	
Grants.gov	$112,550
GovBenefits	$5,180
FY 2011 Ongoing E-Gov Initiatives Total	**$117,731**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource

Grants.Gov

The following is presented pursuant to Sections 737(b) and (d) of the Consolidated Appropriations Act of 2008 (P.L. 110-161).

The Assistant Secretary for Resources and Technology (ASRT) manages the Grants.gov program. Grants.gov is the Federal government's "one-stop-shop" for grants information, providing information on over 1,000 grant programs and $450 billion awarded by the 26 grant-making agencies and other Federal grant-making organizations. The initiative enables Federal agencies to publish grant funding opportunities and application packages online, while allowing the grant community of over one million organizations (State, local, and tribal governments, education and research organizations, non-profit organizations, public housing agencies, and individuals) to search for opportunities and download, complete, and electronically submit applications.

Through the use of Grants.gov, agencies are able to provide the public with increased access to government grants programs and are able to reduce operating costs associated with online posting and application of grants. Additionally, agencies are able to improve their operational effectiveness through the use of Grants.gov, by increasing data accuracy and reducing processing cycle times.

The initiative provides benefits to the following agencies:

- Department of Agriculture
- Department of Commerce
- Department of Defense
- Department of Education
- Department of Energy
- Department of Health and Human Services
- Department of Homeland Security
- Department of Housing and Urban Development
- Department of the Interior
- Department of Justice
- Department of Labor
- Department of State
- U.S. Agency for International Development
- Department of Transportation
- Department of the Treasury
- Department of Veterans Affairs
- Environmental Protection Agency
- National Aeronautical and Space Administration
- National Archives and Records Administration
- National Science Foundation
- Small Business Administration
- Social Security Administration
- Corporation for National Community Service
- Institute of Museum and Library Services

- National Endowment for the Arts
- National Endowment for the Humanities

From its inception, Grants.gov has transformed the Federal grants environment by streamlining and standardizing public-facing grant processes, thus facilitating an easier application submission process for our applicants. The Grants.gov Program Management Office (PMO) works with agencies on system adoption, utilization, and customer satisfaction.

RISK MANAGEMENT OVERVIEW: Risks are categorized and prioritized to facilitate and focus risk management activities. Risk categories are aligned with OMB risk management guidance, ensuring comprehensive consideration of possible risks and simplifying program reporting. Risk prioritization is based on the probability of occurrence and potential impact, and focuses project resources where they are most needed.

All risks are tracked in the Grants.gov Risk Management Database, from identification through resolution. This online database is accessible to all Grants.gov team members and is updated regularly, in keeping with a continuous risk management process. Although physically separate, the Risk Management Database is considered an integral part of the Grants.gov Risk Management Plan.

Risks are categorized to facilitate analysis and reporting. The Grants.gov risk categories are aligned with Office of Management and Budget (OMB) guidance on risk assessment and mitigation. The risk category describes potentially affected areas of the program, and helps put individual risks into context when assessing their severity. The categories are also used to drive risk identification: the lack of identified risks in a given category may indicate overlooked risks. The following risks have been identified to OMB:

Risk 1: Grants.gov may not receive sufficient funding to complete project milestones. The Grants.gov PMO operations are funded entirely by agency contributions, including salaries and expenses for full-time staff, and support contracts for system integration, hardware platforms, upgrades, software licenses, Independent Verification and Validation, outreach and liaison, contact center, performance metrics monitoring, and office support. If the PMO does not receive sufficient funding, or if the agency contributions are not provided in a timely manner, the PMO would have to limit or stop providing the services it offers to its stakeholders.

Risk mitigation response: Grants.gov risk mitigation is a multifaceted approach that includes internal actions as well as external entities. Internally, the PMO incrementally funds contract requirements when adequate funds are not available, and when funds becomes available it will fully fund requirements. The PMO closely monitors contract expenditures and PMO activities such as training and travel expenditures to ensure the available budget will cover the actual expense. Externally at the beginning of the fiscal year the PMO develops and sends documentation to each funding agency to initiate funding transfers and then reports the status of agency contribution to the Grants Executive Board (GEB) and OMB. Another mitigation activity is that the GEB is currently working on a long term funding strategy for Grants.gov. In FY 2010 Grants.gov will transition to a Fee-for-Service based fee structure that was approved by the GEB in FY 2008. This structure will distribute agency costs amongst agencies on usage basis, however it does not alleviate the current funding process of executing 26 funding agreements each fiscal year to transfer operating funds to HHS for Grants.gov. The GEB will explore ways to transfer the funding with out having to execute 26 separate agreements.

Risk 2: Grants.gov receives and distributes grants applications that contain proprietary information that must be safeguarded.

Risk mitigation response: Grants.gov mitigates this risk through the use of policy /procedure and by physical means. Grants.gov has specific policy on the creation of system super user accounts and provides these users recommended authentication procedures. Grants.gov uses encrypted channels and limits the time that application data is retained on the Grants.gov system.

Risk 3: A fundamental concept of electronic commerce is the standardization of a common set of terms to be used by trading partners during business communications. Grants.gov requires common data processes in order to function. The inability to define common data and processes could delay system adoption or impede program goals.

Risk mitigation response: The Grants.gov system was developed in accordance with the electronic standards for core grants data, Transaction Set 194, which were developed by the Inter-Agency Electronic Grants Committee (IAEGC). The Grants.gov PMO worked with the PL 106/107 workgroup and IAEGC to build consensus, and continues to work to minimize the required changes to agency and applicant processes, to minimize agency-specific forms, and to publish existing forms and encourage agencies to use them.

Risk 4: The Grants.gov system's centralized architecture increases the impact of system failure and performance issues.

Risk mitigation response: The PMO has incorporated off-line forms that can be submitted through alternate paths (e.g., e-mail, mail, or fax) and that distribute the computational load. The PMO also ran pilot electronic applications in parallel with paper submissions during it initial operational phases. The Grants.gov system uses a high-availability configuration for central system and has implemented effective monitoring & restoration procedures. The PMO routinely measures system performance and forecasts application loads and recommends that agencies spread opportunity closing dates to spread system loads. In times of heavy system loads the PMO gives a higher priority to application receipt processing and defers back-end processing to after peak capacity periods. In FY 2010 the PMO will continue to deploy system changes and enhancements to reduce application processing load and will continue to enhance the system to increase efficiency.

FUNDING: The total development cost of the Grants.gov initiative by fiscal year -- including costs to date, estimated costs to complete development to full operational capability, and estimated annual operations and maintenance costs -- are included in the table below. Also included are the sources and distribution of funding by agency, showing contributions to date and estimated future contributions through FY 2010.

	2007	TDCTD*	2008 (ECTCD*)	2009 (O&MC*)	2009 Supplemental	2010	GRAND TOTAL
HHS	1,900,000	**6,139,000**	1,957,000	1,889,755	872,931	5,351,254	**18,109,940**
DOT	1,073,700	**5,312,700**	1,105,885	1,067,885	493,131	341,215	**9,394,516**
ED	1,073,700	**5,312,700**	1,105,885	1,067,885	493,131	693,539	**9,746,840**
HUD	1,073,700	**5,312,700**	1,105,885	1,067,885	493,131	414,422	**9,467,723**
NSF	520,600	**3,246,000**	536,187	517,763	239,331	486,442	**5,546,323**
DOJ	520,600	**3,246,000**	536,187	517,763	239,331	594,241	**5,654,122**
DOL	520,600	**3,849,600**	536,187	517,763	239,331	180,930	**5,844,411**
USDA	1,073,700	**3,482,700**	1,105,885	1,067,885	493,131	529,802	**7,753,103**
DOC	520,600	**2,326,000**	536,187	517,763	239,331	335,476	**4,475,357**
DOD	520,600	**1,873,300**	536,187	517,763	239,331	680,529	**4,367,710**
DHS	520,600	**2,326,000**	536,187	517,763	239,331	333,118	**4,472,999**
AID	520,600	**1,426,000**	536,187	517,763	239,331	251,360	**3,491,241**
EPA	520,600	**1,426,000**	536,187	517,763	239,331	479,847	**3,719,728**
DOE	520,600	**1,426,000**	536,187	517,763	239,331	441,866	**3,681,747**
NASA	520,600	**1,426,000**	536,187	517,763	239,331	198,038	**3,437,919**
DOI	520,600	**1,426,000**	536,187	517,763	239,331	835,507	**4,075,388**
CNCS	130,000	**582,600**	133,900	129,299	59,931	60,419	**1,096,149**
VA	130,000	**582,600**	133,900	129,299	59,931	44,617	**1,080,347**
IMLS	130,000	**582,600**	133,900	129,299	59,931	63,224	**1,098,954**

CENTRALLY-MANAGED PROJECTS

The GDM Staff Divisions are responsible for administering certain centrally-managed projects on behalf of all Operating Divisions in the Department. Authority for carrying out these efforts is authorized by either specific statute or general transfer authority (such as the Economy Act, 31 USC 1535). The costs for centrally-managed projects are allocated among the Operating Divisions in proportion to the estimated benefit to be derived.

Project	Description	FY 2010 Funding
CFO Audit of Financial Statements	These funds cover the costs of auditing the HHS financial statements annually (as required by the CFO Act of 1990), producing the Department-wide financial statements, and coordinating the HHS audit process.	$14,966,000
Bilateral and Multilateral International Health Activities	These funds support activities by the Office of Global Health Affairs to develop and coordinate the Department's crosscutting interactions with multilateral organizations and foreign governments, necessitated by the increasing intersections between domestic health priorities and international engagement.	$5,811,000
Regional Health Administrators (RHAs)	The RHAs provide senior-level health leadership and infrastructure in HHS's ten Regions, particularly in the areas of prevention, preparedness, coordination and collaboration. The RHAs represent the Secretary, Assistant Secretary for Health and Surgeon General in the Regions, and are key players in managing ongoing public health challenges.	$3,500,000
Departmental Ethics Program	These funds support attorneys and other legal staff under the direction of HHS's Designated Agency Ethics Official, who provide ethics-related program services, financial disclosure reviews, training programs and audits, as required by the Ethics in Government Act and the Office of Government Ethics.	$2,364,000
Secretary's Advisory Committee on Blood Safety and Availability	This Committee advises the Secretary on a broad range of public health, ethical and legal issues related to blood transfusion and transplantation safety. Such issues require coordination across many of the Operating Divisions. Funds support Committee meetings, workshops, staff, and subject matter experts.	$1,500,000

Presidential Commission for the Study of Bioethical Issues	The Commission was created by Executive Order 13521 on November 24, 2009, replacing the President's Council on Bioethics. Its purpose is to advise the President on bioethical issues that may emerge as a consequence of advances in biomedicine and related areas of science and technology. Funding for the Council (including 13 members and 8-10 staff) comes entirely from HHS.	$1,250,000
HSPD-12 Implementation	These funds are used to fund the HHS Program Management Office for Homeland Security Presidential Directive 12 (HSPD-12), which requires Federal agencies to issue and maintain PIV-2 compliant ID cards to all HHS contractors and employees.	$950,000
Media Monitoring	These funds permit the Office of the Assistant Secretary for Public Affairs to provide a coordinated, succinct daily monitoring service of all agency-relevant media coverage for the entire Department, thus preventing duplication and overlap by the individual Operating Divisions.	$512,000
Core Support for the National Academy of Sciences (NAS)	These funds enable a number of NAS Boards (including the Institute of Medicine) to have experts readily available to provide advice and consultation to HHS in critical scientific areas, and ensure that the most current scientific expertise informs the design and execution of HHS initiatives and programs.	$466,000
Negotiation by NIH of Indirect Cost Rates	At the request of the Operating Divisions, NIH has expanded its capacity to negotiate indirect cost rates with commercial (for-profit) organizations that receive HHS contract and/or grant awards, to ensure that such indirect costs are reasonable, allowable and allocable.	$271,000
Electronic and IT Access for Persons with Disabilities	These funds ensure that HHS complies with the requirements of Section 508 of the Rehabilitation Act Amendments, and that a comprehensive program is implemented which becomes a part of the HHS infrastructure – in the same manner that EEO requirements and programs have.	$179,000
HHS Health and Wellness Center	These funds are used to provide a portion of the ongoing operating costs of a health facility which promotes physical fitness for all HHS employees located in the Southwest DC complex.	$152,000

Motor Vehicle Management Information System (MVMIS)	MVMIS funds are used to support a web-based tool which allows the Department to manage its motor vehicle fleet and be in compliance with all applicable Federal and HHS policies, laws and regulations.	$64,000
TOTAL		$31,985,000

Office of Medicare Hearings and Appeals

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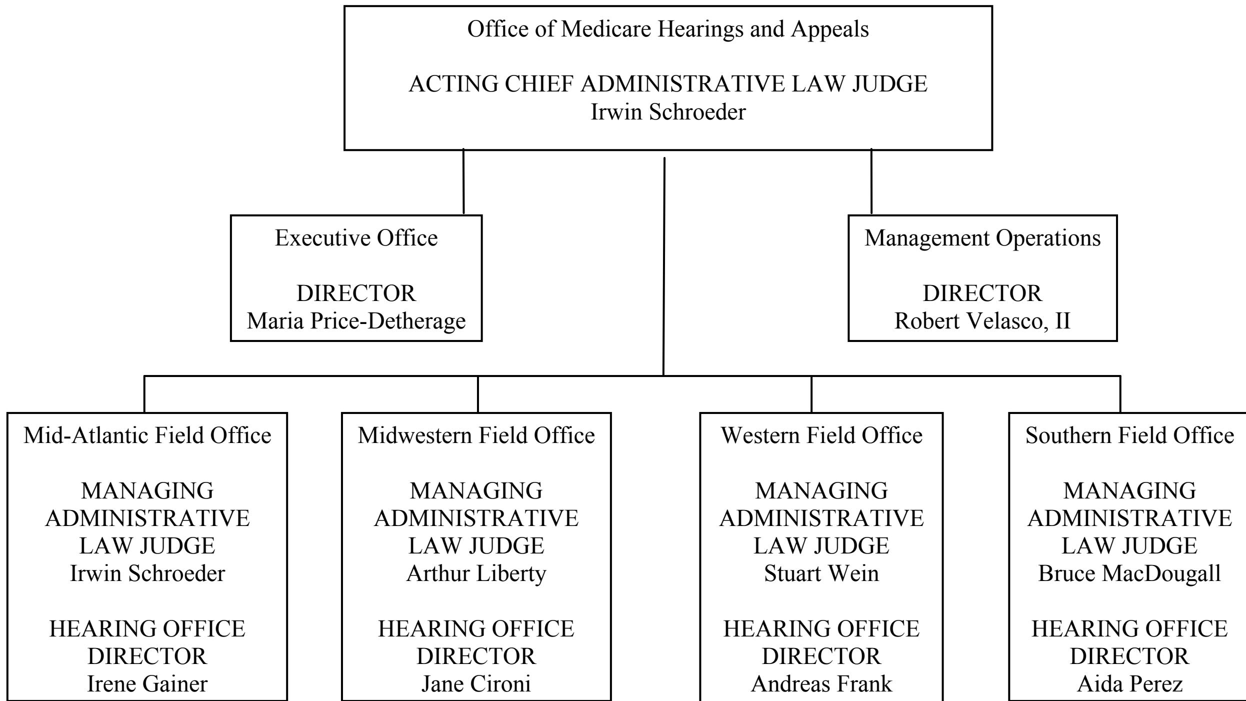
ORGANIZATIONAL CHART



EXECUTIVE SUMMARY

Agency Overview

The Office of Medicare Hearings and Appeals (OMHA), an agency of the U.S. Department of Health and Human Services (HHS), administers hearings and appeals nationwide for the Medicare program. OMHA ensures that the American people have equal access and opportunity to make such appeals and can exercise their rights for health care quality and access. On behalf of the Secretary of HHS, the Administrative Law Judges (ALJs) within OMHA conduct impartial hearings and issue decisions on claims determination appeals involving Medicare Parts A, B, C and D, as well as Medicare entitlement and eligibility appeals.

Vision

OMHA will continue to be a model Federal adjudicative agency for serving the American public by:

- developing and maintaining a highly-qualified, professional staff to adjudicate Medicare appeals;
- utilizing state-of-the-art technology;
- maintaining a quality assurance program that ensures the integrity of decisions and data, while maintaining decisional independence; and
- serving appellants and other customers in such a way as to reflect a seamless Medicare appeals process.

Mission

OMHA provides an independent forum for the fair and efficient adjudication of Medicare appeals for beneficiaries and other parties. This mission is carried out by a cadre of knowledgeable ALJs, exercising judicial and decisional independence under the Administrative Procedures Act, with the support of a professional legal and administrative staff. In fulfilling this mission, OMHA strives for the equitable treatment of all who appear before it, and recognizes its responsibility to be an efficient and effective agency within the U.S. Department of Health and Human Services.

Overview of Budget Request

The FY 2011 President's Budget request for OMHA is $77,798,000 – an increase of $6,651,000 or 9% above the FY 2010 enacted level. The budget supports HHS Strategic Goal 1, "Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care," by supporting the Medicare program. Specifically, OMHA provides the basic mechanisms through which individuals and organizations who are dissatisfied with Medicare determinations affecting their right to, or their participation in, the Medicare program may administratively appeal these determinations.

DISCRETIONARY ALL-PURPOSE TABLE

	FY 2009 Appropriation	**FY 2009 Recovery Act**	**FY 2010 Appropriation**	**FY 2011 President's Budget Request**
Total Funding	$64,604	$0	$71,147	$77,798
Total FTE	357	0	378	422

APPROPRIATIONS LANGUAGE

For expenses necessary for administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions of title XI of such Act), **[$71,147,000]** *$77,798,000*, to be transferred in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. (*Department of Health and Human Services Appropriations Act, 2010)*

AMOUNTS AVAILABLE FOR OBLIGATION[1]

	FY 2009 Enacted	FY 2010 Enacted	FY 2011 Request
Trust funds:			
Annual appropriation	$64,604,000	$71,147,000	$77,798,000
Unobligated balance lapsing	-56,000	–	–
Total obligations	$64,548,000	$71,147,000	$77,798,000

[1] Excludes the following amounts for reimbursable activities carried out by this account: FY 2009 – $27,000; FY 2010 – $112,000.

SUMMARY OF CHANGES

2010	
Total enacted budget authority	71,147,000
(Obligations)	
2011	
Total estimated budget authority	77,798,000
(Obligations)	
Net Change	+6,651,000

	FY 2010 Enacted FTE	FY 2010 Enacted Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. Annualization of 2010 pay increase	378	43,164,000	+44	+219,381
2. Annualization of new positions in FY 2010	378	43,164,000	+44	+369,600
3. Cost of January 2011 pay raise (2.1%)	378	43,164,000	+44	+778,567
4. Rental Payments to GSA		6,691,000		+449,559
Subtotal, Built-in Increases				+1,817,107
B. Program:				
1. Cost of new ALJ teams in FY 2011	378	43,164,000	+44	+4,198,879
2. Travel		185,000		+15,772
3. Transportation of things		216,000		+45,612
4. Communications, misc charges		1,317,000		+264,840
5. Printing and reproduction		26,000		+5,637
6. Contractual services		19,155,000		+219,853
7. Supplies and materials		338,000		+27,040
8. Equipment		55,000		+56,260
Subtotal, Program Increases				+4,833,893
Net Change				**+6,651,000**

BUDGET AUTHORITY BY ACTIVITY

(Dollars in thousands)

	FY 2009 Actual	FY 2010 Enacted	FY 2011 PB
Total, Budget Authority	$64,604	$71,147	$77,798
FTE	357	378	422

AUTHORIZING LEGISLATION

	FY 2010 Amount Authorized	FY 2010 Appropriations Act	FY 2011 Amount Authorized	FY 2011 Pres. Budget
Medicare Prescription Drug, Improvement, and Modernization Act of 2003	Indefinite	$71,147,000	Indefinite	$77,798,000
Activity:				

APPROPRIATIONS HISTORY TABLE

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
Trust Fund Appropriation:	80,000,000	60,000,000	75,000,000	60,000,000
Rescissions				-600,000
FY 2007				
Trust Fund Appropriation:	74,250,000	70,000,000	75,000,000	59,727,000
FY 2008				
Trust Fund Appropriation:	74,250,000	70,000,000	70,000,000	65,000,000
Rescissions				-1,136,000
FY 2009				
Trust Fund Appropriation:	64,604,000	64,604,000	64,604,000	64,604,000
Recovery Act Appropriation				0
FY 2010				
Trust Fund Appropriation:	71,147,000	71,147,000	71,147,000	71,147,000
FY 2011				
Trust Fund Appropriation:	77,798,000			

NARRATIVE BY ACTIVITY

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
Total Funding	$64,604	$0	$71,147	$77,798	+$6,651
Total FTE	357	0	378	422	+44

Authorizing Legislation: Titles XVIII and XI of the Social Security Act
Allocation Method: Direct Federal

Program Description and Accomplishments

The Office of Medicare Hearings and Appeals (OMHA) was established by Section 931 of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), enacted on December 8, 2003. MMA transferred the responsibility for hearing Medicare appeals at the Administrative Law Judge (ALJ) level – the third level of Medicare claims appeals – from the Social Security Administration (SSA) to the Office of the Secretary at the Department of Health and Human Services (HHS). The Medicare Benefits Improvement and Protection Act of 2000 (BIPA) also mandated that ALJ appeals be heard within 90 days after receipt of a request from a Medicare appellant. OMHA began processing cases on July 1, 2005.

OMHA administers its program in four field offices, including the Southern Field Office in Miami, Florida; the Midwestern Field Office in Cleveland, Ohio; the Western Field Office in Irvine, California; and the Atlantic Field Office in Arlington, Virginia. OMHA extensively utilizes video-teleconferencing (VTC) and telephone hearings, in order to provide appellants with hearings which are timely, close to their homes, and have a broad array of access points. VTC technology, which is now commonly used throughout the country in courtrooms and for telemedicine, plays a critical role in OMHA's ability to both meet the BIPA timeframes and provide expanded access for appellants to ALJ hearings.

Since opening its doors in July 2005, OMHA's caseload has continued to increase as follows:

OMHA Claims Received

FY 2006	FY 2007	FY 2008	FY 2009
106,421	137,442	185,665	215,847

In January 2006, OMHA began hearing appeals arising from the new Medicare Part D

Prescription Drug Plan. In January 2007, OMHA began hearing Medicare Part B Income-Related Medicare Adjustment Amount (IRMAA) appeals.

In 2007, OMHA began receiving new cases as a result of the Centers for Medicare & Medicaid Services (CMS) pilot Recovery Audit Contractor (RAC) program. This program includes RACs for Medicare Secondary Payer (MSP) claims, as well as non-MSP claims. The demonstration project was designed to determine whether the use of RACs would be a cost-effective means of adding resources to ensure that correct payments are made to providers and suppliers, thereby protecting the Medicare Trust Funds. CMS selected California, New York and Florida as the three initial States under the pilot program, and later expanded the program to include Massachusetts and South Carolina. As a result of the RAC pilot program, OMHA received more than 20,000 RAC claims through FY 2009. Under Title III, Section 302, of the Tax Relief and Health Care Act of 2006, the RAC program has become permanent and is being expanded to all 50 States in FY 2010. As a result of this permanent program expansion, OMHA expects that it will receive an additional 54,000 RAC specific claims in FY 2011.

Moreover, OMHA's overall workload (in both RAC and non-RAC claims) continues to increase. In FY 2007, OMHA received 137,442 claims. In FY 2008, claims increased to 185,665 and in FY 2009, claims increased to 215,847. The proposed increase of $6,651,000 over the FY 2010 enacted level will be used primarily to fund additional Federal FTEs, cost-of-living increases for Federal staff, and associated programmatic expenses to support the increased caseload.

Since opening its doors, OMHA has undertaken a number of successful initiatives focused on improving the quality and timeliness of its services. These include:

- A five year strategic plan that codifies OMHA's objectives and establishes the foundation for organizational performance
- A best practices initiative that shared and facilitated efficient operational approaches across offices
- A unified workload measurement system (UWMS) that established a methodology for balancing caseload across the agency
- A national data standardization initiative to promote data quality
- An enhanced, citizen-centric internet presence based on usability testing to clearly communicate the Medicare appeals process to citizens
- The establishment of a decision template resource database

Budget Request

OMHA's caseload has continued to increase significantly since it began adjudicating the third level of Medicare appeals in July 2005. In addition to increases in its projected caseload, OMHA began receiving new appeals resulting from CMS' Recovery Audit Contractor (RAC) Program Demonstration in FY 2007. The RAC Program has been made permanent and will expand to all 50 states in FY 2010. In FY 2008 and FY 2009, the RAC Demonstration resulted in about 20,000 additional claims. Given the nationwide implementation, RAC claims are projected to increase to 54,000 in FY 2011. In addition, the non-RAC workload in FY 2011 is projected to increase by 64% compared to FY 2008 (please see the following table).

	Non-RAC Claims	RAC Claims	Total Claims
FY 2008 Actuals	172,250	13,415*	185,665
FY 2009 Actuals	209,234	6,613*	215,847
FY 2010 Projected	265,000	32,000**	297,000
FY 2011 Projected	282,000	54,000**	336,000

*RAC Pilot Program (5 States)
** RAC Program Nation-wide implementation

The FY 2011 budget request for OMHA of $77,798,000 is an increase of $6,651,000 over the FY 2010 enacted level. Although OMHA continues to become more efficient, increasing the number of Administrative Law Judge (ALJ) teams is the only assured method to address the caseload volume. In FY 2011, OMHA will support:

- Twelve new ALJ teams (each consisting of an ALJ, attorney, paralegal, and hearing clerk) to adjudicate all Medicare appeals, including Medicare Parts A, B, C, D, Medicare entitlement and eligibility appeals, Income Related Monthly Adjustment Amount (IRMAA) cases, and RAC cases. (Please see the following table.)

Number of ALJ Teams

FY 2009	FY 2010	FY 2011
65	68	80

- Twenty additional FTE positions, to replace legal and administrative support currently provided by contractor resources working in the four offices nationwide, to adjudicate appeals and ensure strict adherence to all financial and administrative management internal controls.

Additionally, the requested funding will support critical operational investments:

- Maintaining information technology systems, including the Medicare Appeals System (MAS), intranet expansion, and planning for MAS enhancements. MAS is the primary business system used to track and support the adjudication of the second and third levels of the Medicare appeals process. MAS is shared by the Centers for Medicare & Medicaid Services (CMS) and OMHA.

- Maintenance of 59 on-site adjudication hearing rooms and the associated video-teleconferencing (VTC) equipment and telecommunications infrastructure, along with access to external hearing room facilities via commercial vendors.

- Within the FY 2011 OMHA request, $55,502 will be used to support Department-wide enterprise information technology (IT) and ongoing government-wide e-government initiatives. The OMHA account helps to finance specific HHS enterprise IT programs and initiatives, as identified through the HHS Information Technology Capital Planning and Investment Control process. All HHS enterprise IT initiatives meet cross-functional

criteria and are approved by the HHS IT Investment Review Board, based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Performance:

In FY 2009, OMHA met or exceeded six out of the seven agency performance goals as follows: (See Outputs and Outcomes Table below for additional detail.)

- *Increase the number of BIPA cases closed within 90 days* - One of OMHA's long-term goals is to consistently adjudicate BIPA cases within the 90 day statutory timeframe. The five year goal is to achieve 90% of BIPA case processed in 90-days. In FY 2009, OMHA processed 94% of the BIPA cases within the statutory timeframe. OMHA exceeded its performance target for FY 2009 of 87% by 7% primarily due to the continued nationwide implementation of best practices identified in OMHA field offices, and the implementation of a workload measurement system for balancing national caseloads across offices.

- *Increase the number of non-BIPA cases closed within 90 days* - Although there is no statutory requirement to decide non-BIPA cases within 90 days, OMHA identified the timely closure of non-BIPA cases as an important long-term goal. OMHA makes a concerted effort to adjudicate non-BIPA cases expeditiously and adopted many of the same process improvements for non-BIPA cases. This measure assures OMHA meets or exceeds all mandated case processing timelines throughout the Medicare appeals process. OMHA expects the number of non-BIPA cases to decrease in the out years. In FY 2009, OMHA processed 69% of the non-BIPA cases within 90 days, thereby exceeding its performance target of 53% for FY 2009 by 16% primarily due to the continued nationwide implementation of best practices identified in OMHA field offices and other process improvements and efficiencies that support reduced case processing timeframes.

- *For cases that go to hearing, increase the percentage of decisions rendered in 30 days* - OMHA's primary mission is to adjudicate cases within required timelines (e.g., 90 days). Rendering decisions within 30 days of when a hearing is held is a leading indicator of the likelihood of meeting a 90 day timeframe. The percentage represents the cases where a decision was rendered within 30 days of completing the ALJ hearing. In FY 2009, OMHA issued 81% of its decisions for cases that went to hearing within 30 days. This fell short of the performance target of 83% by 2%, which may be attributable to OMHA's increasing caseload.

- *Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council* - The legal accuracy of OMHA decisions remains of paramount importance to the agency. OMHA is committed to providing accurate decisions that are not reversed or remanded on appeals to the Medicare Appeals Council (MAC), which provides the fourth level of Medicare appeals. This goal focuses on maintaining the overall quality and accuracy of OMHA decisions. The performance target for FY 2009

was 1% which OMHA exceeded by having only 0.8% of its decisions reversed or remanded on appeals to the Medicare Appeals Council.

- *Improve the average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level* **-** OMHA is evaluating its customer service through an independent evaluation that captures the scope of the Level III appeal experience by randomly surveying selected appellants and appellant representatives. The survey measures the overall appellant experience, the quality of OMHA materials, hearing scheduling and format, and interactions with OMHA staff. The measure aims to assure that appellants and related parties are satisfied with their Medicare appeals experience with OMHA. On a scale of 1 – 5, the FY 2009 performance target was 3.20; OMHA achieved a result of 4.30 in the appellant survey, which conveys a high level of satisfaction by appellants in their interaction with OMHA.

- *Decrease the cost per claim adjudicated* - OMHA seeks to gain efficiencies and cost savings through reduced case processing timeframes despite rising costs for staffing, rent, contracts and other services needed to support the appeals process. In FY 2009, OMHA exceeded the performance target of a 5% reduction when it actually decreased cost per claim by 18% (to $300 per claim compared to $364 per claim in FY 2008). This increased efficiency is due to several factors, including "start up" costs for the first two year of operations as well as increased efficiencies gained from OMHA's operational and adjudicatory experience.

- *Increase the number of claims processed per ALJ team* – ALJ teams (comprised of an ALJ, attorney, paralegal and hearing clerk) strive to meet statutory timeframes and increasing workloads while also maintaining the quality and accuracy of OMHA decisions. OMHA's caseload increased by 16% in FY 2009 while the number of ALJ teams remained fairly constant at 65 ALJ teams nationwide at the end of FY 2009. The FY 2009 performance target was to increase the number of claims processed by each ALJ team by 2%. In FY 2009, OMHA increased the number of claims by 23% (from 2,710 claims per ALJ team in FY 2008 to 3,336 claims per ALJ team in FY 2009).

OUTPUTS AND OUTCOMES TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY2010
1.1: Increase the number of BIPA cases closed within 90 days *(Output)*	FY 2009: 94% (Target Exceeded)	88%	88%	Maintain
1.2: Increase the number of non-BIPA cases closed within 90 days *(Output)*	FY 2009: 69% (Target Exceeded)	55%	55%	Maintain
1.3: For cases that go to hearing, increase the percentage of decisions rendered in 30 days *(Output)*	FY 2009: 81% (Target Unmet)	84%	84%	Maintain
1.4: Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council *(Output)*	FY 2009: 0.8% (Target Exceeded)	1%	1%	Maintain
1.5: Improve the average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level *(Output)*	FY 2009: 4.30 (Target Exceeded)	3.20	3.20	Maintain
1.6: Decrease the cost per claim adjudicated *(Efficiency)*	FY 2009: -18% (Target Exceeded)	-3%	-3%	Maintain
1.7: Increase number of claims processed per ALJ team *(Efficiency)*	FY 2009:+23% (Target Exceeded)	+1%	+1%	Maintain

BUDGET AUTHORITY BY OBJECT CLASS

	2010 Enacted	2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)...	33,764,000	37,829,508	12.0%
Other than full-time permanent (11.3)..............................	-	-	
Other personnel compensation (11.5)...............................	669,000	586,952	-12.3%
Military personnel (11.7)..	-	-	
Special personnel services payments (11.8).....................	-	-	
Subtotal personnel compensation..............................	**34,433,000**	**38,416,460**	11.6%
Civilian benefits (12.1)..	8,731,000	10,313,967	18.1%
Military benefits (12.2)..	-	-	
Benefits to former personnel (13.0)....................................	-	-	
Total Pay Costs..	**43,164,000**	**48,730,427**	12.9%
Travel and transportation of persons (21.0).........................	185,000	200,772	8.5%
Transportation of things (22.0)..	216,000	261,612	21.1%
Rental payments to GSA (23.1)...	6,691,000	7,140,559	6.7%
Communication, utilities, and misc. charges (23.3).............	1,317,000	1,581,840	20.1%
Printing and reproduction (24.0)...	26,000	31,637	21.7%
Other Contractual Services:			
Advisory and assistance services (25.1)...........................	9,136,000	7,209,671	-21.1%
Other services (25.2)..	3,518,000	3,682,637	4.7%
Purchase of goods and services from government accounts (25.3)..	5,958,000	7,878,780	32.2%
Operation and maintenance of facilities (25.4).................	470,000	512,505	9.0%
Research and Development Contracts (25.5)....................	-	-	
Medical care (25.6)..	-	-	
Operation and maintenance of equipment (25.7)..............	73,000	91,260	25.0%
Subsistence and support of persons (25.8).......................	-	-	
Subtotal Other Contractual Services.........................	**19,155,000**	**$19,374,853**	1.1%
Supplies and materials (26.0)...	338,000	365,040	8.00%
Equipment (31.0)...	55,000	111,260	102.30%
Land and Structures (32.0)	-	-	
Investments and Loans (33.0)..	-	-	
Grants, subsidies, and contributions (41.0)..........................	-	-	
Interest and dividends (43.0)...	-	-	
Refunds (44.0)...	-	-	
Total Non-Pay Costs..	**27,983,000**	**29,067,573**	3.9%
Total Budget Authority by Object Class.........................	**71,147,000**	**77,798,000**	9.3%

SALARIES AND EXPENSES

	2010 Enacted	2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)..	33,764,000	37,829,508	12.0%
Other than full-time permanent (11.3)............................	-	-	
Other personnel compensation (11.5).............................	669,000	586,952	-12.3%
Military personnel (11.7)..	-	-	
Special personnel services payments (11.8)....................	-	-	
Subtotal personnel compensation.............................	**34,433,000**	**38,416,460**	11.6%
Civilian benefits (12.1)..	8,731,000	10,313,967	18.1%
Military benefits (12.2)..	-	-	
Benefits to former personnel (13.0)..................................	-	-	
Total Pay Costs...	**43,164,000**	**48,730,427**	12.9%
Travel and transportation of persons (21.0).......................	185,000	200,772	8.5%
Transportation of things (22.0)..	216,000	261,612	21.1%
Rental payments to Others GSA (23.2)..............................	-	-	
Communication, utilities, and misc. charges (23.3)...........	1,317,000	1,581,840	20.1%
Printing and reproduction (24.0).......................................	26,000	31,637	21.7%
Other Contractual Services:			
Advisory and assistance services (25.1) *.......................	9,136,000	7,209,671	-21.1%
Other services (25.2)..	3,518,000	3,682,637	4.7%
Purchase of goods and services from government accounts (25.3)..	5,958,000	7,878,780	32.2%
Operation and maintenance of facilities (25.4)...............	470,000	512,505	9.0%
Research and Development Contracts (25.5)..................	-	-	
Medical care (25.6)..	-	-	
Operation and maintenance of equipment (25.7)............	73,000	91,260	25.0%
Subsistence and support of persons (25.8)......................	-	-	
Subtotal Other Contractual Services........................	**19,155,000**	**19,374,853**	1.1.%
Supplies and materials (26.0)..	338,000	365,040	25.0%
Total Non-Pay Costs...	**21,237,000**	**21,815,754**	2.4%
Total Salary and Expense..	**64,401,000**	**70,546,181**	9.5%
Direct FTE...	378	422	11.6%

* Funds approximately 87 contractor positions in FY 2010 and approximately 67 contractor positions in FY 2011.

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

	2009 Actual Civilian	2009 Actual Military	2009 Actual Total	2010 Enacted Civilian	2010 Enacted Military	2010 Enacted Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total
Medicare Hearings and Appeals........	357	0	357	378	0	378	422	0	422

Average GS Grade [1]

FY 2006..	GS/12/7
FY 2007..	GS/12/7
FY 2008..	GS-12/5
FY 2009..	GS-11/5
FY 2010..	GS/11/7
FY 2011..	GS/11/7

1. Note: Average GS Grade does not include ALJs

DETAIL OF POSITIONS

	2009 Actual *	2010 Enacted	2011 Estimate
AL-1..	1	1	1
AL-2..	4	4	4
AL-3..	61	64	76
Subtotal, ALJ	66	69	81
ES...	2	2	2
Subtotal, ES	2	2	2
Total - ES Salary	$305,532	$314,698	$324,138
GS-15..	7	7	7
GS-14..	26	26	26
GS-13..	4	5	5
GS-12..	114	115	115
GS-11..	65	66	77
GS-10..			
GS-9..	15	30	37
GS-8..	46	46	46
GS-7..	10	23	28
GS-6..	8	10	10
GS-5..			
GS-4..			
GS-3..			
GS-2..			
GS-1..			
Subtotal, GS	295	328	351
Total - GS Salary	$20,776,116	$22,959,520	$25,476,503
Total Positions	363	399	434
Total FTE	357	378	422
Average ES salary...................................	$152,766	$157,349	$162,069
Average GS grade....................................	11/5	11/7	11/7
Average GS salary..................................	$70,428	$74,787	$75,152

* Reflects actual on board staff as of 09/30/2009

Office of the National Coordinator for Health Information Technology

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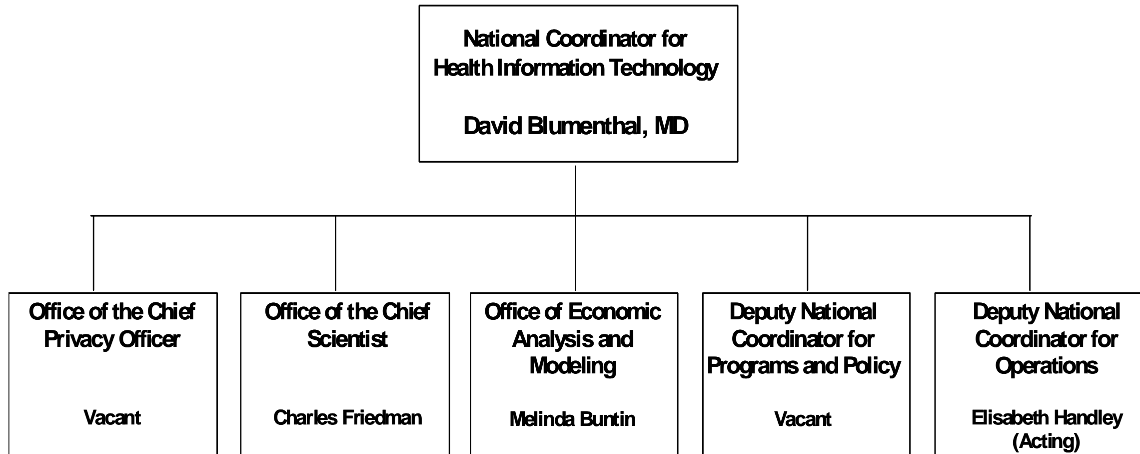
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Deputy National
Coordinator for
Operations
Elisabeth Handley
(Acting)

Executive Summary

Introduction and Mission

ONC Vision

A Nation in which the health and well-being of individuals and communities are enabled by health information technology.

ONC Mission

ONC leads, coordinates, and stimulates public and private sector activities that promote the development, adoption, and use of health information technologies to achieve a healthier Nation.

Introduction

Health information technology (HIT) is a critical component of a modern health care delivery system. If successfully implemented, HIT will improve the quality, efficiency, and value of care delivered by enabling providers, consumers and policy makers to:

- Constantly produce new insights and evidence;
- Seamlessly apply real-time learning from the clinical experience;
- Monitor and manage the health of populations;
- Exchange health information across all points of service; and
- Make better health care decisions for individuals, communities and populations including populations with special needs.

The Office of the National Coordinator for Health Information Technology (ONC) is leading the federal government's efforts to support the thoughtful application of HIT through programs and policies designed to address the obstacles providers have faced in adopting and using HIT.

Though it has been in existence since 2004, ONC was permanently established by statute under the February 2009 American Reinvestment and Recovery Act, Title XIII – Health Information Technology (also cited as Health Information Technology for Economic and Clinical Health or HITECH Act). The HITECH Act was developed to support not only the adoption of HIT, but its meaningful use – an important concept that will promote the use of HIT to improve health outcomes and empower patients.

With its expanded role under HITECH, ONC has been developing programs, management and organizational structures to fulfill its new responsibilities. This budget document describes how ONC's FY 2011 budget request will support HITECH's implementation and the adoption and meaningful use of HIT.

FY 2011 Budget Overview

The FY 2011 Planning Level Budget Request for ONC is $78,334,000 to support program activities and carry out American Recovery and Reinvestment Act (Recovery Act) responsibilities. This represents an increase of $16,992,000 above the FY 2010 Omnibus level and includes a reduction in PHS Evaluation Funds of -$19,011,000. This budget supports the implementation of the "*ONC-*

Coordinated Federal Health IT Strategic Plan" and planned revision, and HHS Strategic Plan, Goal 1.3: improve health care quality, safety, cost and value.

Most importantly, it provides resources required to administer and manage the $2 billion appropriated to ONC under the Recovery Act and ONC's responsibilities as legislated under the HITECH Act.

Program Increases:

Interoperability (+ $12,820,000)
This increase includes additional funding for the Nationwide Health Information Network (NHIN) program and continued funding for further development of the conformance test bed being developed in coordination with NIST. It also includes a new initiative that addresses the need for specific mental health standards. The goal of this initiative is to ensure that standards and certification processes for the unique confidentiality rules that apply to both mental health and substance use disorder diagnosis and treatment are developed and incorporated into electronic health records (EHRs).

Privacy and Security (+ $3,214,000)
This increase will provide resources for the new ONC Chief Privacy Officer, as required under HITECH. Also, this request builds on projects initiated with Recovery Act funding in FY 2010 to increase trust in electronic health information exchange: Cybersecurity programs will ensure that needed policies, technologies, practices, and guidelines are developed to improve health information security – a great concern for the general population. It also provides for continued support for guidance and regulation updates as required under HITECH.

Research and Evaluation (+ $3,106,000)
This increase supports the work begun in FY 2010 under Recovery Act funds and is essential to continued program performance. Understanding and reporting the progress of and improvements in the HIT programs are requirements of HITECH and will support improvements in key program implementation.

Program Decreases:

Adoption (- $1,894,000)
Funding is reduced from the FY 2010 level for Health Information Exchange interoperability support. The budget priority focuses on other state-level activities to enable adoption.

Operations (- $254,000)
Funding is reduced for grants administration support. With the establishment of a permanent grants office in ONC, the cost of grants administration is decreased.

Public Health Evaluation Funds (- $19,011,000)
No Public Health Evaluation Funds are included in this budget, resulting in a decrease of $19,011,000 in PHS Evaluation Funds across all programs.

Discretionary All-Purpose Table

(Dollars in Thousands)

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Budget Authority....................	$43,552	$2,000,000	$42,331	$78,334
PHS Evaluation Funds...........	17,679	-	19,011	-
Total, Program Level..............	$61,231	$2,000,000	$61,342	$78,334
FTE...	31	-	75	120

The American Recovery and Reinvestment Act appropriated $2 billion to ONC to implement the HITECH Act. Of these funds, HHS transferred $20 million to the National Institute of Standards and Technology (NIST) as required under the Recovery Act.

Office of the National Coordinator for Health Information Technology

Summary of Recovery Act Obligations and Performance*

(dollars in millions)

ARRA Implementation Plan	FY 2009	FY 2010	FY 2011	FY 2009 – FY 2011
Program 1 - Subtitle D Enforcement	$0.00	$16.17	$0.00	$16.17
Program 2 - Regulations, Guidance and Studies	$0.57	$7.55	$0.00	$8.12
Program 3 - Grants to State and Qualified State-Designated Entities	$0.00	$564.00	$0.00	$564.00
Program 4 - HIT Research Center and Regional Extension Centers	$0.00	$648.00	$0.00	$648.00
Program 5 - Health IT Workforce	$0.00	$118.00	$0.00	$118.00
Program 6 - Beacon Communities	$0.00	$235.00	$0.00	$235.00
Program 7 - Omnibus Plan	$0.00	$282.21	$32.93	$315.14
Program 8 - Other Activities	$0.00	$30.50	$0.00	$30.50
Recovery Act required transfer to NIST	$0.00	$18.03	$1.98	$20.00
Total Obligations	**$0.57**	**$1,919.46**	**$34.91**	**$1,954.93**

*This table reflects additional information than what is included in the Budget Appendix.

By the end of FY 2011, HHS will show progress toward establishing the infrastructure necessary to encourage the adoption and meaningful use of HIT by establishing Regional Extension Centers in order to provide technical services to providers. The high priority performance goals below support this effort:

High Priority Performance Goals	FY 2010 Target	FY 2011 Target
By the end of FY 2011, establish the infrastructure necessary to encourage the adoption and meaningful use of HIT by:		
1. Establishing a network of 70 Regional Extension Centers by the end of FY 2010.	70	N/A
2. Registering 30,000 providers to receive services from Regional Extension Centers by end of FY 2010; 3. Registering 100,000 providers to receive services from Regional Extension Centers by end of FY 2011.	30,000	100,000
4. Achieving 20% adoption of EHRs among providers working with Regional Extension Centers by end of FY 2011.	N/A	20%

Data source:

Evaluation contractor will validate data reported by each Regional Extension Center grantee.

Budget Exhibits

Appropriations Language
Office of the National Coordinator for Health Information Technology

Health Information Technology

For expenses necessary for the Office of the National Coordinator for Health Information Technology, including grants, contracts and cooperative agreements for the development and advancement of interoperable health information technology **[**$42,331,000**]***$78,334,000*: **[**Provided, That in addition to amounts provided herein, $19,011,000 shall be available from amounts available under section 241 of the Public Health Service Act.**]** (Department of Health and Human Services Appropriations Act, 2010.)

Office of the National Coordinator for Health Information Technology

Amounts Available for Obligation

	FY 2009 Actual	FY 2010 Est.	FY 2011 PB
General Fund Discretionary Appropriation:			
Annual Appropriation	$ 43,552,000	$ 42,331,000	$ 78,334,000
Subtotal, Adjusted Appropriation	$ 43,552,000	$ 42,331,000	$ 78,334,000
Recovery Act Appropriation (P.L. 111-5):			
General Fund Appropriation	$ 2,000,000,000	$ -	$ -
Total, Discretionary Appropriation	$ 2,043,552,000	$ 42,331,000	$ 78,334,000
Discretionary Appropriation less ARRA	$ 43,552,000	$ 42,331,000	$ 78,334,000
Unobligated Balances:			
Unobligated balance, Recovery Act start of year	$ 2,000,000,000	$ 1,999,430,000	$ 97,430,000
Unobligated balance, Recovery Act end of year	$ 1,999,430,000	$ 97,430,000	$ 44,490,000
Total Obligations	$ 44,122,000	$ 1,944,331,000	$ 131,274,000
Obligations less ARRA	$ 43,552,000	$ 42,331,000	$ 78,334,000

Office of the National Coordinator for Health Information Technology

Summary of Changes

2010	
Total estimated budget authority..	$42,331,000
(Obligations)..	-$61,342,000
2011	
Total estimated budget authority..	$78,334,000
(Obligations)..	-$78,334,000
Net Change obligations..	+$16,992,000
Net Change budget authority..	+$36,003,000

	FY 2011 Estimate FTE	FY 2011 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Built-in:	120		+ 45	
1. Cost of January 2011 Civilian Pay Raise of 2.1 percent		$12,951,210		+$4,717,180
2. Cost of January 2011 Commission Officer Pay Raise of 2.1 percent		$250,000		+$20,000
Subtotal, Built-in Increases.......................	120	$13,201,210	+ 45	+$4,737,180
A. Program:				
1. Interoperability..		$22,770,000		+$12,820,000
[Including decrease in Evaluation Funds of]		[$0]		-[$6,000,000]
2. Privacy and Security....................................		$6,850,000		+$3,214,000
[Including decrease in Evaluation Funds of]		[$0]		-[$3,000,000]
3. Research and Evaluation.............................		$6,701,000		+$3,106,000
[Including decrease in Evaluation Funds of]		[$0]		[$0]
Subtotal, Program Increases......................		$36,321,000		+$19,140,000
Total Increases...		$49,522,210		$23,877,180
Decreases:				
4. Adoption..		$4,439,000		-$1,894,000
[Including decrease in Evaluation Funds of].		[$0]		-[$4,011,000]
5. Operations..		$24,372,790		-$4,991,180
[Including decrease in Evaluation Funds of]		[$0]		-[$6,000,000]
6. [Total Decrease PHS Evaluation Funds].......		$0		-[$19,011,000]
Total Decreases..		$28,811,790		-$6,885,180
Net Change...	120	$78,334,000	+ 45	+$16,992,000

Office of the National Coordinator for Health Information Technology

Budget Authority by Activity

(Dollars in thousands)

	FY 2009 Actual	FY 2010 Estimate	FY 2011 PB	FY 2011 PB
Health Information Technology				
Adoption BA..	$2,059	$2,322	$4,439	+$2,117
[Evaluation Funds]................................	[$1,800]	[$4,011]	[$0]	-[$4,011]
Total Adoption Program..........................	[$3,859]	[$6,333]	[$4,439]	-[$1,894]
Interoperability BA..................................	$15,355	$3,950	$22,770	+$18,820
[Evaluation Funds]................................	[$14,084]	[$6,000]	[$0]	-[$6,000]
Total Interoperability Program...................	[$29,439]	[$9,950]	[$22,770]	+[$12,820]
Privacy and Security BA..........................	$1,706	$636	$6,850	+$6,214
[Evaluation Funds]................................	[$0]	[$3,000]	[$0]	-[$3,000]
Total Privacy and Security Program..........	[$1,706]	[$3,636]	[$6,850]	+[$3,214]
Research and Evaluation BA.....................	$2,518	$3,595	$6,701	+$3,106
[Evaluation Funds]................................	[$1,551]	[$0]	[$0]	[$0]
Total Research and Evaluation Program....	[$4,069]	[$3,595]	[$6,701]	+[$3,106]
Operations BA..	$21,914	$31,828	$37,574	+$5,746
[Evaluation Funds]................................	[$244]	[$6,000]	[$0]	-[$6,000]
Total Operations Program........................	[$22,158]	[$37,828]	[$37,574]	-[$254]
Total, Budget Authority	$43,552	$42,331	$78,334	+$36,003
Evaluation Funds	$17,679	$19,011	$0	-$19,011
Total Program Level	$61,231	$61,342	$78,334	+$16,992
FTE	31	75	120	+45

Office of the National Coordinator for Health Information Technology

Authorizing Legislation

	FY 2010 Amount Authorized	FY 2010 Appropriations Act	FY 2011 Amount Authorized	FY 2011 President's Budget
Health Information Technology		$42,331,000		$78,334,000
PHS Evaluation Funds (non-add)		[$19,011,000]		[$0]

Office of the National Coordinator for Health Information Technology

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
Budget Authority........................	$75,000,000	$58,100,000	$32,800,000	$42,800,000
PHS Evaluation Funds............	$2,750,000	$16,900,000	$12,350,000	$18,900,000
Rescission (PL 109-148).........				($428,000)
Transfer to CMS......................				($29,107)
Total......................................	$77,750,000	$75,000,000	$45,150,000	$61,242,893
FY 2007				
Budget Authority........................	$89,872,000	$86,118,000	$51,313,000	$42,402,000
PHS Evaluation Funds............	$28,000,000	$11,930,000	$11,930,000	$18,900,000
Total......................................	$117,872,000	$98,048,000	$63,243,000	$61,302,000
FY 2008				
Budget Authority........................	$89,872,000	$13,302,000	$43,000,000	$42,402,000
PHS Evaluation Funds............	$28,000,000	$48,000,000	$28,000,000	$18,900,000
Rescission (PL 110-161).........				($741,000)
Total......................................	$117,872,000	$61,302,000	$71,000,000	$60,561,000
FY 2009				
Budget Authority........................	$18,151,000	$43,000,000	$60,561,000	$43,552,000
PHS Evaluation Funds............	$48,000,000	$18,900,000	$0	$17,679,000
ARRA (PL 110-161)................				$2,000,000,000
Total......................................	$66,151,000	$61,900,000	$60,561,000	$2,061,231,000
FY 2010				
Budget Authority........................	$42,331,000	$0	$42,331,000	$42,331,000
PHS Evaluation Funds............	$19,011,000	$61,342,000	$19,011,000	$19,011,000
Total......................................	$61,342,000	$61,342,000	$61,342,000	$61,342,000
FY 2011				
Budget Authority........................	$78,334,000			
PHS Evaluation Funds............	$0			
Total......................................	$78,334,000			

Narrative by Activity

Authorizing Legislation: PHS Act 42 U.S.C. 201, as amended by TITLE XIII—Health Information Technology: Health Information Technology for Economic and Clinical Health Act (HITECH Act) in H.R.1, the American Recovery and Reinvestment Act of 2009.

Based on efforts to reorganize the office and programs to achieve the mission and the goals of HITECH, ONC modified the budget presentation to reflect priorities.

HHS and ONC priorities: HHS and ONC are working to achieve four basic priorities:

1. Define "meaningful use of HIT" in coordination with the Centers for Medicare and Medicaid Services (CMS);
2. Bolster public trust in electronic information systems by ensuring privacy and security;
3. Encourage and support the widespread adoption of HIT and the attainment of meaningful use through incentives and grant programs; and
4. Foster continued HIT innovation.

Regulatory activities: In December 2009, CMS, in close coordination with ONC, accomplished a major step toward the first priority through a notice of proposed rulemaking (NPRM) that will be finalized in 2010.

HHS was deliberate in defining meaningful use of HIT to advance five health care goals:

1. Improving the quality, safety, and efficiency of care while reducing disparities;
2. Engaging patients and families in their care;
3. Promoting public and population health;
4. Improving care coordination; and
5. Promoting the privacy and security of EHRs.

ONC and CMS accomplished a major step toward the second and third priorities by issuing an interim final rule (IFR) that adopts an initial set of standards, implementation specifications, and certification criteria for EHRs. A third regulatory action, creating a process for certifying EHRs, is in advance stages.

Taken together, these three regulations will form the basis for receiving incentive payments from Medicare and Medicaid. They also send a clear signal to providers to start taking steps to adopt and use EHRs in a meaningful manner, to vendors to start enhancing their products to make them capable of meaningful use, and to vendors, health care organizations and consumers concerning how personal health information must and can be kept private and secure.

Though regulation constitutes a vital tool to achieve HITECH's goals, the thoughtful and judicious use of funds to support the adoption and meaningful use of HIT generally, and EHRs in particular, is also critical to the creation of a modern electronic health information system in the United States. Within ONC's revised budget categories described below, this document discusses how ONC will use its FY 2011 budget to accomplish the four key priorities. Funds requested support programs that have two characteristics that distinguish them from ONC's HITECH programs:

1. They represent ongoing activities of ONC that are vital to its mission, preceded HITECH, and will continue after Recover Act funds are exhausted.
2. They are vital to ONC's and HITECH purposes but are not specifically required under that legislation.

Adoption

The proportion of hospitals and health care professionals that have adopted EHRs remains small. HITECH was an historic, Federal effort to transform the Nation's HIT landscape by providing substantial Medicare and Medicaid incentives to reduce the financial barriers to adoption and use of EHRs.

In addition to the incentives, HITECH instructed HHS to undertake a series of grant programs that systematically address the obstacles that providers face in adopting and meaningfully using EHRs. In particular, HHS and ONC have allocated $643 million to funding Health Information Technology Regional Extension Centers (RECs) and $50 million to an Health Information Technology Research Center (HITRC), as well as $118 million to training an improved and expanded HIT workforce. All mandated under HITECH, these programs will help to overcome technical and logistical obstacles faced by providers in adopting EHRs.

ONC's 2011 budget request supports the administration of these grant programs and provide oversight and accountability for their careful implementation. In addition, the request supports activities devoted to engaging consumers in the collection and use of electronic health information (a vital complement to and enabler of the effective use of EHRs) and developing information on the long-term consequences, including unintended effects, of the adoption and meaningful use of EHRs. Specifically, the FY 2011 request will enable ONC to:

- Support the operations of the HITECH grant programs;
- Continue ONC efforts to identify and take appropriate actions to mitigate unintended consequences resulting from increased adoption and use of EHRs;
- Identify ways to engage patients and families in their care through consumer e-health tools; and
- Track the adoption and use of EHRs across the Nation.

Interoperability

Interoperability is the ability of two or more systems to exchange information and to use the information that has been exchanged. This concept is fundamental to ONC's mission and necessary to attaining meaningful use of EHRs because, by statute, hospitals and health care professionals must exchange information to be considered meaningful users.

Using Recovery Act funds, ONC is funding several major programs focused on interoperability:

- Identifying existing or develop new standards for EHRs that enable those products to meet interoperability requirements under meaningful use;
- Developing certification criteria and a certification process to ensure that EHRs have incorporated the necessary standards and implementation specifications to support interoperability required under definitions of meaningful use;

- Providing the core set of needed publicly accessible specifications, tools and services for the NHIN; and
- Building the nationwide capability for health information exchange through the State Health Information Exchange grant program, a program specifically funded under the Recovery Act.

Complementing these HITECH programs, the FY 2011 budget request will enable ONC to:

- Administer and monitor its interoperability programs;
- Maintain ONC's historic and continuing responsibilities for identifying, developing and adopting standards, technical specifications, and certification criteria;
- Continue ONC's progress toward making publicly available a reference implementation of the NHIN for entities to use to exchange information with each other;
- Continue to pilot new NHIN standards and services; and
- Continue support of the Federal Health Architecture (FHA).

Privacy and Security

Privacy and security is the foundation upon which trust in electronic health information and participation in health information exchange will be built. If individuals and health care professionals do not believe that their health information will be protected and remain confidential, the Nation will not achieve the level of participation in health information exchange that is needed to improve individual and population health. Bolstering trust by ensuring privacy and security is fundamental to ONC's mission and a basic priority for ONC.

ONC's FY 2011 budget request will enable ONC to:

- Aggressively implement and enforce, in coordination with the Office for Civil Rights (OCR), new authorities and program related to privacy and security under HITECH;
- Provide hospitals and health care professionals with best practices and guidance on developing, implementing and maintaining organizational privacy and security policies;
- Identify opportunities to improve the current privacy and security legislation framework;
- Continue the security initiative started with Recovery Act funds; and
- Study medical identity theft and risk mitigation.

Research and Evaluation

Technologies continuously innovate and improve through research to identify new methods and approaches, creation of better products, and careful evaluation of current practices. By supporting research, innovation, analysis, and evaluation, ONC can accelerate the pace at which HIT is adopted and promotes the quality, safety, and efficiency of health care.

ONC is using Recovery Act funds to achieve some of its goals in the area of research and evaluation. Specifically, it has devoted $60 million to its Strategic Health Information Technology Advanced Research Program (SHARP) and is using Recovery Act funds to carry out mandated studies under HITECH legislation.

ONC's FY 2011 budget request seeks support for several complementary programs related to research and evaluation:

- Support for the evaluation of programs specifically created to implement HITECH legislation;
- Ongoing collection and analysis of longitudinal data on the adoption of HIT and the evolution from adoption to meaningful use;
- Continuation of ongoing HITECH-required reports;
- Bolstering ONC's essential capacities for research, modeling, and analysis; and
- Monitoring emerging innovative technologies in the marketplace.

Operations

Based on the expanded role and responsibilities for ONC under HITECH, ONC required additional operational resources. ONC's request will enable it to:

- Support the additional staffing levels required for oversight of national grant programs and new regulatory responsibilities;
- Support increased administrative, financial and reporting requirements; and
- Support increased need for space and related infrastructure.

These major areas of activity are described on the following page, including accomplishments and the FY 2011 budget requests in greater detail.

Adoption

(Dollars in thousands)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$2,059	$1,768,200	$2,322	$4,439	+ $ 2,117
PHS Evaluation Funds	$1,800	$0	$4,011	$0	- $ 4,011
Total Program Level	$3,859	$1,768,200	$6,333	$4,439	- $ 1,894

Authorizing Legislation: None
Allocation Method: Contract, Grant, Cooperative Agreement

Program Description and Accomplishments

Over 80 percent of the $2 billion in funds appropriated to ONC under the Recovery Act are directed toward state and community efforts to encourage adoption and support the attainment of meaningful use by hospitals and health care professionals. These constitute the major grant programs authorized by HITECH that are being conducted by ONC.

Grant Programs to Support the Attainment of Meaningful Use

Regional Extension Program
ONC established a grants program with Recovery Act funding to establish approximately 70 RECs. These centers will provide hospitals and clinicians with hands-on technical assistance in the selection, acquisition, implementation, and meaningful use of certified electronic health record systems. Additional assistance to health care providers will be provided through establishment of a Health Information Technology Research Center (HITRC). The HITRC will gather relevant information on effective practices from a wide variety of sources across the country and help the RECs collaborate with one another and with relevant stakeholders to identify and share best practices in EHR adoption, effective use, and provider support.

In August 2009, a Funding Opportunity Announcement (FOA) was released for the program and the first round of cooperative agreements are slated to be awarded by the end of January 2010; the second and final cycle of awards will be made by the end of March 2010.

A High Priority Performance Goal for HHS is to establish the infrastructure necessary to encourage the adoption and meaningful use of HIT. Measures for this goal focus on the largest Recovery Act investment in HIT infrastructure – the RECs. By the end of FY 2011, ONC aims to establish a network of approximately 70 RECs, register 100,000 providers for services, and achieve a 20 percent adoption of EHRs among providers by the end of FY 2011.

ONC plans to collect data from administrative and grants management records regarding the number of RECs established. Each REC will be required to plan and implement the outreach, education, and technical assistance programs necessary to meet the objective of assisting providers in its geographic service area to improve the quality and value of care they furnish by attaining or

exceeding meaningful use criteria established by the Secretary. Each REC will report data on a routine basis including the number of providers with signed agreements to work with the REC, the number of providers who have purchased an EHR, the number of providers who have adopted an EHR and the number of providers who have become meaningful users of EHRs.

Workforce Training Program

In addition to ensuring that technical resources are available to hospitals and clinicians who are adopting HIT, the lack of a qualified health information professional workforce must be addressed. The Nation's current training capacity will not be adequate to produce the trained workforce that is needed to support progress to meaningful use of HIT. It is estimated that this training capacity must be increased to produce at least 50,000 additional, appropriately trained HIT workers by 2014. Accordingly, HITECH Subtitle C, §3016 requires that assistance to institutions of higher education be provided to establish or expand medical HIT education programs to ensure the rapid and effective utilization and development of health information technologies.

By the end of March 2010, awards for the creation of several programs that are aimed to support the education of health professionals, including curriculum development, competency exams, and training will be in place.

State Health Information Exchange Program

HITECH Subtitle C, §3013 required that a program be established to promote the electronic movement and use of health information among organizations. ONC established a substantial grant program that will provide funding to states and territories through cooperative agreements for planning, capacity building, and implementation activities that will enable health care providers across states to share health information at all points of service delivery. This state-based program targets developing the capacity for widespread and sustainable health information exchange to enable the meaningful use of EHRs and will mobilize clinical data needed for consumer engagement and health reform across all states.

These grants will help states to realize interoperable HIE where authorized health care providers and patients can access personal health information for prevention and care management and population level data is available for research and public health. The infrastructure necessary for widespread adoption of HIE will be developed over the next five years through the federally sponsored work on standards, certification, the NHIN, supporting governance mechanisms and federal, state and organizational policies.

The FOA for this program was also released in August 2009 and, starting in January 2010, awards will begin to be made to state-identified health information exchange organizations.

Beacon Communities Program

The Beacon Community grants program will demonstrate that interoperable HIT can have substantial, positive, short-term effects on the efficiency and quality of health care. This program will generate valuable lessons concerning how to achieve HIT-supported health system improvement, and increase momentum for the adoption and meaningful use of HIT. It will also demonstrate the feasibility of achieving the health care delivery system outcome and efficiency objectives for the meaningful use criteria for HIT incentive payments. Selected communities will

demonstrate in CY 2012 the health system improvements that can be achieved nationwide in future years. This will be accomplished by selecting communities that are national leaders in HIT and information exchange. These communities will be able to demonstrate improved care coordination and performance monitoring by accelerating their capabilities through concentrated investment of federal resources. Consistent with ONC's desire and responsibility to coordinate HIT activities across the Federal government, the Beacon Community program is closely aligned with the Department of Defense (DoD) and the Department of Veterans Affairs (VA) Virtual Lifetime Electronic Record (VLER) initiative and ongoing HIT work at the Health Resources and Services Administration (HRSA) in support of federally qualified community health centers.

By the end of March 2010, up to 15 awards will be made to communities across the country in which clinicians, hospitals and consumers show how the meaningful use of EHRs can achieve measurable improvement in the quality and efficiency of health services or public health outcomes in a given geographic area.

These critical HITECH grant programs are supported through the Adoption program, as well as through program staff positions, consultant contracts, and grants management support described under Operations.

Additional Activities to Support the Attainment of Meaningful Use
In addition to these grant programs focused on supporting hospitals and health care professionals, ONC is supporting targeted Recovery Act funded activities to address specific meaningful use health care goals:

- Consumer e-Health Tools – ONC will identify and describe consumer perspectives on consumer e-health tools, including patient decision aids. This information will assist physicians and hospitals to more effectively achieve meaningful use of certified EHR technology, specifically those objectives related to engaging patients and families in their health care and managing chronic conditions. To become meaningful users, providers must increasingly share and exchange data with their patients, and will eventually have to interact seamlessly with personal health records (PHRs).

- Provider Workflow Relative to Meaningful Use Criteria –This project will extend beyond the availability of Recovery Act funds and represents a core, ongoing activity of ONC. Specifically, ONC will design and implement a longitudinal cohort study of a sample of physicians who will be tracked over an extended period of time to measure how they respond to the adoption and meaningful use of EHRs.

- Unintended Consequences in Health Information Exchange – As the number of providers that use EHRs and engage in electronic health information exchange grows in response to incentives, ONC anticipates that there will be unintended consequences. These include identifying quality and safety issues, liability issues, ethics issues and other unintended consequences.

ONC is also supporting Federal and private sector collaboration to further adoption and use of EHRs, including:

- Health Information Technology Policy Committee - As required by HITECH Subtitle A, Part 1 §3002, in 2009, ONC chartered the HIT Policy Committee, a FACA Committee, to make policy recommendations to the National Coordinator relating, but not limited to, defining meaningful use criteria for the CMS incentives program under HITECH, the protection of the privacy of health information and promotion of security in a qualified EHR, utilization of a certified EHR for each person in the United States, the use of certified EHRs to improve the quality of health care, the use of electronic systems to ensure the comprehensive collection of patient demographics and the implementation of a nationwide HIT infrastructure and implementation of the Federal HIT Strategic Plan, among other things. These activities are well under way and the Committee and its work groups meet on a regular basis and have provided valuable insight and recommendations to the National Coordinator.

Federal coordination is another important strategy in increasing adoption and meaningful use of HIT. ONC's coordination role preceded and will extend beyond HITECH activities. ONC collaborates with multiple Federal entities to further the goal of advancing and adopting interoperable EHRs and health information exchange. Some examples include:

- ONC is collaborating with CMS to define meaningful use of an EHR and create an executable payment incentive program. This work, begun in FY 2009 with Recovery Act funds, will inform the incentives program for HIT adoption that will be conducted by CMS.
- Working in close collaboration with HRSA, the Centers for Disease Control and Prevention (CDC), the National Library of Medicine (NLM), the National Science Foundation (NSF) and others, ONC is crafting a program to increase the HIT workforce as prescribed in HITECH.
- ONC is coordinating closely with AHRQ to leverage contracts that support the establishment of health information exchange organizations and to document the benefits of EHRs on health care quality and efficiency.
- ONC is working closely with DoD, VA, and HRSA in funding the Beacon Community initiative.

Federal policy coordination involves a broad array of policy activities across HHS and other Executive Branch agencies. Specific areas are described below.

Increase the alignment of Federal regulations, where possible, and Federal HIT policies to ensure:

- Improved HIT policy coordination across the Federal government;
- Increased Federal and state policy consistency and understanding through efforts to communicate Federal policy and reduce confusion about its implications for States and localities;
- Facilitation of provider adoption and attainment of meaningful use by reducing obstacles to health information exchange created by conflicting Federal policies and programs.

Efforts to date include working with:

- the Internal Revenue Service on: (1) hospital tax-exempt status and Stark and Anti-kickback, and (2) Health Information Organizations and tax-exempt status;
- CMS on Clinical Laboratory Improvement Amendments (CLIA);

- Drug Enforcement Agency on e-Prescription regulations; and
- OCR and CMS on HIPAA-related activities.

Additional work includes ONC's continued support of the development of Clinical Decision Support (CDS) as a vital way to use HIT to improve the quality and safety of care provided in the US. Clinical decision support is a term that encompasses a wide variety of tools and technologies that have in common the presentation of computer-mediated information - intelligently filtered at appropriate times - to enhance and inform decisions related to health and health care. Simply put, CDS can make clinicians, hospitals, and patients better at using health information to make good health care decisions. ONC had an extensive CDS program prior to HITECH, in collaboration with multiple other federal agencies, and believes that work on CDS constitutes a core ONC activity that must continue well into the future.

State Coordination

ONC has long worked with states to help them support the adoption and use of EHRs, and proposes to build on these previous efforts. States play a critical role in ONC's strategy to support hospitals and health care professionals in attaining meaningful use and encouraging widespread health information exchange. Efforts to coordinate with states (in addition to the State Health Information Exchange Program) include:

- State Alliance for e-Health – Under ONC leadership, significant progress continues through the State Alliance for e-Health (State Alliance), which provides the Federal government the ability to communicate and coordinate with state governments on policy issues that include privacy and security. The State Alliance is a consensus-based, executive-level body of state elected and appointed officials (in all levels of state government), formed to address the unique role that states can play in facilitating electronic health information exchange. By design, the State Alliance supports populations of all states and territories – which include minorities, children and other vulnerable populations, under-served communities, providers, public and private programs, and others. The State Alliance explores solutions to programmatic and legal issues.

  In 2009, an important accomplishment was the convening of bi-monthly learning network meetings with key state government individuals involved in HIT/HIE and appointed by the Governors, and the state guide to support their work. This effort leveraged state interest in HITECH planning and implementation grants to further the goal of states in meeting the intent of meaningful use with an emphasis on public trust through privacy and security, and information exchange across state lines.

  During 2009, the State Alliance also convened representatives of 20 state medical boards with a goal of defining a path to licensure portability, which resulted in a summary document, the *State Alliance for e-Health Licensure Portability Summit*. This document continues to serve as a tool to promote license portability among state medical boards.

  In 2010, the contract for the work of the State Alliance will be renewed. Plans for 2010 will focus on supporting state governments as they continue to implement their HITECH grants to promote exchange and meaningful use, as well as address state leadership, policy and planning relative to state barriers to exchange (laws, policies, etc.).

- State Health Policy Consortium – The State Health Policy Consortium, to be initiated in 2010, builds on the momentum created by the Health Information Security and Privacy Collaboration (HISPC) and leverages the state government and 'grass roots-level' expertise. It will continue to support other ONC efforts, such as the grants to states or state-designated entities and the work being done by the State Alliance for e-Health by:
    - Expanding state government and "grass roots-level" involvement in the harmonization and/or standardization of state policies that will facilitate health information exchange.
    - Convening select states or groups within states to collaborate around specific policy issues identified by ONC, including privacy and security.

<u>Funding History</u>

FY 2006	$3,600,000
FY 2007	$4,225,000
FY 2008	$1,320,000
FY 2009	$3,859,000
FY 2010*	$6,333,000

*FY 2010 Funding supplemented with Recovery Act funds.

<u>Budget Request</u>

The FY 2011 request for Adoption is $4,439,000; a decrease of $1,894,000 from the FY 2010 Omnibus level. This funding level supports implementation, continuation and oversight of HITECH activities.

Funding to continue work related to clinical decision support to address key functional aspects of HIT for which it is commonly understood that technology performance will have to improve and open problems addressed in order to reach the goal of meaningful use by 2014. Work in this area to date has emphasized clinical decision support but will be expanding to include usability and human-computer interactions.

As the number of providers that use EHRs and engage in electronic health information exchange grows in response to Medicare and Medicaid incentive payments and ONC initiatives, ONC anticipates that there will be unintended consequences. These include identifying quality and safety issues, liability issues, ethics issues and other unintended consequences of HIE. In FY 2011, ONC will manage a panel on unintended consequences to identify and address issues that arise as a consequence of changes in the HIT market and health information exchange.

Funding will continue to support the identification of consumer perspectives on consumer e-health tools and the development of patient decision aids. As in 2010, this information will assist physicians and hospitals to more effectively achieve meaningful use of certified EHR technology as the criteria becomes more demanding, specifically those objectives related to engaging patients and families in their health care and managing chronic conditions.

Also critical is continuation of the support for the State Alliance for e-Health. Plans for 2011 will continue to focus on supporting state governments as they implement their HITECH grants, while promoting exchange and focusing on state barriers to exchange (laws, policies, etc.). Work will continue through regional efforts to facilitate inter-state exchange and to capitalize on already established relationships to mobilize states that do not clearly see the benefits of engaging in HIT/HIE or are not as skilled in doing so. Emphasis will also be given to developing inter-state compacts and/or uniform state laws to facilitate information exchange across state borders. The State Alliance will be required to work with other organizations that can support their goals such as the National Conference of Commissioners on Uniform State Laws, the National Conference of State Legislatures, the Association of State and Territorial Health Organizations, the National Governors Association, and the National Academy for State Health Policy.

Work will include continued collaborations with CMS on future modifications of meaningful use, FDA relative to EHRs being categorized as medical devices, OCR relative to HIPAA guidance (as discussed in the privacy and security section), the Federal Trade Commission (FTC) on consumer protections, and continued work with CMS on the Clinical Laboratory Improvement Amendments (CLIA).

HITECH mandates that ONC carry out a number of programs that will further adoption of HIT with the goal of meaningful use beginning in 2011. Included are:

> HITECH Sections: 3001(c)(5), 3001(c)(8) and 3004 requires the development of (1) regulations and associated guidance needed to adopt standards, and certification criteria, and (2) guidance or a regulation for a process to recognize certification bodies. The process for developing standards and certification criteria and recognizing certification bodies will change to support meaningful use. It is likely that regulations and guidance will have to be developed annually to support these changes.
>
> These funds support the HIT Policy Committee, a public-private FACA that provides advice to the National Coordinator with a focus on achieving health information interoperability and full participation of stakeholders in the adoption of a nationwide HIT infrastructure that allows for the electronic use and exchange of health information.

Adoption resources will continue the work to implement HITECH responsibilities through collaboration with other HHS entities and while coordinating across the public and private sectors.

By the end of FY 2011, HHS will show progress toward establishing the infrastructure necessary to encourage the adoption and meaningful use of HIT by establishing Regional Extension Centers in order to provide technical services to providers. The high priority performance goals below support this effort:

High Priority Performance Goals	FY 2010 Target	FY 2011 Target
By the end of FY 2011, establish the infrastructure necessary to encourage the adoption and meaningful use of HIT by:		
1. Establishing a network of 70 Regional Extension Centers by the end of FY 2010.	70	N/A
2. Registering 30,000 providers to receive services from Regional Extension Centers by end of FY 2010; 3. Registering 100,000 providers to receive services from Regional Extension Centers by end of FY 2011.	30,000	100,000
4. Achieving 20% adoption of EHRs among providers working with Regional Extension Centers by end of FY 2011.	N/A	20%

Data source:
Evaluation contractor will validate data reported by each Regional Extension Center grantee.

Interoperability

(Dollars in thousands)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$15,355	$84,300	$3,950	$22,770	+ $ 18,820
PHS Evaluation Funds	$14,084	$0	$6,000	$0	- $ 6,000
Total Program Level	$29,439	$84,300	$9,950	$22,770	+ $ 12,820

Authorizing Legislation: None
Allocation Method: Contract, Cooperative Agreement

Program Description and Accomplishments

Funding for interoperability activities supports work to enable health information to be captured and exchanged among HIT systems – whether small physician practices or large hospital systems. The funding is allocated among several components necessary to achieve exchange of health information among different entities and organizations. These elements allow ONC to:

- Identify existing or develop new standards and implementation specifications for EHRs;
- Develop and maintain certification criteria and a certification process;
- Provide a core set of needed publicly accessible specifications, tools and services for the NHIN; and
- Coordinate Federal participation in health information exchange (i.e., the Federal Health Architecture).

This funding addresses the need to:

- Maintain ONC's historic and continuing responsibilities for identifying, developing and adopting standards, technical specifications, and certification criteria;
- Continue ONC's progress toward making publicly available a reference implementation of the NHIN for entities to use to exchange information with each other;
- Continue to pilot new NHIN standards and services; and
- Continue support of the Federal Health Architecture (FHA).

Moreover, the availability of standards and certification criteria supporting meaningful use is critical to achieving the goals of the HITECH legislation. The meaningful use requirements progress from a focus on data collection to an increasing requirement for improved processes of care, better care coordination, and demonstration of improved outcomes. This progression of meaningful use depends fundamentally on improving the interoperability of EHRs and actual information exchange.

Standards and Certification
Ongoing standards and certification efforts by ONC are focused on aligning the set of adopted standards, implementation specifications, and certification criteria with the progressively more

demanding meaningful use requirements. Meaningful use requirements will be established through regulation by CMS, in close coordination with ONC. ONC, in turn, is working closely with CMS to align standards and certification with meaningful use requirements. ONC will also leverage the work and expertise of the NLM in developing standardized terminologies. The RxNorm terminology is an example of a standardized terminology developed by the NLM. ONC will adopt a set of standards, implementation specifications, and certification criteria through regulation.

Incorporation of these standards and implementation specifications will advance interoperability among systems engaged in health information exchange and widespread adoption of interoperable health information technologies. On December 30, 2009 an interim final rule was put on display by the Federal Register that described the initial set of standards, implementation specifications and certification criteria for HIT adopted by the HHS Secretary. A subsequent final rule will be published in 2010.

Under HITECH, federal agencies that are engaged in health care delivery and health information exchange are required to incorporate this set of adopted standards and implementation specification into their systems. Hospitals and health care professionals in the private sector are required to use EHRs that are certified to meet the adopted set of standards and implementation specifications in order to receive the incentive payments from Medicare and Medicaid.

In furtherance of these activities during 2010, ONC will refine the initial work begun in 2009 to support EHR meaningful use for implementation in 2011. ONC will:

- Support the new standards areas and recommendations of the HIT Policy Committee and the HIT Standards Committee established pursuant to HITECH;
- Identify and address the overlaps among standards supporting meaningful use;
- Harmonize inconsistencies in the meaningful use standards across standards development organizations, such as aiming for the same coding systems for demographic data and clinical information;
- Engage stakeholders in the standards development processes;
- Support the development and continued use of tools that enable standards users to more effectively identify and integrate meaningful use standards and their components into their work.

The HIT Standards Committee, a Federal Advisory Committee Act (FACA) body, is a public-private enterprise focused on supporting the goals of HITECH through the development of necessary standards, implementation specifications and certification criteria. The HIT Standards Committee makes recommendations to the National Coordinator in accordance with policies developed by the HIT Policy Committee (discussed further in the Adoption section). ONC staff will continue to actively coordinate across the relevant Federal departments and agencies to ensure that the Federal representation on the HIT Standards Committee is fully engaged and informed to speak on behalf of broad Federal interests.

The EHR certification process will be established through HHS regulation in 2010. This new certification process will be in accordance with the requirements of HITECH and provide confidence to the market that certified EHRs have the necessary functionality to support hospitals and health care professionals in meeting the meaningful use requirements. ONC is collaborating

with NIST to develop and apply tests of the conformance of EHRs to the standards and other capabilities needed for meaningful use functions and implement the initial phase of the new certification program.

Nationwide Health Information Network (NHIN)
The NHIN is a collection of standards, protocols, legal agreements, specifications, and services that enables the secure exchange of health information over the Internet. The NHIN is a key component of the nationwide HIT strategy and will provide a common platform for health information exchange across diverse entities, within communities and across the country, helping to achieve the goals of the HITECH Act. The NHIN is a critical part of meeting ONC's mission and achieving established priorities. It will enable health information to follow the consumer, be available for clinical decision making, and support appropriate use of health care information beyond direct patient care so as to improve public health. This level of broad health information exchange is necessary to achieve established health outcome goals.

The NHIN is evolving to meet the emerging needs of those wishing to exchange health information securely over the Internet. The desired outcome is to promote a more effective marketplace, greater competition, and increased choice through accessibility to accurate information on health care costs, quality, and outcomes.

The HIT Policy Committee formed a workgroup to offer recommendations on creating a policy and technical framework that allows the Internet to be used for the secure and standards-based exchange of health information, in a way that is open to all and fosters innovation. ONC will consider the recommendations of the HIT Policy Committee as it moves forward. ONC is working to establish an incremental approach for the NHIN that will generate immediate value (e.g., enable providers to achieve meaningful use) while creating the components that will be needed for more advanced information exchange (e.g., broadcast query).

One important part of ONC's NHIN strategy is to provide a reference implementation of the NHIN for entities to use to exchange information with each other. A reference implementation is a working software application that meets all the specification criteria for exchanging health information. It is both a quality check of the standards and implementation specifications and a template that federal and private partners can use to develop their own software. The CONNECT project supports such a reference implementation. CONNECT is a Federal Health Architecture (see discussion below) initiative to develop a federal software solution to link federal systems to the NHIN. CONNECT was built in open source and has now been made available to the health care industry at large. The CONNECT initiative takes the NHIN specifications and creates a production-ready open-source software solution that can be adopted by both federal and private entities. CONNECT provides a full software instantiation of the NHIN specifications and services. ONC will continue to support the CONNECT efforts with this funding.

HITECH Subtitle A, Part 1 §3001(c)(8) specifies that ONC has the responsibility to establish a governance mechanism for the NHIN. To discharge this responsibility, ONC will publish a notice of proposed rulemaking in 2010 after gathering input from a wide array of sources. Establishing a governance mechanism is critical to the success of the NHIN and of achieving ONC's mission and the goals of HITECH.

Federal Health Architecture (FHA)

The Federal Health Architecture (FHA) is a partnership among Federal agencies, ONC, and the Office of Management Budget (OMB). The Department of Health and Human Services (HHS), through ONC, is the Managing Partner. The DoD and the VA serve as Lead Partners. The Lead Partners provide program funding annually. In addition, more than 20 agencies, all with health-related responsibilities, contribute time and expertise to participate in specific FHA activities. Through this group, a collaborative Federal voice informs the development of the NHIN from the government's perspective and provides a venue for implementing and deploying a Federal version of the architecture that will allow data exchange with all entities across the Nation.

HHS Agencies:	**Non HHS Agencies:**
	Department of Agriculture
Administration for Children and Families	Department of Defense
Administration on Aging	Department of Energy
Agency for Healthcare Research and Quality	Department of Homeland Security
Centers for Disease Control and Prevention	Department of Justice
Centers for Medicare & Medicaid Services	Department of Labor
Food and Drug Administration	Department of State
Federal Occupation Health	Department of Transportation
Health Resources & Services Administration	Department of Veterans Affairs
Indian Health Service	Environmental Protection Agency
National Institutes of Health	National Aeronautics and Space Administration
Substance Abuse and Mental Health Administration	Office of Personnel Management
	Social Security Administration

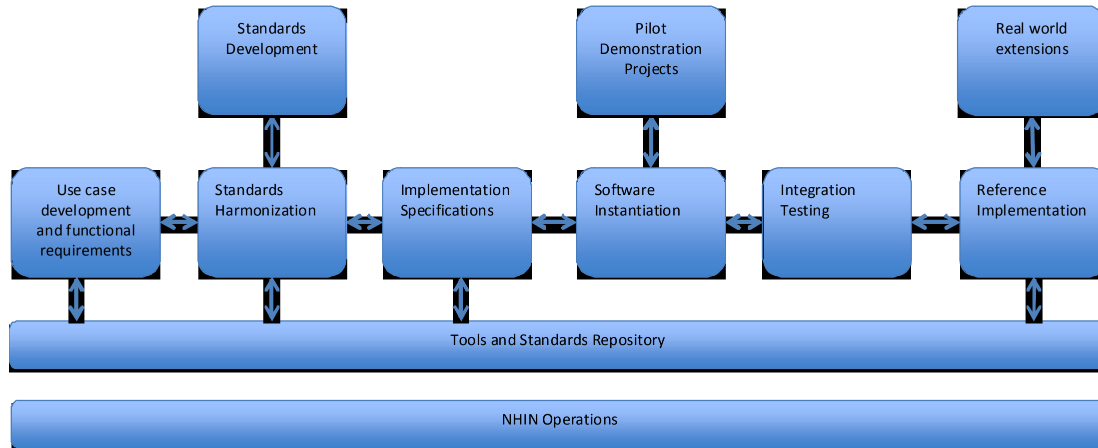
Recovery Act Activities

ONC is working closely with the National Institute for Standards and Technology (NIST), to develop an effective set of standards testing, conformance testing and interoperability testing components for EHRs with funding under the Recovery Act. The resulting HIT standards testing and evaluation infrastructure will support effective industry consensus standards development processes and will provide the U.S. HIT industry and federal activities with robust conformance and interoperability testing capabilities. Deployment of these technologies will promote interoperable HIT adoption.

To continue the work begun in 2009 with Recovery Act funds, ONC is working with NIST to provide the testing and certification processes as required by HITECH Subtitle A, Part 1 §3001(c)(5). These activities will continue collaboration toward incorporating more stringent requirements in standards that will meet meaningful use goals in 2012 and future years.

Recovery Act funds will also support the development of the standards, tools, policies, governance, interoperability framework, and technical infrastructure to support the NHIN and create standards-based interoperability for health information. The interoperability framework will develop standards and software to support data exchange.

The diagram below illustrates how the standards development tasks relate to one another. Ultimately, the data standards and software developed as part of this process will support NHIN software development and data standards. Each box corresponds to an activity further described on the following pages.



Standards development activities will develop a robust process based on federal best practices.

- *Use case development and functional requirements for interoperability* – Standards and software developers require precise functional requirements and use cases to document the real-world challenges that must be addressed. Standardizing documentation of functional requirements and use cases is a critical step in streamlining the development process. Working closely with consumers, providers, government organizations and other stakeholders, ONC will identify use cases (specific operational scenarios), prioritize them through a governance process, and create explicit, unambiguous documentation of the use cases, functional requirements and technical specifications for interoperability.

- *Harmonization of standards* – The harmonization process integrates different views of health care information into a consistent view. For example, one use case may need patient demographic information (Age, Sex, Address), while another may describe similar demographic information in a different way (Date of Birth, Gender, City/State). These descriptions will need to be harmonized and produce an inclusive, consistent view of the interoperability requirements. This process will include merging related concepts, adding new concepts, and mapping concepts from one view of health care information into another view.

- *Standards Development* – Modification or extension of existing standards or the development of new standards to support use case development.

- *Tools and Standards Repository* – To accelerate the development, use, maintenance and adoption of interoperability standards across the health care industry, and to spur innovation, ONC will develop tools to facilitate the entire standards lifecycle and maximize re-use of concepts and components – from standardized use case development, to harmonization, and software developer access to standards, including tools and a repository for browsing, selecting, and implementing appropriate standards.

- *Interoperability Specifications* – ONC will contract for the full specification of priority use cases (for data, services, vocabularies and value sets), which will enable the testing and validation of these standards within the NHIN architecture. This work will develop an interoperability specification that is independent of a specific software architecture (a platform-independent model, or PIM) and also an interoperability specification that is specific to the NHIN architecture (a platform-specific model, or PSM). Federal agencies that have different software requirements can use the PIM to develop interoperable software that can exchange data with NHIN. States, companies, or NHIN partners can use the PSM to develop new applications that conform to the NHIN interoperability specification.

- *Reference Implementation* – A reference implementation is the fully 'instantiated' software solution that is analyzed to be compliant with the standards and serves as a "reference" to other software developers of what an interoperable solution looks like. Fully documented, a reference implementation defines a well-understood solution to the use case, and provides other developers an opportunity to see and interact with a working model of the technology solution. The reference implementation will be accessible as a public resource with compiled code, source code and supporting documentation. The reference implementation will be accessible to software developers through the Tools and Standards Repository activities.

- *Integration Testing* – Testing is an important part of validating that any technology solution satisfies the goals of interoperability. Integration testing evaluates how a particular system integrates with existing technology solutions. NIST will provide tools to test a particular implementation for conformance to a set of standards specification. ONC will contract for the development of an integration testing "harness" that will test how a particular component that has satisfied conformance testing requirements integrates into the reference implementation.

- *Certification* – ONC will work with NIST and other stakeholders to develop a robust certification process that includes:
  - Developing a process for certifying HIT, including PHR and EHR technology;
  - Establishing technical requirements; and
  - Maintaining the master list of all Certified EHR Technology Products. This list will be readily available for providers and purchasers of EHR technology products to meet this meaningful use requirement.

- *Real World Extensions: Interim Governance, NHIN Demonstrations and Pilots* – ONC will contract for limited, but real world demonstration pilots. These activities provide the necessary implementation feedback of problems, risks, and lessons learned to standards harmonization and specifications refinement processes. This is the final step of feedback to the standards development process, and will provide real world vetting for the standards activities.

- *NHIN Operations and Infrastructure* – To support the ongoing demonstrations and production pilots of health information exchange across a trusted network, ONC will fund:
  - Coordinating and managing the addition of new participants onto the NHIN, ensuring that technical and organizational processes are followed;

- Standing up, administering and operating the NHIN digital certificates and operational and services registries;
- Providing NHIN network support functions for the network (help desk);
- Providing basic network monitoring services;
- Sponsoring network penetration studies to ensure security of the network; and
- Providing collaboration tools to elicit and share implementation lessons learned.

Performance Measurement

To assess the effectiveness of this program, ONC is developing new performance measures with ambitious targets to gauge Federal progress toward the goal of enabling meaningful use through implementation of required standards in Federal and commercial systems.

Funding History

FY 2006	$31,880,000
FY 2007	$33,963,000
FY 2008	$26,327,000
FY 2009	$ 29,439,000
FY 2010*	$9,950,000

*FY 2010 funding supplemented with Recovery Act Funds.

Budget Request

The FY 2011 planning level budget for Interoperability is $22,770,000. It is an increase of $12,820,000 over the FY 2010 Omnibus and supports implementation of HITECH requirements.

Standards ($7.3M, +$4.7M from FY 2010)

Funds for the management of the HIT Standards Committee, a public-private FACA required in HITECH Subtitle A, Part 1 §3003 that provides advice to the National Coordinator with a focus on achieving health information interoperability. Because implementation of HIT is an incredibly complex undertaking, the FACA will solicit and consider input from both the public and private sectors. These funds will ensure compliance with all FACA requirements for this.

The development and implementation of standards in HIT are critical to enabling an interoperable, secure capability for health information exchange and for reaching the goal of meaningful use. Funding will support further development and harmonization of standards necessary to support the evolving definition of meaningful use as it changes between 2011 and 2013 to incorporate additional EHR functions. Since those changes are not currently known, the program must be anticipatory and flexible.

Federal Health Architecture is incrementally funded, which allows for discussions to occur with existing funding partners, as well as opportunity to seek out additional partners to secure future funding if required and approved. FHA is not building a health information exchange system but rather helping to architect solutions. The operations and maintenance costs for the program are less than might be expected for such a large undertaking and these costs will be absorbed by the participating agencies. FHA partners reevaluate the lifecycle costs yearly during strategy planning

to identify the next year's work plan. ONC is participating with the HHS CIO Office as the lead partner for FHA.

Nationwide Health Information Network ($11.5M, +$4.1M from FY 2010)
FY 2011 funding is requested to support ongoing activities to implement the established incremental approach for the NHIN that will generate immediate value in enabling hospitals and health care professionals to achieve meaningful use and create the components that will be needed for more advanced information exchange in the coming years.

Funding that supports ongoing NHIN governance activities will continue. As a requirement of HITECH Subtitle A, Part 1 §3001(c)(8), the NHIN governance mechanism will continue to be developed and implemented.

Funding will support the cooperative agreement activities for the Recovery Act-funded state and state-designated entities for planning, capacity building, and implementation activities is essential to ensure appropriate management and oversight of this large investment of funds. Activities will include providing for contracted subject matter expertise, oversight and costs associated with business (non-programmatic) award, management and administration of the cooperative agreements.

Mental Health and Substance Abuse ($4.0M, +$4.0M from FY 2010)
Through a collaboration among ONC, the Substance Abuse and Mental Health Services Administration (SAMHSA) and State substance abuse and mental health agencies, this funding supports the planning, development, and/or initial implementation of interoperable state agency data systems that meet federal data standards, and will assist mental health and substance abuse (MHA/SA) providers in the adoption of certified HIT, primarily EHR systems. Additionally, it supports more cost effective development and deployment of interoperable EHRs by means of software re-use (versus repeated re-invention). The overall goal is to integrate substance abuse and mental health prevention and treatment into the larger primary care delivery system HIT framework and within the larger universe of Medicaid and other safety net services. This effort will also demonstrate and deploy state-of-the-art, privacy protection technology, based upon new standards. It recognizes that there are unique confidentiality rules that apply to both mental health and substance use disorder diagnosis and treatment.

ONC FY 2011 OMB Circular A-11, Exhibit 300: Capital Asset Plan and Business Case Summaries can be found at http://it.usaspending.gov/ .

Privacy and Security

(Dollars in thousands)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$1,706	$35,100	$636	$6,850	+ $ 6,214
PHS Evaluation Funds	$0	$0	$3,000	$0	- $ 3,000
Total Program Level	$1,706	$35,100	$3,636	$6,850	+ $ 3,214

Authorizing Legislation: None
Allocation Method: Contract, Cooperative Agreement, Grant

Program Description and Accomplishments

Efforts to increase health information exchange will not reach their potential unless individuals and health care professionals are confident that personal health information will be private and secure. This includes both information in EHRs and information moving through the health care system. For this reason, ONC is taking proactive steps to assure that privacy and security are addressed in every phase of the development, implementation and adoption of policies and technical standards that will form the foundation and infrastructure for HIT and health information exchange.

ONC's strategy for bolstering public trust in electronic information systems through a comprehensive approach to privacy and security includes two major components:

1. ONC will aggressively implement and enforce, in coordination with OCR, the multiple new authorities and programs related to privacy and security under HITECH;
2. ONC will identify and take actions to address gaps and issues in current privacy and security laws and guidance.

ONC's FY 2011 budget request addresses the need to:

- Provide hospitals and health care professionals with best practices and guidance on developing, implementing and maintaining organizational privacy and security policies;
- Implement and provide guidance regarding new privacy and security regulations;
- Identify gaps in current privacy and security legislation and guidance;
- Continue a security initiative started with Recovery Act funds; and
- Gain a better understanding of issues related to medical identity theft and risk mitigation.

Privacy and Security Framework
To increase public trust in electronic health information exchange and to ensure the safe and secure encryption of health information, ONC continues to work with other HHS agencies to develop a nationwide privacy and security framework for electronic exchange of individually identifiable health information. Work to date has resulted in a Privacy and Security Framework that establishes a set of principles for privacy and security to guide policy and technical development across the Federal government, state governments, and the private sector. This document also includes a tool

box comprised of HIPAA guidance related to the principles, a draft personal health record privacy notice, and security guidance for small practices.

ONC now needs to provide more detailed guidance to hospitals and health care professionals with best practices and guidance on developing, implementing and maintaining organizational privacy and security policies. To provide more useful guidance as states and the private sector organizations begin to develop and implement plans for health information exchange, ONC will develop implementation guidance and activities to help entities put these principles into operation consistent with HITECH and meaningful use as defined for 2011. This is also a critical step to inform federal policy initiatives in other areas such as NHIN governance, and to inform technology development, including standards and products to assure policy is integrated into technology. ONC will leverage its Regional Extension Program to get these best practices and guidance on privacy and security out to hospitals and health care professionals.

Building on HITECH Regulatory Authorities

HITECH provides new regulatory authorities to HHS for privacy and security. ONC will support, in close coordination with OCR, to continue activities to develop HIPAA amendments and tools. It will also support continuing the development of guidance regarding breach notification and technical security safeguards.

Using Recovery Act funding, ONC will conduct a study regarding privacy and security for non-HIPAA covered entities, which is required under HITECH Subtitle D, Part 2 §13424(b). This study and subsequent report to Congress on privacy and security requirements for entities that are not HIPAA covered entities or business associates will be developed in conjunction with OCR and the Federal Trade Commission, and provided to Congress by February 17, 2010. ONC's FY 2011 budget request will allow ONC to continue follow-up actions to address identified gaps, overlaps and inconsistencies in privacy and security protections, with a particular focus on those entities not currently covered by existing federal law.

Cybersecurity

Using Recovery Act funds, ONC will launch a cybersecurity initiative in FY 2010. This funding will enable ONC to continue critical work to protect electronic health information. Increased adoption of HIT, combined with increased health information interconnections will create a novel information environment, with risks as well as opportunities. All of the multiple, independent entities that belong to this information "ecosystem" are governed by diverse legal and regulatory authorities, and each has its own unique mission and vision. Because the health information ecosystem has no exact analog in other sectors, the nature and the impact of information security vulnerabilities is not yet well understood; information on vulnerabilities and breaches is anecdotal. ONC views work on cybersecurity as a core, ongoing ONC requirement that will extend beyond the Recovery Act funding.

Funding of Recovery Act Activities

ONC is working closely with OCR and SAMHSA to implement required HITECH changes to the HIPAA privacy and security rules; conduct audits to ensure covered entities and business associates are complying with HIPAA and HITECH privacy and security requirements; and conduct studies

and draft regulations, guidance, and reports that HITECH requires the Department to complete by specific deadlines.

HITECH Subtitle A, Part 1 §3001(e) requires establishing a Chief Privacy Officer (CPO) position. This position will shortly be filled and with supporting resources will advise the National Coordinator on privacy, security, and data stewardship of electronic health information and coordinate with other Federal agencies (and similar privacy officers in such agencies), with State and regional efforts, and with foreign countries with regard to the privacy, security, and data stewardship of electronic individually identifiable health information. Since the CPO position and related activities will exist without time limitation, funds will support these through the FY 2011 budget request.

In addition to the activities highlighted above, ONC is conducting the following privacy and security activities focused on consumers:

- *Consumer Permissions* - ONC will identify current trends and best practices with respect to consumer permissions employed by different models of electronic health information exchange to gain consumer trust through providing consumers with choice(s) in how their health information is exchanged electronically. These models included health information organizations, PHRs, health record banks, and integrated delivery systems or networks. Recommendations will inform policy development relative to consumer permissions.

- *On-line Dispute Resolution* - In close coordination with the National Science Foundation, ONC will plan to oversee demonstrations to test and determine the utility and scalability of on-line dispute resolution facilitated by EHRs, with secure portals for patient access, in a variety of health care settings.

Funding History

FY 2006	$13,921,000
FY 2007	$8,343,000
FY 2008	$15,932,000
FY 2009	$1,706,000
FY 2010*	$3,636,000

*FY 2010 Funding supplemented with Recovery Act funds.

Budget Request

The FY 2011 request for Privacy and Security is $6,850,000. This is an increase of $3,214,000 above the FY 2010 Omnibus and supports implementation and oversight of HITECH requirements.

Privacy ($3.0M, +$0.6M from FY 2010)
Funding is included for the Chief Privacy Officer, as required by HITECH Subtitle A, Part 1 §3001(e), who will advise the National Coordinator on privacy, security, and data stewardship of electronic health information and coordinate with other Federal agencies (and similar privacy officers in such agencies), with State and regional efforts, and with foreign countries with regard to the privacy, security, and data stewardship of electronic individually identifiable health

information. The office, established during FY 2009, will continue to support initiatives important to securing health information during electronic exchange.

In 2011, one or more contracts will be funded to continue ONC's on-going work on identifying gaps in HIPAA privacy and security statutes, translate those gaps into policy options, present those options to the HIT Policy Committee and its Privacy and Security Workgroup, support the deliberations of those groups, and translate their recommendations into policy and guidance from ONC.

Beginning in 2010, ONC will convene a new Federal HIT Interagency Security Advisory Panel. The purpose of the Security Advisory Panel is to learn from the expertise of the most sophisticated federal agencies concerning approaches and options to improving the security of health information. The Advisory Panel will be chaired by the Director of Programs and Policy.

Several Privacy and Security and Policy activities begun in FY 2009 are mandated in HITECH and, although previously funded through Recovery Act dollars, must be continued annually. These activities include:

- *Guidance and tools to support HIPAA modifications:* HITECH Subtitle D, Part 2 §13421(b) allows for the amendment of HIPAA to make it consistent with the Recovery Act, which will be accomplished in FY 2010. Guidance and tools will need to be developed in conjunction with OCR in 2011 to support those changes. For example, the current draft of the Privacy and Security Framework includes a tool box with HIPAA guidance that is cross-walked to the privacy and security principles. This tool box will now need to be revised consistent with HITECH and meaningful use. The measure of success of the project will be in terms of the numbers of questions received about the areas of HIPAA added by HITECH before and after the guidance is issued.

- *Breach Notification Guidance:* HITECH Subtitle D, Part 2 §13402(h)(2) requires that annual guidance be issued specifying the technologies and methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals (as it relates to breach notification). Initial guidance was developed in conjunction with OCR and issued on April 17, 2009. After receiving and incorporating comments on the initial guidance, it will be updated on April 17, 2010.

  The April 17, 2011 guidance is anticipated to build on the guidance issued in 2010 by incorporating advancements in technology and any new policy development. This guidance will be targeted to specific aspects of meaningful use including public trust, exchange and public health that have raised the most questions by stakeholders. Again, draft updated guidance will be vetted among a diverse set of stakeholders in order to achieve the right balance of guidance.

- *Security Guidance:* HITECH Subtitle D, Part 2 §13401(c) requires that annual guidance is issued relative to technical safeguards to carry out security beginning in 2009. Such guidance was issued in conjunction with OCR in 2009 and will be again in 2010 and 2011. The additional guidance will build on the work of the previous year, incorporating advances

in technology and new policy development particularly as it relates to meaningful use and will be developed in conjunction with OCR and the Chief Technology Officer, as appropriate. Draft guidance will be vetted by a diverse set of stakeholders, including the security community, to enhance successful communication and increase the usefulness of the assistance.

- *Privacy and Security Requirements for non-HIPAA covered entities;* HITECH Subtitle D, Part 2 §13424(b) requires that a study be conducted and a report be developed and issued to Congress on privacy and security requirements for entities that are not HIPAA covered entities or business associates as of the date of enactment of the Recovery Act. This study and report will be developed in conjunction with OCR and the Federal Trade Commission, and provided to Congress by February 17, 2010.

Security ($3.9M, +$2.6M from FY 2010)
Cybersecurity activities in FY 2011 will focus on understanding and mitigating data breaches, developing an incidence response program and providing education and outreach relative to enhancing HIT/HIE security. ONC will analyze data breach information collected by OCR in 2009 to identify patterns and causes with the goal of understanding how and why breaches occur so that preventive measures can be developed. ONC will contract for the development of a database and analytical tools to implement this program. A critical gap ONC has identified is the lack of either a public or private incident response program that provides means to collect and analyze cybersecurity incidents (e.g., hacking). ONC will contract for a feasibility study and pilot implementation of a healthcare incident response program. Finally, ONC will focus on communications, education, and outreach programs that promote HIT security and cybersecurity through the dissemination of security updates.

ONC continues to provide leadership in two areas related to privacy and security in electronic health information exchange – using HIT - to minimize fraud and abuse and support cost containment efforts. FY 2011 funds will allow ONC to continue its efforts to finds ways that HIT can minimize the negative impacts in these two areas.

The Privacy and Security initiative will continue the work as required under HITECH through collaboration with other HHS entities and while coordinating across the governments – both at the Federal and State levels.

Research and Evaluation

(Dollars in thousands)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$2,518	$93,300	$3,595	$6,701	+ $ 3,106
PHS Evaluation Funds	$1,551	$0	$0	$0	$ 0
Total Program Level	$4,069	$93,300	$3,595	$6,701	+ $ 3,106

Authorizing Legislation: None
Allocation Method: Contract, Grant, Cooperative Agreement

Program Description and Accomplishments

ONC's Research and Evaluation activities include measuring the success of programs funded under the Recovery Act, supporting innovation in HIT, and other ongoing ONC efforts to further adoption and meaningful use of HIT. Important efforts to support HIT research and innovation will also be continued in FY 2011 using Recovery Act funds, as will ONC's evaluations of all of its major initiatives. The specific HITECH programs to address these goals are described below.

The following funded activities will play a critical role in bringing information to bear on management decisions as HITECH programs are implemented:

- Support for the ONC innovation research agenda and continue innovation tracking;
- Development of ONC's capacity for analysis, modeling and internal research on the value of HIT; and
- Continuation and augmentation of our evaluation and adoption monitoring activities.

Evaluation, Monitoring and Analysis
ONC recognizes that effectively measuring progress and evaluating success is critical to implementing and managing ONC's program and meeting set goals. This includes both measuring the progress of individual programs and studying the collective impact of these efforts toward achieving ONC's mission. Independent evaluations of ONC's major initiatives will be conducted to ensure the effective and efficient use of Recovery Act dollars to accomplish the goal of widespread adoption and use of HIT. In addition, ONC has and will continue to support surveys and studies that elucidate progress towards the adoption and meaningful use of EHRS. These programs are intended to outlast Recovery Act funds, so ONC has built them into the ongoing annual budget request.

Finally, to support policy development, program design, and the analysis of evaluation data, it is important that ONC have internal modeling and analysis resources. Economic and behavioral models will be used to describe and understand the factors driving the adoption, meaningful use, interoperability of EHRs, and information exchange. They will also help to better inform the value delivered by ONC programs and communicate that information to key audiences.

Funding of work mandated by or related to Recovery Act Activities

Evaluation, Studies, Performance Monitoring, and Strategic Plan
Independent evaluations will be conducted to assess the effective use of the $2 billion of Recovery Act funds appropriated to ONC for discretionary programs under the HITECH Act to promote widespread adoption and use of HIT in the following five categories:

- An overall, summative evaluation ("Global Evaluation") to determine the combined success of the Recovery Act programs and activities in achieving HITECH goals, and illuminate the contribution of each component program;
- Individual evaluations of four specific programs funded by Recovery Act ("component evaluations") that will measure the effectiveness of each individual program in meeting stated goals;
- Reports and studies that are required under Title XIII of the HITECH Act; and
- Revision of the Federal Health IT Strategic Plan and development of relevant metrics and tools necessary to track overall performance toward the HITECH goals.

Recovery Act funding will also establish a performance management dashboard to assist ONC in monitoring HITECH programs and grantees, in assessing overall progress towards the goals outlined in the HITECH Act.

Research, Development and Innovation
The overall goal of these HITECH activities is to support research and development of HIT innovations that will accelerate the transformational improvement of U.S. health care to a high-performance, 21st-century system that supports the health of individuals and of the population as a whole.

- *Strategic Health IT Advanced Research Projects (SHARP)* – This activity will fund research projects focused on areas where breakthrough improvements can greatly enhance the transformational effects of HIT and address well-documented problems that have impeded adoption and the pathway to meaningful use. The four focus areas for the SHARP awardees will be: security of HIT; patient-centered cognitive support; health care application and network platform architectures; and secondary use of EHR data.

- *Support for HIT Innovation* – Without adequate innovation research and investment, a nation risks failing to keep up with the most effective techniques to leverage health care information to improve safety, quality, and outcomes of health care while providing a more efficient health care system through reduced clinical and administrative costs. Specifically, this initiative seeks to identify HIT innovations which have value within health care, but for which there is currently not an available market.

Performance Measurement

Since 2008, ONC has collected data on physician adoption rate of EHRs and started collecting data on non-federal hospital adoption of EHRs in 2009. Further refinement of adoption measures, for both hospitals and providers, is ongoing and should be completed this spring. Such measures will monitor the progress of EHR adoption.

The success of programs designed to increase adoption will collectively move the Nation closer to a transformed health system that makes health information available and actionable for individuals and health care professionals.

Funding History

FY 2006	$2,000,000
FY 2007	$1,000,000
FY 2008	$3,675,000
FY 2009	$4,069,000
FY 2010*	$3,595,000

*FY 2010 Funding supplemented with Recovery Act funds.

Budget Request

The FY 2011 request for Research and Evaluation is $6,701,000; an increase of $3,106,000 above the FY 2010 Omnibus level. This funding level supports implementation, continuation and oversight of HITECH activities.

Adoption Surveys ($3.2M, +$1.7M from FY 2010)
ONC contracts two national surveys – one of physicians' offices and the other of hospitals – to assess the current state of HIT adoption and investigate approaches that might accelerate HIT adoption in a cost-effective manner. Through a Memorandum of Understanding, the CDC will continue surveying physicians to measure the adoption rate of EHRs in physician offices and will increase the survey sample size more than 10,300 physicians – a more than five-fold increase. Funds will also support continuation of contracted analyses of hospital adoption rates through established surveys. In addition, funding will be allocated for a national-level tracking survey and for studies of the barriers to and costs and benefits of the adoption and meaningful use of HIT.

Evaluation and Reports ($3.5M, +$1.4M from FY 2010)
Understanding and reporting the progress and improvements in the HIT programs are requirements of HITECH and continued support will assure ongoing evaluation and dissemination of information about key program components. ONC will produce reports, data, and analyses that facilitate progress towards meaningful use, information exchange, and the use of HIT to transform the delivery system through a better understanding of key elements necessary to achieve those goals. These initiatives will also help ONC monitor progress toward achieving the objectives of the revised HIT strategic plan and provide audiences, including the Congress and ONC's stakeholders, with updates on ONC programs.

Operations

(Dollars in thousands)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$21,914	$19,100	$31,828	$37,574	+ $ 5,746
PHS Evaluation Funds	$244	$0	$6,000	$0	- $ 6,000
Total Program Level	$22,158	$19,100	$37,828	$37,574	- $ 254
FTE	31	0	75	120	+ 45

Authorizing Legislation: None
Allocation Method: Contract

Program Description and Accomplishments

ONC operates as a Staff Division within the Office of the Secretary and provides continuing leadership for the development and nationwide implementation of interoperable HIT to improve the quality and efficiency of health care. The Recovery Act initiated significant new ONC programs and activities in order to enable health care providers to adopt and meaningfully use HIT.

To effectively meet the requirements of HITECH, and to provide the structure needed for developing and overseeing programs and regulations to successfully accomplish the mandates of the Recovery Act and the goals of the Administration, ONC is increasing Federal staffing levels in FY 2010. Term and permanent positions will be established to provide sound, Federal oversight to new programs and responsibilities, including grants oversight. Term positions will be established for up to four years to develop and oversee programs, such as the new grants programs, that are for a limited time. Permanent staff will be recruited for new responsibilities that are long-term in nature. ONC will also use other hiring mechanisms approved under the Recovery Act including Schedule A and details, as provided in HITECH Subtitle A, Part 1 §3001(d); and Intergovernmental Personnel Act Mobility Program (IPA) appointments. The use of Federal staff rather than contract staff will allow some cost savings that can be utilized to ensure appropriate oversight.

Operations funding includes direct support for new HITECH grant programs and coordination activities including personnel compensation, facilities and systems support, travel, and associated program support costs. The increased need for space and related infrastructure (such as furniture, computers, equipment and supplies) will accommodate new staff while moving contractor support off-site. Memoranda of Understanding, Inter-Agency Agreements and contracts will be completed in support of ONC administrative, financial, logistical and planning activities.

ONC is launching a comprehensive communications initiative in FY 2010 that will support all components of adoption and meaningful use through the timely dissemination of information through a wide array of tools including, but not limited to, blogs, e-mail alerts, and postings to websites. ONC is collaborating with CMS, OCR and other partners to implement the communications and outreach activities needed to promote acceptance of the broader goals and to

support the specific programs and policies of HITECH. These communication activities are essential components of a powerful change management strategy. ONC will focus on informing patients, providers, and caregivers about the benefits of EHRs and providers as well as increasing their knowledge of protections for privacy and security of personal health information. These activities are very closely coordinated with CMS provider communications focusing on the incentives program for meaningful use. They will be jointly led by ONC and OCR. OCR's involvement relates to its mandate to educate the public on uses of and safeguards for protected health information, and overseen by the interagency HITECH Communications Workgroup - chaired by ONC.

Funding History

FY 2006	$10,299,000
FY 2007	$13,771,000
FY 2008	$13,307,000
FY 2009	$22,158,000
FY 2010*	$37,828,000

*FY 2010 Funding for Communications and Outreach is supplemented with Recovery Act funds.

Budget Request

The FY 2011 budget for Operations is $37,574,000 to fund increased service levels. This request is a decrease of $254,000 from the FY 2010 Omnibus level. Continued funding at this level will provide necessary federal stewardship to support the $2 billion Recovery Act investment in HIT.

Operating Expenses ($32.4M, -$4.1M from FY 2010)
The role and nature of ONC has changed significantly since the passage of HITECH – from a policy-oriented staff division to an operational entity charged with implementation and oversight of $2 billion in grants and procurements. While the Recovery Act provided program funding for non-federal entities, it did not provide funding for administration of these important grant programs. The ONC budget requests resources to provide appropriate grants administration and oversight. To operate these new programs, ONC needs to expand and redirect the workforce from a policy focus to program operations and oversight. The budget reflects increased costs for staffing, rent and operating costs associated with ONC's significantly increased responsibilities to support HIT implementation. ONC anticipates some cost savings through the planned increases in federal staff, which are estimated to be a lower cost than contractor support. This funding will allow ONC to support and manage its programs toward achievement of the national HIT agenda, while improving office operations to allow ONC to prudently oversee and coordinate ongoing programs and Recovery Act activities.

Communications and Outreach ($5.2M, +$3.9M from FY 2010)
Funding is required to maintain the multi-faceted communication and outreach program to health care stakeholders, including consumers. This effort is essential to build knowledge of the benefits of the meaningful use of HIT, the protections that will accompany such use, and specific opportunities for advancing HIT implementation through Recovery Act programs. The planned work is closely coordinated with CMS, OCR and FTC, as appropriate, and will be performed under a competitive contract. It will include the requirements of Subpart D, Part 1§12403(a): that a multi-

faceted national education campaign be initiated and maintained to educate individuals about the potential uses of their protected health information, the effects of such uses, and the rights of individuals with respect to such uses. The program is to incorporate a variety of languages and present information in a clear and understandable manner. To achieve the communication goals a sustained approach is essential.

Public Health Service Act Evaluation Funds

ONC's program level budget includes $0 of Public Health Service (PHS) Act Evaluation Funds. It is a decrease of $19,011,000 from the FY 2010 Omnibus level.

Supplementary Tables

Office of the National Coordinator for Health Information Technology

Budget Authority by Object

	2010 Estimate	2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1).........	8,234,030	12,951,210	4,717,180
Other than full-time permanent (11.3).........	-	-	-
Other personnel compensation (11.5).........	-	-	-
Military personnel (11.7).........	230,000	250,000	20,000
Special personnel services payments (11.8).........			
Subtotal personnel compenstion.........	**8,464,030**	**13,201,210**	**4,737,180**
Civilian benefits (12.1).........	1,976,167	3,108,290	1,132,123
Military benefits (12.2).........	115,000	125,000	10,000
Benefits to former personnel (13.0).........			
Total Pay Costs.........	**10,555,197**	**16,434,500**	**5,879,303**
Travel and transportation of persons (21.0).........	1,084,500	712,000	(372,500)
Transportation of things (22.0).........	15,000	15,000	-
Rental payments to GSA (23.1).........	5,600,000	6,000,000	400,000
Communication, utilities, and misc. charges (23.3).........	1,000,000	800,000	(200,000)
Printing and reproduction (24.0).........	300,000	200,000	(100,000)
Other Contractual Services:			
Advisory and assistance services (25.1).........	7,804,803	3,537,000	(4,267,803)
Other services (25.2).........	7,476,500	39,380,500	31,904,000
Purchase of goods and services from			-
government accounts (25.3).........	6,795,000	9,585,000	2,790,000
Operation and maintenance of facilities (25.4).........	1,500,000	1,545,000	45,000
Research and Development Contracts (25.5).........			-
Medical care (25.6).........			-
Operation and maintenance of equipment (25.7).........	-		-
Subsistence and support of persons (25.8).........			
Subtotal Other Contractual Services.........	**23,576,303**	**54,047,500**	**30,471,197**
Supplies and materials (26.0).........	50,000	50,000	-
Equipment (31.0).........	150,000	75,000	(75,000)
Land and Structures (32.0).........			
Investments and Loans (33.0).........			
Grants, subsidies, and contributions (41.0).........			
Interest and dividends (43.0).........			
Refunds (44.0).........			
Total Non-Pay Costs.........	**31,775,803**	**61,899,500**	**30,123,697**
Total Budget Authority by Object Class.........	**42,331,000**	**78,334,000**	**36,003,000**

Office of the National Coordinator for Health Information Technology

Salaries and Expenses

	2010 Estimate	2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)..	8,234,030	12,951,210	4,717,180
Other than full-time permanent (11.3)........................			
Other personnel compensation (11.5)........................			
Military personnel (11.7)..	230,000	250,000	20,000
Special personnel services payments (11.8).............			
Subtotal personnel compenstion........................	**8,464,030**	**13,201,210**	**4,737,180**
Civilian benefits (12.1)...	1,976,167	3,108,290	1,132,123
Military benefits (12.2)..	115,000	125,000	10,000
Benefits to former personnel (13.0).............................			
Total Pay Costs..	**10,555,197**	**16,434,500**	**5,879,303**
Travel and transportation of persons (21.0)..................	1,084,500	712,000	(372,500)
Transportation of things (22.0)......................................	15,000	15,000	-
Rental payments to Others GSA (23.2)........................			
Communication, utilities, and misc. charges (23.3).......	1,000,000	800,000	(200,000)
Printing and reproduction (24.0)..................................	300,000	200,000	(100,000)
Other Contractual Services:			
Advisory and assistance services (25.1)....................	7,804,803	3,537,000	(4,267,803)
Other services (25.2)..	7,476,500	39,380,500	31,904,000
Purchase of goods and services from government accounts (25.3)...................................	6,795,000	9,585,000	2,790,000
Operation and maintenance of facilities (25.4)...........	1,500,000	1,545,000	45,000
Research and Development Contracts (25.5)............			
Medical care (25.6)...			
Operation and maintenance of equipment (25.7).......			
Subsistence and support of persons (25.8)................			
Subtotal Other Contractual Services..................	**23,576,303**	**54,047,500**	**30,471,197**
Supplies and materials (26.0)......................................	50,000	50,000	-
Total Non-Pay Costs...	**26,025,803**	**55,824,500**	**29,798,697**
Total Salary and Expense...	**36,581,000**	**72,259,000**	**35,678,000**
Direct FTE...	75	120	45

Office of the National Coordinator for Health Information Technology

Detail of Full Time Equivalents (FTE)

	2009 Actual Civilian	2009 Actual Military	2009 Actual Total	2010 Est. Civilian	2010 Est. Military	2010 Est. Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total
Health Information Technology.									
ONC FTE Total........................	30	1	31	73	2	75	118	2	120

Increase of 45 FTE in 2010 due to addition of permanent and term staff to support Recovery Act activities........

Average GS Grade

FY 2006...................................	12.9
FY 2007...................................	12.8
FY 2008...................................	13.2
FY 2009...................................	13.2
FY 2010...................................	13.3
FY 2011...................................	13.6

Office of the National Coordinator for Health Information Technology

Detail of Positions

	2009 Actual	2010 Estimate	2011 Estimate
SES...	$1,062,318	$1,355,571	$1,687,757
Total - ES Salary	$1,062,318	$1,355,571	$1,687,757
GS-15..	$1,874,414	$3,101,794	$4,604,163
GS-14..	$965,371	$1,944,750	$3,314,323
GS-13..	$284,090	$889,960	$1,577,418
GS-12..	$65,447	$379,806	$295,742
GS-11..		$124,087	$1,222,452
GS-10..			
GS-9..	$80,982	$668,062	$499,355
GS-8..			
GS-7..			
GS-6..			
GS-5..			
GS-4..			
GS-3..			
GS-2..			
GS-1..			
Total - GS Salary	$3,270,304	$7,108,459	$11,513,453
Average ES level			
Average ES salary..........................	$199,328	$169,446	$187,529
Average GS grade..........................	13.2	13.3	13.6
Average GS salary..........................	$126,307	$94,981	$101,860
Average CO salary	$100,000	$112,000	$112,000

SPECIAL REQUIREMENTS

FY 2011 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

$21,675 of the FY 2011 ONC budget will be used to support HHS-wide enterprise information technology and ongoing government-wide e-government initiatives through a contribution to a joint funding agreement managed within the Assistant Secretary for Administration (ASA) Office of the Chief Information Officer (OCIO). The ONC contribution will help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Federal Health Architecture Program

The Federal Health Architecture (FHA) is an ongoing initiative that is a partnership among all Federal entities with a health care practice. HHS is the Managing Partner, together with the Department of Defense (DOD) and the Department of Veterans Affairs (VA) serving as Lead Partners. FHA provides Federal expertise and experience as a coordinated voice, reviewing standards recommendations produced through the standards process, and then works with and across agencies toward implementation of these standards. These activities include coordination of Federal participation in health care-related standards development organization activities, communication, and collaboration on national health information technology (HIT) standards. The Federal Government also requires all Federal health care delivery systems that support direct patient care to implement recognized standards in new and upgraded health-related technology systems for exchanging information with external systems.

FHA was initiated in July 2003 and is governed by principles that focus on achieving the vision of interoperable health information in support of the agency business priorities, Federal mandates and the national HIT agenda to enable better care, increase efficiency and improve population health. FHA's priorities are driven by federal agency value propositions related to identifying needs for secure, interoperable health information exchanges, architecting solutions, planning HIT investments, developing and implementing solutions, and measuring progress. These activities support the requirements of the HITECH Act as discussed in Sec. 3011 (a) (1to develop health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner . FHA demonstrates the value of each task or activity and ensures that every undertaking is stakeholder-driven. This ensures alignment of FHA objectives, deliverables and timeframes to agency priorities and mandates.

In FY 2009, FHA carried out the operational activities to realize its 2007 strategy and goals of five initiatives and further refined initiative goals to support federal agency priorities.

1) CONNECT is a software solution that organizations can use to securely link their existing HIT systems into the NHIN. More than 20 federal agencies collaborated to build CONNECT through the FHA. The CONNECT solution enables secure and interoperable electronic health information exchanges with other NHIN-participating organizations, including federal agencies, state, tribal and local-level health organizations, and healthcare participants in the private sector. CONNECT was jointly developed with the Lead Partners and used during NHIN demonstration projects in September and December, 2008 by DoD, VA, Social Security Administration (SSA), Centers for Disease Control (CDC), Indian Health Service (his) and the National Cancer Institute (NCI). The health information exchange solution (CONNECT) was advanced into limited production by SSA and a private sector health information exchange organization in Virginia in February, 2009, and released as publicly available, open-source software April, 2009.

2) Federal Adoption of Standards for Health Information Technology (FAST) evolved into the Federal Health Information Technology Standards Organization Participation (FHITSOP) to provide a working environment from where the one voice to represent the federal perspective to Standards Development Organizations (SDO) could be developed.

3) Federal Health Information Technology Planning and Reporting (FHIPR) created an investment guide and reporting capabilities together with support in work groups that assured successful investments and outcome measurements for participating agencies. The guide and reporting capabilities reached the goal of providing support and guidance for health information exchange-specific investments to agencies for the purposes of planning investments and reporting outcomes.

4) Federal Health Interoperability Sharing Environment (FHISE) is a knowledge base and tool set that provides information to help guide program managers and enterprise architects in identifying, creating, and/or implementing products that have been created and made available by others while carrying out the national HIT agenda. The knowledgebase and end user tools were released at the end of July, 2009 and updated in September, 2009. In the fall of 2009, FHIPR and FHISE work groups merged and provided guidance to OMB on the creation of harmonized segments for the health domain. Our work efforts resulted in six health segments that agencies will align with investments in the upcoming fiscal year. Additional work commenced on the creation of a citizen centric information driven framework to address federal, state, local and private business challenges.

5) Federal Security Strategy (FSS) has produced a document that helps federal agencies, state, local, and tribal governments as well as private entities, identify the Federal Information Security Management (FISMA) and Health Insurance Portability and Accountability Act (HIPAA) implementation considerations for nationwide health information sharing. Additional project planning is underway to support federal agencies in working together to achieve a policy that supports their security missions as they relate to health information exchanges.

These initiatives provide for information dissemination and support and guidance across federal agencies. Each of the initiatives is designed to support the President's health information technology initiative.

Schedule risk is managed throughout the entire lifecycle of each initiative for the program. FHA has a risk mitigation plan that is available upon request. In addition, FHA has developed an operational plan that outlines the following years' deliverables as well as a strategic plan for adjusting the direction of the program as a whole when needed. The identified tasks have been prioritized by the FHA Leadership Council. As part of the operational planning efforts, project charters, project plans, and project cost estimates are developed for tracking purposes. Changes in scope undergo an impact analysis including cost and appropriateness by the Leadership Council prior to moving forward.

FHA is incrementally funded, which allows for discussions to occur with existing funding partners, as well as the opportunity to seek out additional partners to secure future funding if required and approved. FHA is not building a health information exchange system but rather helping to architect solutions. The operations and maintenance costs for the program are less than might be expected for such a large undertaking and these costs will be absorbed by the participating agencies. FHA

partners reevaluate the lifecycle costs yearly during strategy planning to identify the next year's work plan.

Federal Health Architecture Program Funding

	2009 Actual	2010 Estimate	2011 Estimate
Department of Health & Human Services.	3.662	3.538	3.538
Department of Veterans Affairs................	1.936	2.013	2.094
Department of Defense............................	1.936	2.013	2.094
Total...	**7.534**	**7.564**	**7.726**

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HHS SERVICE AND SUPPLY FUND

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 + / - FY 2010
BA	$858,937,000	$0	$1,027,332,000	$1,064,817,000	$37,485,000
FTE	1,335	0	1,394	1454	+60

Authorizing Legislation: 42 U.S.C. 231
2011 Authorization……………………………………………………………..……Indefinite
Allocation Method ……………………………………………………………Contract, Other

Statement of the Budget

The FY 2011 budget for the Service and Supply Fund (SSF) is $1,064,817,000, an increase of $37,485,000 from the FY 2010 SSF Board-approved level of $1,027,332,000 (both fiscal year budgets approved August 6, 2009). The overall increase in the budget from FY 2010 to FY 2011 is primarily a reflection of increases in revenue from non-HHS customers. The FY 2011 and FY 2010 SSF budgets were approved by the SSF Board on August 6, 2009.

The Program Support Center's (PSC) budget request for FY 2011 is $1,008,564,000, which is an increase of $51,130,000 above the FY 2010 budget request of $957,434,000. This budget includes modest increases to accommodate the demand for additional services from outside HHS customers as well as increases in contract costs and Transhare benefits.

The total FY 2011 request for the Non-PSC SSF activities is $56,253,000, which is a decrease of $13,645,000 from the FY 2010 level of $69,898,000. Overall, the approved revenue for longstanding Non-PSC SSF activities has remained level, with increases for contracts and FTE costs. The SSF Board approved an increase to the budget for the Web Communications Division (approximately $581,000) to enable the activity to respond to the Administration's directive to both expand the amount of information available on-line and make it more user-friendly. However, this increase in FY 2011 follows a significant increase (approximately $3,921,000) in the budget from FY 2009 to FY 2010 for web activity in response to the same set of Administration priorities. The Board also approved a $2,955,000 increase to the budget for the Homeland Security Presidential Directive -12 (HSPD-12) to support the use of Personal Identification Verification (PIV) cards for information technology (IT) access and single sign-on functionality. What appears to be a proportionately large decrease in the FY 2011 budget request is largely due to the inclusion of the value of interagency agreements that fund the salaries and benefits of Commissioned Corps Officers detailed to non-HHS entities, which was included in the FY 2010 budget. Since these interagency agreements are not considered in the total FY 2011 budget request, the Non-PSC activity budget decreases by $3,934,000 in FY 2011.

Due in part to the SSF Board's request for additional IT expertise as well as an escalating workload, the Board approved a reorganization of the Fund Manager's office for FY 2010. This reorganization created a new branch within the Office of the Budget with three additional full time equivalent (FTE) personnel to include the IT functionality.

Use of SSF Retained Equity

The SSF Board of Directors approved the use of the Fund's retained equity (also referred to as the "SSF Reserves") in FY 2010 for IT and homeland security related investments in HHS' IT infrastructure and systems. A total of $29,459,000 was approved for use in FY 2010 to fund these activities. Of this total, $20,082,000 was approved for use in FY 2010 to fund a major transition to a new contract for IT hardware, software, and email managed by the Information Technology Infrastructure and Operations (ITIO) office within the PSC. Additional information on this ITIO transition process is described in the narrative for the Information and Systems and Management Service of the PSC (ISMS), found later in this document.

The successful re-compete of the IT contract also cleared the way for the resumption of some other IT investments for which SSF Reserves funding was previously approved by the SSF Board. At the end of FY 2009, a total balance of $3,412,000 for ITIO Network, Security, and Server projects that was not obligated in that fiscal year was reinstated to fund the continuation of these Board approved activities in FY 2010. The $5,490,000 balance of the $29,459,000 total approved for FY 2010 is designated for the implementation of the HSPD-12. For FY 2010, HSPD-12 will pursue a streamlined "single sign-on" process tied to the logical access to HHS systems and applications. Additional information on this activity is found later in this narrative.

Program Description – Service and Supply Fund Overview and Activity Narratives

This section describes the activities funded through the HHS Service and Supply Fund (SSF), which is a revolving fund authorized under 42 U.S.C. 231. The SSF provides consolidated financing and accounting for business-type operations which involve the provision of common services to customers. The SSF is governed by a Board of Directors, consisting of representatives from each of HHS' ten OPDIVs and the OS. A representative from the Office of Inspector General (OIG) serves as a non-voting member of the SSF Board.

The SSF does not have its own appropriation but is funded entirely through charges to its customers (HHS OPDIVs and Staff Division (STAFFDIV)), plus other Federal departments and agencies) for their usage of goods and services. The SSF is comprised of two categories of activities: 1) the PSC; and 2) those activities which are performed throughout the rest of HHS (Non-PSC). Each activity financed through the SSF is billed to the Fund's customers, based on either fee-for-service billing based upon actual usage of service or an allocated methodology. Each of these activities is described below.

Program Support Center Activities

The Program Support Center's (PSC) budget request for FY 2011 is $1,008,564,000, which is an increase of $51,130,000 above the FY 2010 budget request of $957,434,000.

Administrative Operations Service (AOS)

Administrative Operations Service (AOS) provides a wide range of administrative and technical services to customers within HHS and to other Federal agencies. The mission of AOS is to provide high-quality administrative support services at competitive prices by capitalizing on its expertise and leveraging economies of scale.

Major service areas include:

- *Property Management Services*, comprised of facilities management, space leasing, disposition of surplus Federal property, logistics services including receiving, asset management, warehouse storage, distribution, labor services and OS Executive Motor Pool transportation;
- *Security and Emergency Services*, comprised of personnel and physical security services, and HSPD-12 services;
- *Technical Support Services*, comprised of visual communications, print procurement and publications, HHS Forms Management, the Southwest Complex Copier Program; mail and messenger services, and Parklawn Conference Center;
- *Equal Employment Opportunity (EEO) Services* which performs EEO counseling, prepares Letters of Acceptance, investigates EEO complaints and prepares Final Agency Decisions for PSC and SAMHSA;
- *Payroll Services*, which manages all aspects of payroll customer services liaison between HHS' payroll service provider, the Defense Finance and Accounting Service (DFAS), and HHS on all pay-related issues, including HHS pay policy, employee pay records, and supporting systems, and monitoring DFAS performance against the Service Level Agreement;
- *Commissioned Corps Support Services*, comprised of Commissioned Corps Payroll, which administers over $1 billion annually in a system of basic pay, allowances and special or incentive pay for active duty Commissioned Corps Officers and annuitants of the Public Health Service (PHS). The Commissioned Corp Support Services is also comprised of Commissioned Corps Systems Branch, which maintains and operates the systems housing current and historical pay and leave records for Commissioned Corp Officers as well as the Medical Affairs Branch, which provides administrative management and direction concerning medical issues, and;
- *Other Administrative and Corporate Support*, comprised of HHS Regional Administrative Support, child subsidy benefits, and three Cooperative Administrative Support Units.

In FY 2009, AOS had a $48,000,000 business growth within the Cooperative Administrative Support Units (CASU) and is expecting a $55,000,000 growth in FY 2010.

The FY 2011 budget for Administrative Operations Service is $385,776,000, which is an

increase of $52,936,000 above the FY 2010 budget request of $332,841,000. This increase is attributable to a $55,433,000 increase in external business within three CASUs and an overall reduction of $2,497,000 in contracts.

Financial Management Service (FMS)
The Financial Management Service (FMS) serves as a major part of the foundation of HHS' finance and accounting operations through the provision of grant payment management services; accounting and fiscal services; debt management services; and rate review, negotiation, and approvals for departmental and other Federal grant and program activities to HHS and other Federal agencies. FMS also offers fiscal advice, as well as technical and policy guidance to assist in implementing new initiatives and assure compliance with regulatory requirements. FMS has achieved significant improvements in the strength of the SSF Balance Sheet. Efficiency has improved according to several measures, inventories are down while revenues are up, asset usage is down, and the total liabilities of the SSF have decreased significantly during the year. In FY 2009, FMS received two "clean" audit opinions from independent audit firms. FMS also processed more than $33 billion in Recovery Act payments.

The FY 2011 budget for Financial Management Service is $66,406,000, which is an increase of $1,284,000 above the FY 2010 budget request of $65,122,000. This $1,284,000 increase is attributable to inflationary increases in rent, utilities, labor costs, contracts and intergovernmental support.

Federal Occupational Health Service (FOH)
The Federal Occupational Health Service (FOH) provides comprehensive, high-quality, customer-focused occupational health services in strategic partnership with Federal agencies nation-wide to improve the health, safety, and productivity of the Federal workforce. Services include health and wellness programs, work/life services, and environmental health and safety services. FOH programs provide strategic prevention and early intervention services to employees and Federal agency employers, such as:

- Health screenings for cholesterol, diabetes, blood pressure, and cancer to identify diseases in their early stages when they can be treated or cured, preventing costly complications and treatment.
- Smoking cessation programs aimed at reducing tobacco use, preventing lung cancer, heart disease and stroke and reducing other health care costs.
- Influenza immunization programs to reduce the incidence of infections among employees which in turn reduces job absenteeism, decreases health care costs and improves productivity.

FOH currently provides services to 45 Federal agencies and serves over 1.5 million Federal employees. Approximately 94% of FOH's services are provided to Federal agencies outside of HHS. FOH certified 500 Federal Bureau of Investigation (FBI) biological safety cabinets at 460 FBI locations in 50 states, Puerto Rico, Virgin Islands, Guam and Saipan. In FY 2009, FOH medically cleared more than 14,000 law enforcement personnel for respirator training in two days following the H1N1 outbreak and developed H1N1 Pandemic Worker Protection Programs for multiple agencies.

The FY 2011 budget for Federal Occupational Health Service is $149,495,000, which is an increase of $4,346,000 above the FY 2010 budget request of $145,149,000. This increase is due to inflationary increases in rent and utilities, labor costs, contracts and intergovernmental support.

Information Systems Management Service (ISMS)
The Information Systems Management Service (ISMS), formerly named Enterprise Support Services, provides high-quality information technology services, including project management, application development, operations and maintenance, and infrastructure support services. ISMS is also responsible for records management where appropriate and for responding to requests for access to information from the public. ISMS assumed responsibilities related to enterprise support services, business technology optimization and information technology (IT) formerly performed by the Administrative Operations Service. ISMS also assumed responsibilities related to the HHS Consolidated Acquisition System (HCAS) as well as operations and maintenance responsibilities for the Unified Financial Management System (UFMS) formerly performed by the Financial Management Service. Information systems management was consolidated into a single office for better accountability and efficiency.

In FY 2009 the ISMS HHS Information Technology Infrastructure Office (ITIO) embarked upon an effort to completely overhaul the delivery of hosted IT activities. To do so HHS ITIO issued a request for proposal (RFP) to procure a wide range of IT services. This was a full and open competition with a small business set aside. The objectives of the procurement were to:

- Acquire centralized IT services and products to support ITIO customers' business requirements;
- Provide a high-quality computing platform that is reliable, competitively-priced, and responsive to customer needs; and
- Improve organizational performance through enhanced end-user service, response time, and overall service-delivery.

There were four separate service offerings under one RFP release. The four functional areas and their objectives are:

- Desktop & End-user Computing Services (Seat Management) - ensure the timely provision and management of productivity tools such as desktops, printers, laptops and other mobile devices;
- Infrastructure & E-mail Services – ensure that these services are available to sustain the interconnected computing environment. These services ensure that the HHS network is secure, efficient, and responsive;
- Application Hosting Services - ensure a secure, reliable, cost-efficient environment in which business applications can be hosted; and
- Continuity of Operations & Disaster Recovery Services – ensure that these services are available to protect data and recover systems quickly to enable continued efficient operation of the business.

HHS adopted a government-owned, contractor-operated (GOCO) model to deliver infrastructure and e-mail services to improve service availability and performance. HHS also adopted a contractor-owned, contractor operated (COCO) model to provide Application Hosting, Desktop and End-User Computing, and Continuity of Operations/Disaster Recovery (COOP/DR) services. The COCO model provides HHS with the flexibility to provide the services at a competitive price without incurring the cost of ownership of assets. Overall, the combined service models provide HHS with the control and flexibility to meet mission demands.

In addition to new activities described above, ISMS personnel continue to be involved in developing an enterprise-wide solution for HHSIdentity Enterprise Access Manager (EAM). HHSIdentity EAM was created under one integrated infrastructure which can use identity cards or one ID and password login to access multiple applications. EHRP and EWITS (including the Transhare and Parking modules) were the initial systems included in HHS single sign-on solution. Additional systems continue to be added as efforts continue.

The FY 2011 budget for Information Systems Management Service is $173,620,000, which is $1,902,000 above the FY 2010 budget request of $171,717,000. This increase is attributable to an estimated increase in the rates under the new IT contract.

Strategic Acquisition Service (SAS)
The Strategic Acquisition Service (SAS) is responsible for providing leadership, guidance and supervision of fully integrated acquisition and strategic support services to HHS and other Federal agencies. SAS streamlines procurement operations in HHS through activities such as the reduction of duplicate contracts, the use of consolidated contracts, and the implementation of new procurement practices designed to provide higher quality procurement services at reduced cost. The major divisions within SAS are: *Acquisition Management*, which includes negotiated contracts, simplified acquisitions, and purchase card management services; and the *Supply Service Center*, which provides pharmaceutical, medical and dental supplies to Federal agencies and other customers worldwide. In FY 2009, SAS awarded $940,000,000 in contract obligations and achieved $35,000,000 in cost avoidance through effective competition and negotiation. SAS also implemented a partnership with the U.S. Navy Reserve to procure and distribute pharmaceuticals ad medical/dental supplies for humanitarian missions to Jamaica, Guyana, El Salvador, and the Dominican Republic.

The FY 2011 budget for SAS is $163,028,000 which is an increase of $11,710,000 above the FY 2010 budget request of $151,318,000. This increase is attributable to a $10,007,000 in support of new acquisition business with external customers and $1,703,000 in rents/utilities.

Human Resources Centers
Within HHS, there are five Human Resources Centers (HR Centers). PSC oversees the financial aspects of three HR Centers that are located in Baltimore, Rockville, and Atlanta. A fourth HR Center is serviced by the National Institutes of Health (NIH) and is located in Bethesda. A fifth HR Center is serviced by the Indian Health Service (IHS) and is located in Rockville. The cost and FTE associated with the NIH and IHS sites are included in the respective OPDIV's budget requests. All sites report to HHS' Office of Human Resources for program and policy direction.

These centers are responsible for providing high quality human resource services to HHS components and other customer agencies.

The HR Centers provide human resources strategic programs, customer service, and workforce relations support for HHS customer organizations. They serve as the principal advisor to the customer organizations' leadership on matters related to human resources management, including strategic human capital planning, recruitment and placement, position classification and management, compensation and pay administration, executive resources, workforce planning, labor and employee relations, employee services, and employee benefits, entitlements and advisory services. HHS HR Centers interpret regulations, directives, and other guidance related to human resources programs. In addition, they provide policy direction, coordination and operational control for human resources programs.

HHS University

The HHS University (HHSU) supports HHS' mission and goals by providing high-quality, cost-effective continued learning and development opportunities. HHSU employs innovative approaches and emerging learning technologies, including on-line training courses. HHSU manages HHS' Learning Management System (LMS). Available to all HHS employees, LMS provides one-stop access to training, and allows tracking and reporting of training activities at any level within HHS. LMS also makes tools available to assist HHS with effective human capital management, through activities such as talent management, succession planning, and knowledge and content management.

The FY 2011 budget for Human Resources Centers and HHS University is $70,239,000, which is an increase of $2,920,000 above the FY 2010 budget request of $67,319,000.

Other Non-PSC SSF Activities

The Non-PSC Activities of the SSF provide services that differ from those at the PSC by their predominant focus on facilitating compliance with public law, regulations, or other Federal management guidelines, as well as targeted workforce management. These Non-PSC SSF Activities are described below.

Acquisition Integration and Modernization (AIM)

AIM creates a seamless integration of HHS-wide procurement practices, systems, internal controls, oversight, and performance measurements to improve and standardize the acquisition process. AIM leverages HHS spending opportunities, captures knowledge within the acquisition workforce, and seizes opportunities to adopt and tailor best practices. The AIM activity was added to the SSF effective October 1, 2004.

During FY 2009, AIM developed process standardization in the areas of market research, multi-agency contracting, acquisition strategies for major investments, security of facilities and information systems, accessibility of electronic information technology, adjudication of contract protests, and quality and timeliness of contract award information; and launched a Recovery Act Acquisition Desk reference to support compliance with the acquisition-related requirements of

the Recovery Act.

From FY 2007 to FY 2009, AIM put more focus on critical performance factors, resulting in significant performance improvement - from 40% of the OPDIVs being rated excellent in FY 2007 to 68.9% in FY 2009. To display these performance improvements we have visually depicted these highlights through the use of an acquisition dashboard. The factors contained in the dashboard are: 1) emphasize the use of performance-based acquisitions; 2) increase the use of competition; 3) promote timely data reporting; and 4) support workforce training and development. Further refinements to expand strategic sourcing/smart buying initiatives and to increase the performance-based acquisition goal were incorporated for FY 2010.

In FY 2010 and FY 2011, AIM will continue to pursue opportunities to standardize and modernize acquisition processes with a focus on:

- Expanding strategic sourcing/smart buying initiatives;
- Performing additional purchase card oversight and procurement management reviews to assess how well HHS manages its procurement function;
- Implementing major acquisitions and capital investments;
- Verifying contractor accounting systems;
- Validating contract closeouts;
- Creating an electronic desk reference for project officials; and
- Developing an acquisition community of practice.

AIM will continue to review performance criteria to ensure goals/performance standards are still relevant; and will explore additional methods to benchmark opportunities.

The FY 2011 budget for AIM is $1,127,000, which is only a slight increase over the FY 2009 budget ($1,000 increase or .089% increase).

Audit Resolution

Audit Resolution, as mandated by P.L. 96-304 and P.L. 98-502, resolves grantee audit findings within a statutorily mandated six-month period. Based on findings identified by auditors in a grantee’s A-133 audit, Audit Resolution reviews and resolves audit findings of grantee organizations affecting the programs of more than one HHS OPDIV or Federal agency. Audit Resolution makes recommendations and ensures that corrective action is taken on deficiencies in grantee accounting systems, internal controls, or other management systems. Under the authority of OMB Circular A-50, paragraph 7.c., Audit Resolution, as an audit follow-up official, has responsibility for ensuring that timely responses are made to all audit reports, disagreements are resolved, and corrective actions are implemented.

Audit Resolution is responsible for providing HHS-wide guidance and coordination of the audit resolution function. Audit Resolution is also responsible, for identifying and following up with all grantees that have not submitted their annual A-133 audit in a timely manner. Audit Resolution also provides departmental leadership in working with OMB and the OPDIVs to annually update the Compliance Supplement. In addition, Audit Resolution provides functional leadership for completing and reconciling the Annual Management Report on Final Action to the Congress with OIG. Audit Resolution also works closely with the OPDIVs to measure, identify,

and implement corrective actions to prevent improper payments from a programmatic perspective.

The FY 2011 budget for Audit Resolution is $1,506,000 which is an increase of $151,000. This increase is for additional FTE necessary to accommodate increased workload and to ensure that audit resolution work continues to be performed in accordance with statutorily mandated timeframes.

Claims

The OGC Claims Office is a component of the General Law Division of Office of the General Counsel (OGC) and is responsible for processing administrative tort claims (e.g., medical malpractice, vehicle accidents, acts, or omissions that cause damages), which are received and adjudicated by the OGC Claims Office on behalf of HHS. The Federal Tort Claims Act (FTCA) requires claimants to file administrative claims with the responsible agency before filing suit against the United States in Federal court. Each agency is given six months to settle or deny administrative claims. If no action is taken within six months, the claimant may then file suit in Federal court. As such, the function of processing administrative claim performed by the OGC Claims Office is mission critical work that is required by Federal statute.

Processing administrative tort claims includes logging in matters, creating files, researching the issues, coordinating with claimants, and preparing recommendations for the HHS settlement authority. The settlement authority on these claims also resides within OGC. OGC settles claims where appropriate, and denies claims where not. For unsettled claims, which result in litigation, OGC works with the Department of Justice to defend the agency. At the administrative adjudication level, those HHS agencies that use the services provided by the OGC Claims Office pay for those services via the HHS Service and Supply Fund (e.g., most medical malpractice claims are from HRSA-funded Community Health Centers and from Indian Health Service clinics). Claims that result in litigation go through an additional process and are worked by other OGC personnel (e.g., a secretary, paralegals, and attorneys). Thus, all tort claims are processed from beginning to end by OGC personnel.

In FY 2009, the OGC Claims Office received 501 tort claims, 285 of which were related to community health centers. As of January 15, 2010 (FY2010), OGC received 134 tort claims of which 69 were related to community health centers.

The FY 2011 budget request for Claims is $1,202,000, a $37,000 increase over FY 2010.

Commissioned Corps Force Management (CCFM)

Force management of the Commissioned Corps (Corps) is administered by two offices within the Office of Public Health and Science (OPHS) - the Office of Commissioned Corps Force Management (OCCFM) that reports to the Assistant Secretary for Health (ASH) and the Office of Commissioned Corps Operations (OCCO) within the Office of the Surgeon General (OSG). OCCFM establishes timelines, performance standards, and methods for the evaluation of the operations and management of the Corps, and works closely with the OSG to facilitate operations and the implementation of policies and programs. OCCO manages the personnel administration for the assignment, appointment, promotion, assimilation, training and awards for

Corps members. The OCCFM is a fee-for-service activity. For this fee, OCCFM establishes time lines, performance standards, and measurements for the evaluation of the operations and management of Commissioned Corps officers. Other services provided include officer recruitment, marketing, training, and the full cadre of personnel services for the Corps officers. The CCFM FY 2011 budget of $23,164,000 is calculated by multiplying the SSF Board-approved rate per officer by the actual number of officers on board.

In FY 2011, CCFM will conduct a feasibility study for applying a multivariate regression analysis for the recruitment and retention of Commissioned Corps officers. The Corps faces significant shortages in many categories and assignments and is striving to fulfill its mission of public health care. CCFM will also perform work associated with ongoing policy document revisions for posting on the Commissioned Corps Issuance System web site. The eCCIS project management approach is a lengthy process, consisting of over 300 existing policies and requiring the development of new policies as new initiatives arise. The maintenance of the eCCIS currently requires: 1) technical advice for policy content and revision; 2) conversion of current issuances into a searchable, web-friendly format; 3) conversion, timely preparation and validation of issuances; and 4) updated legal glossaries with cross-formatted tables of content that are consistent with other uniformed services. These activities are in addition to the normal workload of OCCFM and OCCO. Of the total CCFM budget, these activities total less than $300,000.

For FY 2011, the CCFM program requests a funding level of $23,164,000, a decrease of $12,089,000 below the FY 2010 level. This decrease is the result of a technical change, excluding the value of interagency agreements that fund the salaries and benefits of Commissioned Corps officers detailed to non-HHS agencies. The FY 2010 budget included estimates of the salaries and benefits paid to the Corps members that were assigned to agencies outside of HHS. An FY 2011 estimate for Corps detailees is not included in the SSF budget because efforts are underway to establish Treasury transfers to facilitate this reimbursement process for use in future fiscal years.

Departmental Contracts Information System (DCIS)

DCIS provides a central repository for HHS procurement data, and is HHS' primary method for submitting required procurement reports to the Federal Procurement Data System Next Generation/OMB (FPDS-NG), under P.L. 93-400. DCIS collects, stores, and compiles contract information to produce various reports for the OMB, GAO, the Congress, state governments, and HHS management. Additionally, DCIS compiles information for HHS responses to Freedom of Information Act (FOIA) requests.

HHS implemented version 1.3 of FPDS at the beginning of FY 2010. DCIS will implement version 1.4 of FPDS in FY 2011 to provide Treasury Account Symbols in the required format to be reported in USASpending.gov. In addition, DCIS will deploy an ad hoc reporting system as well as a new search engine, which will facilitate quick answers to ad hoc queries. This will support the Open Government Directive.

The FY 2011 Budget for DCIS is $1,085,000; a slight increase of $33,000 to exercise an existing support contract option. HHS will continue system maintenance and the necessary upgrades in

FY 2011.

Homeland Security Presidential Directive-12 (HSPD-12)
The HSPD-12 program implements the Presidential Directive to provide greatly-enhanced security for physical access to HHS facilities and logical access to systems and applications. The HSPD-12 Smartcards, know as Personal Identity Verification (PIV) Cards will be issued to all permanent Federal, contractor, and affiliate staff, after a rigorous background adjudication process. The PIV Cards are printed in accordance with National Institute of Standards and Technology (NIST) standards and contain electronic credentials on the embedded smart chip. A total of 49,250 PIV Cards have been issued. The rate of issuance has increased dramatically with the introduction of local printing. HHS is committed and on track to issue all 104,583 planned PIV Cards by July 1, 2010.

HHS has tightly integrated the programs supporting physical access to facilities and logical access to systems under the Identity and Access Management at HHS Program (IAM@HHS), which is aligned with the HHS Chief Information Officer (CIO) Council's Federal Identity and Credential Access Management (FICAM) Program. Per the FICAM Roadmap published by the Office of Government Wide Policy at GSA, IAM@HHS has integrated all FICAM-related milestones into the IAM@HHS project plan. Additionally, this implementation approach will conform to the HHS Federal Segment Architecture Methodology Program. HHS is required to submit the FICAM Segment as a portion of HHS' segment architecture submission to OMB.

The interface between the physical and logical systems that was implemented in FY 2009 within OS is being extended to a number of OPDIV's and HHS regional offices. PIV Cards from all HHS OPDIV's and external agencies are recognized by the SW Complex's physical access control system. Once fully deployed, all HHS-owned and operated physical access control systems will be enabled to grant physical access to all HHS employees and contractors holding PIV Cards. Use of PIV Cards to access logical systems now supports five applications with plans for major expansion in FY 2010 and FY 2011 to encompass all Federal Information Security Management Act (FISMA) applications including 33 HHS-wide applications. PIV Cards are being used for two factor authentication for remote access on a limited but expanding basis.

The FY 2011 budget for HSPD-12 is $13,173,000, which is an increase of $2,955,000. This increase will support ongoing operations and maintenance as well as logical access contracts. SSF Reserves funding in the amount of $5,490,817 has also been approved in FY 2010 to accelerate integration of HHS-wide applications into single sign-on services which accept the PIV Card.

High Performing Organizations and Commercial Services Management (HPO & CSM)
HPO & CSM supports Commercial Services Management (CSM) Reporting, the inventory and reporting of Federal Activities Inventory Reform (FAIR) Act inventory, and the active sponsorship of High Performing Organizations (HPO) creation and insourcing through central service activities. The FAIR Act of 1998 (P.L. 105-270), authorizes and requires annual inventories of agency positions. Section 647 (b) of Division F of the Consolidated Appropriations Act, FY 2004, P.L. 108-109 requires annual commercial services management

reports. Section 735 of Title VII of the Omnibus appropriations Act, 2009, P.L. 111-8 addresses insourcing. This legislation requires central service activities to ensure that consideration is given to using, on a regular basis, Federal employees to perform new functions and to review functions that are currently performed by contractors.

The FY 2011 budget for HPO & CSM is $287,000, which is the same as the FY 2010 budget.

Office of Small and Disadvantaged Business Utilization (OSDBU)
OSDBU was established in 1979 under P.L. 95-507, the Small Business Act. OSDBU provides leadership, guidance and recommendations to ensure that small businesses are given an equitable opportunity to participate in the provisions of goods and services by HHS. The activities and performance goals for Small Business can be grouped into three broad categories: training, vendor outreach, and meeting or exceeding Small Business goals.

OSDBU will continue to increase the use of mechanisms and programs which “maximize opportunities for small businesses”. It will work to disseminate best practices and policy that ensures sufficient numbers of small businesses are considered during the procurement process including those needs as necessary to meet contract needs under the Recovery Act.

In FY 2011 OSDBU will implement the HHS Mentor Protégé Program. This program will provide an avenue for small businesses (Protégé) to achieve greater entrepreneurial success by partnering with large contractors (Mentor) who provide technical and management guidance. HHS, in turn, will benefit from a growing industry of capable small businesses that can perform and deliver on the contractual needs of HHS.

The FY 2011 budget for OSDBU is $2,818,000 which is an increase of $126,000 over FY 2010. This increase will support a new operational position in the office for the HHS Mentor Protégé Program.

Tracking Accountability in Government Grants System (TAGGS)
TAGGS is HHS’ publicly accessible online database of grant funding. The system supports HHS’ transparency and accountability efforts under the Federal Funding Accountability and Transparency Act (FFATA) and the Recovery Act by posting grant award data online; and feeding financial, programmatic, and performance data to USASpending.gov and Recovery.gov. The system also maintains and operates HHS’ Recovery Act Recipient Reporting Readiness Tool to assist grant recipients and HHS agencies with improving data quality and tracking, and validating award information prior to submission of OMB FederalReporting.gov reports. Tracking and posting searchable award data online since 1995, TAGGS highlights HHS’ on-going commitment to increase the transparency of Federal funds and show the public where and how their tax payer dollars are spent.

Performance Achievements:

- Successfully completed all USASpending.gov data submission requirements each month for FY 2008 and FY 2009.

- Developed, maintained, and operated the Recovery Act Recipient Reporting Readiness Tool to help facilitate HHS' 99% success rate for Agency review of FederalReporting.gov recipient reports.
- Successfully met and exceeded SSF performance metrics for FY 2009, achieving over 87 % of project abstracts in the database for FY 2009 grant awards. On target to meet performance metrics for FY 2010.

The FY 2011 budget for TAGGS is $1,125,000, which includes an increase of $51,000 from the approved FY 2010 budget to support increased OMB FFATA and Recovery Act reporting requirements.

Web Communications and New Media Division (WCD)

WCD is a part Office of the Assistant Secretary for Public Affairs (ASPA). WCD is responsible for the coordination of all HHS web communication and outreach activities, including implementing Web 2.0 applications, related to health and human service information, education and public interaction.

WCD designs, develops, maintains, hosts and assures Section 508 compliancy for more than a dozen Web sites, encompassing over 150,000 Web pages. WCD has developed major Web sites supporting health reform and the Recovery Act. WCD will take over and upgrade, with the United States Department of Agriculture (USDA), the Food and Drug Administration (FDA), and the Centers for Disease Control and Prevention (CDC), the foodsafety.gov site as a part of the food safety report to the President. Additionally, in response to the Administration's demand for expanded use of social media and networking tools, the WCD is preparing to support HHS-wide use of video, online discussion tools. WCD recently launched an Internet-based video public service announcement promoting flu prevention.

WCD also manages four enterprise applications including a collaborative portal tool encompassing over 500 communities across the OPDIVS, a 508 policy-testing tool, a web content management system, and a Google search appliance. Staffing to support these efforts includes experts in many areas including: technical implementation, content development, Section 508 legislation, graphics and design, database maintenance, media and communications, and Web 2.0 and usability analysis. WCD serves in an expert consulting and clearance function for all OPDIVs as well.

Support of these efforts is resource intensive both in staffing and funding. The FY 2011 request reflects an increase to address ongoing responsibilities as well as increased demands. The FY 2011 budget for WCD is $10,766,000, which is an increase of $581,000. The increase reflects the priorities of the Administration and the resulting uses of the internet and other Web-based tools by HHS and its constituency.

FY 2011 Congressional Justification

Program Support Center
Overview of Key Performance Measures, Outcomes and Outputs

Key Outcomes and Outputs

PSC Key Performance Measures Table

Long Term Objective: ***Improve quality – Provide quality administrative support so that high performance can be maintained in HHS Program Services.***

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
1.1.1: Increase the percentage of services achieving timelines targets. (Outcome)	FY 2009: 93% (95% Target Not Met)	95%	95%	Maintain
1.1.2: Increase the percentage of customers responding to PSC comment cards and indicating excellent/good ratings for satisfaction of services. (Outcome)	FY 2009: 88% (90% Target Not Met)	90%	90%	Maintain
1.1.3: Increase the percentage of cost centers processing billings to coincide with service delivery (Outcome)	FY 2009: 97% (95% Target Exceeded)	95%	95%	Maintain

Long Term Objective: ***Increase Cost Savings to HHS by Expanding Market Share or Increasing Size of Customer Base.***

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
1.2.1: Increase percentage of new customers acquired annually. (Outcome)	FY 2009: 3% (2% Target Exceeded)	2%	2%	Maintain
1.2.2: Increase in sales revenue from the top 20 cost centers. (Outcome)	N/A	N/A	5%	Baseline
1.2.3: Increase business from customers outside of HHS. (Outcome)	N/A	N/A	5%	Baseline

Long Term Objective: ***Increase Cost Savings to HHS through Asset Management***

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
1.3.1: Participate in Department-wide consolidations. (Outcome)	FY 2009: 2 consolidation (1 Target Exceeded)	1 consolidation	N/A	N/A
1.3.2: Maintain PSC overhead rate to be less than 1.6% of total costs. (Outcome)	FY 2009: 1.2% (1.6% Target Exceeded)	1.6%	1.4%	-0.2
1.3.3: Maintain percentage of revenue consumed by intra-service costs. (Outcome)	FY 2009: 5% (4% Target Not Met)	N/A	N/A	N/A
1.3.4: Increase the percentage of overall employee satisfaction PSC-wide. (Outcome)	FY 2008: 53% (75% Target Not Met)	75%	75%	Maintain
1.3.5: Increase the percentage of cost centers recovering within an established variance and achieving target Net Operating Result (NOR). (Outcome)	FY 2009: 56% (75% Target Not Met)	75%	75%	Maintain

Improve Quality:

PSC has a long term goal of consistently improving the delivery of quality, timely and efficient services so that HHS OPDIVs may receive superior service while maintaining focus on their mission-related programs. There are three important measures that indicate quality of service – timeliness, customer satisfaction and timely billing.

Performance Measure 1.1.1 (Timeliness: Target not met in FY 2009):

Timely service and responsiveness are critical elements that determine a customer's level of satisfaction with PSC. PSC consistently focus on maintaining and improving timeliness in order to maintain and improve the customers' perceptions of PSC as a service provider. PSC seeks to provide timely, accurate and efficient products and services to all customers through simplified, streamlined processes and procedures and through employment of best business practices.

PSC measures the timeliness of service delivery against the timeliness performance standards established for each product and service listed in our comprehensive Directory of Products and Services. Service delivery is considered timely when the requested service is delivered to the customer in a prompt manner and within the time frame published for the timeliness performance standard for that product or service. An example of a timeliness performance standard is the following: "95% of Express Orders will be processed and shipped within 1 business day". This timeliness performance standard applies to the pharmaceutical, medical, and dental supplies and services provided by the Supply Service Center under the Strategic Acquisition Service (SAS).

The target for each timeliness standard is set to achieve maximum customer satisfaction for timely delivery of products and services. In most cases, the timeliness targets are set at 95 to 100%. These standards exist in order to set expectations with the customer and to allow the customer to hold PSC accountable.

For Performance Measure 1.1.1, PSC tracks performance data to determine the percentage of its products and services that are achieving their individual timeliness standards. While these standards will be rolled up to the highest PSC level for reporting purposes, each Cost Center Manager of a product or service line is held responsible for meeting their goals. The responsibilities of a Cost Center Manager are assigned and documented under the Performance Management Appraisal Program (PMAP). Individual product and service lines results will be analyzed monthly and reviewed for problem resolution and tracked for improvement. PSC Business Operations (PBO) provides monthly training to the Cost Center Managers so that they can properly analyze the performance results of their respective products and services.

For FY 2009, PSC tracked 169 individual timeliness standards for 75 products and services. There were more products and services in FY 2009 compared to FY 2008 because of the new products and services such as ONE DHHS, Project Management Services, IT Security Services and Financial Reporting. In FY 2009, the performance results were timely 93% of the time which did not meet the performance target of 95%. PSC did not meet the FY 2009 target because of the initial challenges in some processes created by the organizational realignment. Cost centers were moved from Financial Management Service (FMS), Administrative

Operations Service (AOS) and Enterprise Support Service (ESS) to the newly-formed Information and Systems Management Service (ISMS).

In FY 2010 and FY 2011, the target for Timeliness will remain constant at 95%. PSC will continue to analyze the targets established for each product and service to ensure that appropriate yet challenging targets are established. We will continue to achieve the timeliness standards at least 95% of the time in upcoming years.

Performance Measure 1.1.2 (Customer Satisfaction: Target not met in FY 2009):

The other factor in measuring quality is overall customer satisfaction. PSC has placed great emphasis on providing quality, value-added services to all customers through reengineered processes and procedures; upgraded infrastructure, tools and systems; transparency; management and employee attention to quality, and through employing best business practices. PSC will measure the perceived quality of its service delivery as the percentage of customers expressing overall satisfaction with the quality of services provided. When PSC's customers are satisfied with products and services they are receiving, it allows them to keep focus on their core mission.

Additionally, it is important for PSC to track customer satisfaction because the higher the satisfaction ratings, the more likely customers are going to continue purchasing PSC products and services, as well as increase their purchases. More sales have an overall effect on price per service in that the total cost of the service is being spread over a larger customer base, thus reducing the price per unit. It is clear that customer satisfaction has a direct relationship not only to quality, but also to price for customers.

The customer satisfaction measure defines quality as those customers who are highly satisfied with overall service. PSC encourages customers to complete an on-line survey upon delivery of products and services and makes the survey available on PSC's website.
Survey responses are collected and analyzed on a monthly basis to arrive at the customer satisfaction rating. The monthly performance results are distributed to the cost center managers to resolve issues and to monitor the performance of their respective areas.

In FY 2009, PSC did not meet the Customer Satisfaction performance target. Based from the customer comments, most of the dissatisfaction was due to the initial challenges of the recently implemented organizational realignment which disrupted some processes and created some learning curve for some reassigned personnel. Cost centers were moved from Financial Management Service (FMS), Administrative Operations Service (AOS) and Enterprise Support Service (ESS) to the newly-formed Information and Systems Management Service (ISMS).

The PSC realignment was approved by HHS so that PSC can better serve its customers and can best leverage the expertise of its employees. The biggest driver in the realignment was the formation of ISMS as the IT services organization. PSC has proven itself to have strong IT capabilities. As PSC have grown organically, the IT assets were distributed throughout PSC. At a certain time, this distribution of expertise made sense but now poses a challenge in managing these assets and competencies and how to better serve the customers. Best practices, especially for an organization of PSC's size, point to a structure where these assets are managed centrally.

PSC also needs to better cultivate IT skills and to more effectively manage information resources, which are becoming more important to the PSC's service delivery structure of essential service offerings.

Despite falling slightly under target in FY 2009, the FY 2010 and FY 2011 targets will remain constant at 90%. PSC expects to improve its Customer Satisfaction performance in the coming years.

Performance Measure 1.1.3 (Timely Billing: Target exceeded in FY 2009):

In an effort to improve the quality of PSC service delivery, PSC established this performance measure in FY 2008 that strives to achieve timely billings. As a fee-for-service organization, it is important for PSC to process its billings when services are rendered in order to collect revenue from its customers in a timely manner. This performance measure was under development during FY 2007 wherein 87% was established as the baseline. The 87% resulted from the cost centers billing on time 707 instances out of 815 actions in FY 2007.

Timely billing in the PSC Revenue, Invoicing, and Cost Estimation System (PRICES) system is affected by the prompt receipt of billing data from the service providers, the availability of the related UFMS reports and the efficient set-up by the cost center managers for the customers' billing information in PRICES. Billing is considered timely when the invoices for the products and services of a certain cost center are entered by the Cost Center Manager into PRICES on or before the monthly cut-off date or deadline. To illustrate this timely billing, if the cut-off date for entering December invoices is January 3rd, the Cost Center Manager must complete his/her billing on January 3rd with a work order date of December 31st in order for the PRICES system to process this billing for the December billing deadline and for the billing to be considered timely.

In FY 2009, the PSC exceeded the target of 95% with a rating of 97%. This is a 2% improvement over the FY 2008 performance result. The performance targets will remain at 95% for FY 2010 and FY 2011.

Improve Cost Savings to HHS by Expanding Market Share:

The PSC seeks to expand its portion of the Federal shared services market in order to establish itself as the leader in shared services, benefit from economies of scale, achieve operational efficiencies, foster standardization, and free customers to focus on their core mission. As the shared services provider for HHS, it is essential that our prices be competitive and costs be controlled. To best serve our customers, we strive to identify ways that costs can be reduced and prices can be maintained and/or reduced.

One method of controlling price increases is through obtaining new Federal customers, not just HHS customers, but especially customers outside the Department. By doing this, the PSC can spread overhead costs to a greater number of work units; achieve economies of scale through volume buys, thus lowering the cost to customers. This is most effective when a greater portion

of the expanded market includes external customer agencies, which has a direct effect on HHS customer. As a result, we must monitor our customer's usage of services (in addition to managing costs, which is discussed in the next series of performance goals).

There are three measures utilized to track customer usage. The first measure, performance measure 1.2.1 (Increase in Number of Customers) tracks the percentage of new customers acquired annually. The second measure, performance measure 1.2.2 (Increase in Revenue for top 20 Cost Centers) is new for FY 2011. This performance measure is being utilized to track the increase in sales for the top 20 cost centers. The third measure, performance measure 1.2.3 is also new for FY 2011. This performance measure is being utilized to track the increase in revenue from customers outside of HHS.

Performance Measure 1.2.1 (Increase in Number of Customers: Target exceeded in FY 2009):

This performance standard is measured by the increase in the number of customers billed through PRICES. In FY 2009, the PSC once again tried to increase its customers by 2% over the previous year's (2008) numbers. The bulk of the FY 2009 customers were 34% from DOD, 9% from City/State Government, 5% from DOI and 4% from DOJ.

For FY 2010 and FY 2011, PSC has set a target of maintaining growth for the number of new customers at a rate of 2% over the prior year.

Performance Measure 1.2.2 (Increase in Revenue for top 20 Cost Centers: New in FY 2011):

In an effort to improve cost savings by expanding market share, PSC has established a new performance measure for FY 2011 to achieve an increase in sales revenue for each of the top 20 cost centers. Below is the table of the top 20 cost centers for FY 2009:

Rank	Product/Service	Service Area	FY 2009 Revenue
1	CLINICAL SERVICES	FOH	$101,024,540
2	KC CASU	AOS	$76,592,352
3	ACQUISITIONS MANAGEMENT	SAS	$72,835,071
4	DENVER CASU	AOS	$51,744,916
5	NY CASU	AOS	$50,508,481
6	SUPPLY SERVICE CENTER (PERRY POINT)	SAS	$45,304,249
7	IT SERVICES (ITO)	ISMS	$44,474,599
8	ENTERPRISE APPLICATIONS	ISMS	$28,893,792
9	ENVIRONMENTAL HEALTH SERVICES	FOH	$28,600,312
10	TELECOMMUNICATIONS MGMT./WITS	ISMS	$28,503,358
11	UFMS O and M	ISMS	$27,933,045
12	EAP	FOH	$23,525,643
13	ACCOUNTING SERVICES	FMS	$21,939,009
14	PERSONNEL/PHYSICAL SECURITY-HSPD12	AOS	$19,885,776
15	PAYMENT MANAGEMENT - GENERAL	FMS	$17,576,461
16	ENTERPRISE EMAIL SYSTEM	ISMS	$14,671,039
17	BUILDING OPERATIONS - DELEGATED	AOS	$13,276,523
18	PAYROLL	AOS	$11,680,752
19	COST ALLOCATION	FMS	$10,109,885
20	DEBT MANAGEMENT	FMS	$9,514,572

Like most businesses, most of PSC's sales come from a small subset of their operating units or products. For PSC, these operating units and products are represented by Cost Centers. The top 20 Cost Centers account for more than 75% of all sales revenue of PSC's 60+ Cost Centers. PSC's intention is to put a greater focus on these sales leaders because of their proven attractiveness and the benefits derived from increasing sales in those areas. Those benefits include reducing prices for customers, creating a larger base against which to spread overhead costs, and the ability to absorb losses from new or struggling cost centers.

This performance measure will be under development in FY 2011 and a baseline will be set. A preliminary target is being established for FY 2011 to strive for 5% increase in total sales revenue from the top 20 PSC revenue-producing cost centers. The sales revenue data for this performance measure will be obtained from the Cost Recovery Reports. In this performance

measure, each CASU, e.g. Kansas City CASU will be considered as one cost center because it utilizes the same resources when it is providing products and services to customers.

What will be compared in this performance measure is the increase in sales revenue for the top 20 revenue-producing cost centers that have the same ranking in the previous fiscal year's top 20 cost centers. For example, Clinical Services which is ranked number 1 in the FY 2009 top 20 cost centers will be compared to the cost center ranked number 1 in the FY 2010 top 20 cost centers in sales revenue. If we assume that Acquisition Management will be ranked number 1 in the FY 2010 top 20 cost centers, then the sales revenue of Clinical Services (ranked number 1 in FY 2009) will be compared to the sales revenue of Acquisition Management (assumed number 1 in FY 2010 for illustration purposes). During this sales revenue comparison, the increase in revenue for the number 1 ranked cost center will be calculated. In the same manner, the sales revenue for the cost center ranked number 2 in FY 2009 will be compared to the cost center ranked number 2 in FY 2010. This methodology will be repeated for the top 20 cost centers for FY 2009 and FY 2010 and the percentage increase for each ranking will be calculated. Then, the percentage increases will be added and divided by the number of rankings. In this case, 20 percentage increases will be added and then divided by the number of rankings which is 20. The resulting quotient will be the percentage increase in sales revenue for the top 20 revenue-producing cost centers.

Performance Measure 1.2.3 (Increase in Business from Customers outside of HHS: New in FY 2011):

In another effort to improve cost savings by expanding market share, PSC has established a new performance measure for FY 2011 to achieve an increase in business from federal customers outside of HHS. This performance measure calculates the share of non-HHS revenue as a percentage of total PSC revenue.

As a shared service provider for HHS, PSC's primary responsibility is the support of HHS's needs for administrative services. Nonetheless, PSC aggressively markets its services to other Governmental Agencies (OGAs) as well. By selling its services to OGAs, volume discounts can lower the unit price for all PSC's customers. An additional benefit occurs on the costing side because the increase in business is handled without a proportional increase in expenses (economies of scale). And, the PSC's overhead expense is spread over a greater base, which reduces rates for HHS customers. For these reasons, PSC is committed to increasing sales from all customers, including those outside of HHS.

This performance measure will be under development in FY 2010 in order to establish a baseline. The data for this performance measure will be obtained from the billings by Customer Report and Cost Recovery Reports. A preliminary target is being established for FY 2011 to strive for 5% increase in business from customers outside of HHS. In FY 2009, $374 million, which is 48% of the total $772 million PSC revenue, was from non-HHS customers. With this in mind, PSC is expecting that non-HHS business in FY 2010 will be 53% of total PSC revenue.

Improve Cost Savings to HHS through Asset Management:

Two critical factors that influence a customer's decision to purchase services from PSC are quality of the service and the price. PSC's first three performance measures address methods for monitoring quality, timeliness and improving customer satisfaction.

The previous three performance measures focus on monitoring volume of products and services purchased, which directly correlates to the prices PSC charges its customers. The remaining performance measures address factors that influence price; however, this set of measures focuses on the overall cost of delivering the products and services. If PSC costs can be maintained or reduced and the volume of services purchased remains steady or increases, there will be a positive result for the customer (i.e. prices remain the same or decrease).

Performance Measure 1.3.1 (Department-wide Consolidations: Target exceeded in FY 2009; Discontinued for FY 2011):

This performance measure was established in FY 2007 and replaced a retired measure that previously tracked PSC's contributions to the Department's goal for a reduction in administrative staff. This measure is intended to track PSC's participation in Department-wide consolidations which will address the overall Department goal of reducing administrative costs.

In FY 2009, PSC exceeded the performance target under this Department-wide Consolidations performance measure by its involvement in two Department-wide consolidations through HHSIdentity EAM (Single Sign-On) and iProcurement. ISMS personnel of the PSC were involved in the development of the HHSIdentity EAM project. Two systems, EHRP and EWITS (including the Transhare and Parking modules) were the initial systems included in the Department's single sign-on solution. iProcurement was developed to provide the Department with a functionality that streamlined the requisitioning process. Through a self-service web interface, users can quickly perform requisitions to ensure prompt receipts of goods. iProcurement enables easy online ordering and self-service tracking and receiving which helps reduce routine purchasing inquiries and non-sourced spending. The integration of dynamic approval hierarchies ensures compliance with federal regulations regarding procurement and speed purchase of items that have a short approval process. iProcurement helps procurement professionals to focus on supplier relationships and strategic sourcing.

The target for FY 2010 is for PSC to participate in at least one consolidation. PSC decided to discontinue this performance measure in FY 2011 in order for PSC to concentrate on metrics that it has more control and are more related to price, service quality and customer satisfaction.

Performance Measure 1.3.2 (Overhead Costs: Target exceeded in FY 2009):

PSC recognizes that it must be prudent in controlling overhead costs (those not involved directly in the performance of our products and services). To achieve this outcome, PSC originally established a performance measure to reduce the resources consumed by overhead to the extent possible while still maintaining required internal support functions.

For FY 2009, the target was 1.6%, and the PSC achieved its target by maintaining a low overhead rate of 1.2%. In FY 2010, the performance target will be the maintenance of an overhead rate of 1.6%. For FY 2011, the target for this performance measure will be reduced to 1.4% because PSC was able to control overhead costs to 1.4% in FY 2008 and the trend continued for FY 2009.

Performance Measure 1.3.3 (Intra-service Costs: Discontinued starting in FY 2010; Target not met in FY 2009):

Intra-service costs are the costs of PSC services provided by one PSC cost center to another PSC cost center. This performance measure is being dropped for FY 2010 as PSC does not believe it will significantly contribute to PSC's long term goal to improve cost savings. The tedious process of internal billings, which are not accounted for in the financial statements, does not justify the labor costs invested in this metric. PSC is searching for another performance measure that will enable PSC to reduce costs and has the right and appropriate data collection and measurement system to support it.

The target for FY 2009 was to maintain 4.0% of revenue consumed by intra-service costs which was the same target in FY 2008. PSC did not meet this target in FY 2009 with intra-service cost performance result of 5%.

As indicated above, in FY 2010, this performance measure is discontinued.

Performance Measure 3.4 (Employee Satisfaction: Target not yet available for FY 2009):

Studies have shown that there is a direct link between employee satisfaction, productivity, and customer satisfaction. As a result, it is essential that PSC monitor employee satisfaction levels because dips in satisfaction may result in lower levels of productivity, which then has a correlation to a potential increase in costs. PSC recognizes the importance of employee satisfaction with respect to the overall success of the organization.

To measure employee satisfaction levels, PSC relies on the results of the Department's bi-annual human capital survey (even years) and the OPM HCIS (odd years). PSC previously participated in the HHS-wide Human Resource Management Index (HRMI) Survey. The results of the FY 2008 Human Capital Improvement Survey that were released to PSC in April 2009 indicated that 27% of PSC employees responded to the survey. The personnel who participated in the survey revealed an overall job satisfaction rating of 53%. Therefore, the FY 2008 target of 75% was not met. To address the outcome of the FY 2008 HCIS, PSC evaluated the results and planned new strategies to address the shortcomings. The PSC implemented "Operation High GEAR", a series of 15 initiatives to address tactical and strategic goals to transform the PSC into a customer-focused shared services organization. Five of these initiatives are designed to improve PSC's Human Capital experience. In FY 2009, PSC completed 8 of the 15 initiatives and the other 7 are still in progress. The completed initiatives were Initiative 1: Realign the PSC, Initiative 2: Utilize Meaningful Key Performance Indicators, Initiative 3: Provide One-Stop Service, Initiative 4: Utilize Customer Relationship Management Tools, Initiative 8: Improve E-Gov

Travel CoE Communications, Initiative 9: Improve the HSPD-12 Badge Process, Initiative 10: Transhare and Parking Automated Systems and Initiative 11: SAS Knowledge Management. The initiatives that are scheduled to be completed in FY 2010: Initiative 5: Develop and Manage PSC Service Portfolio, Initiative 6: Create Service Manager Role, Initiative 7: Strategically Manage PSC's Human Capital and Align with the PSC Service Portfolio, Create, Initiative 12: Institute a PSC-Wide Internship Program, Initiative 13: Create an Awards Program, Initiative 14: Create Private Sector Shared Service and OPDIV Exchange Program, and Initiative 15: Improve Employee Recruitment.

PSC will continue to measure employee satisfaction as a critical component of its performance management program. PSC plans to improve human capital processes by focusing on human capital strategy, workforce planning and recruiting, knowledge management, career development, rewards and recognition, succession planning, work-life balance and change management. PSC anticipates launching the IDP Program in June 2010. The IDP Program will ensure employees receive the training and other developmental opportunities they need to advance in their careers and to meet the PSC's mission requirements. The PSC's IDP Program utilizes the IDP system owned by HHS University. The implementation of the IDP system has been delayed by Rockville Human Resource Center staffing shortages and failure of HHS University to implement the performance management module of the Saba Learning Management System since FY 2006. In the interim, supervisors are utilizing Annual Training Plans and other software tools to document employees' training and other developmental opportunities.

The PSC implemented the Employee Awards and Recognition Program as a means to ensure that managers are aware of their role in rewarding high performance and motivating their employees as well as providing the tools available to support them. The PSC also provided work-life balance programs such as Alternative Work Schedules (AWS) and Child Care Subsidy which began on October 1, 2000. Lastly, PSC implemented its Succession Planning Program to ensure it is proactively planning for the loss of employees in mission-critical positions. The Succession Planning Programs helps improve job satisfaction through mentoring and training that prepares personnel to be ready for the mission critical positions. In the end, these efforts will assist the PSC in achieving higher levels of satisfaction across the organization and help it achieve the targets of 75% overall job satisfaction for FY 2009, FY 2010 and FY 2011.

The FY 2009 Employee Satisfaction performance results will not be available until February 2010.

Performance Measure 3.5 (Cost Recovery: Target not met in FY 2009):

The Cost Recovery performance measure is one of several performance measures with a long-term objective of increasing cost savings to HHS through asset management. As a working capital fund, PSC must fully recover its operating costs with customer revenue at the agency level. However, in order to ensure that this rolled up information is being managed as effectively as possible, PSC also tracks this information at each individual cost center (product/service) level.

The Cost Recovery performance measure enables PSC management to evaluate the performance, cost, and business results of each product line; identify problem areas; and take appropriate action. PSC monitors cost center performance with an expectation that all costs will be covered by revenue recognition.

While PSC continues to strive for full cost recovery at the organizational level and cost center level each year, it realizes that unforeseen circumstances and business fluctuations may alter its operations during the course of the year. Therefore, PSC set its FY 2009 target to have 75% of its cost centers recover costs within an established variance. The PSC did not meet its target in FY 2009. The performance result was 56% which was a decline of 5% from FY 2008. The decrease was mainly due to the challenges brought by the reorganizational realignment. PSC expects that cost recovery will improve in FY 2010 because of the Operation High Gear initiatives including the creation of a Service Portfolio Manager who will assist the Service Director to achieve numerous process improvement and the achievement of key metrics such as cost recovery. The target of 75% will remain in effect for FY 2010 and FY 2011.

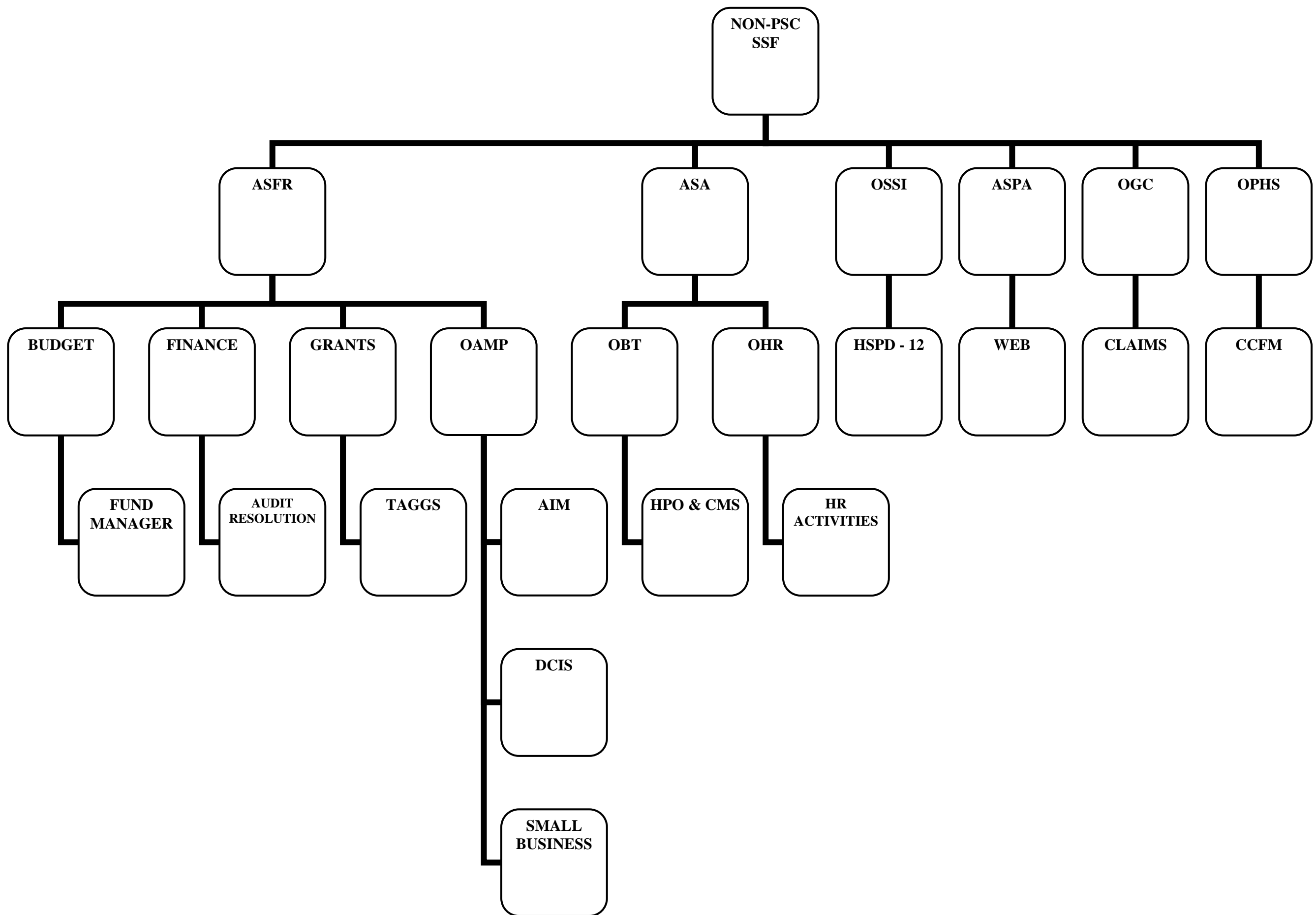
FY 2011 Congressional Justification

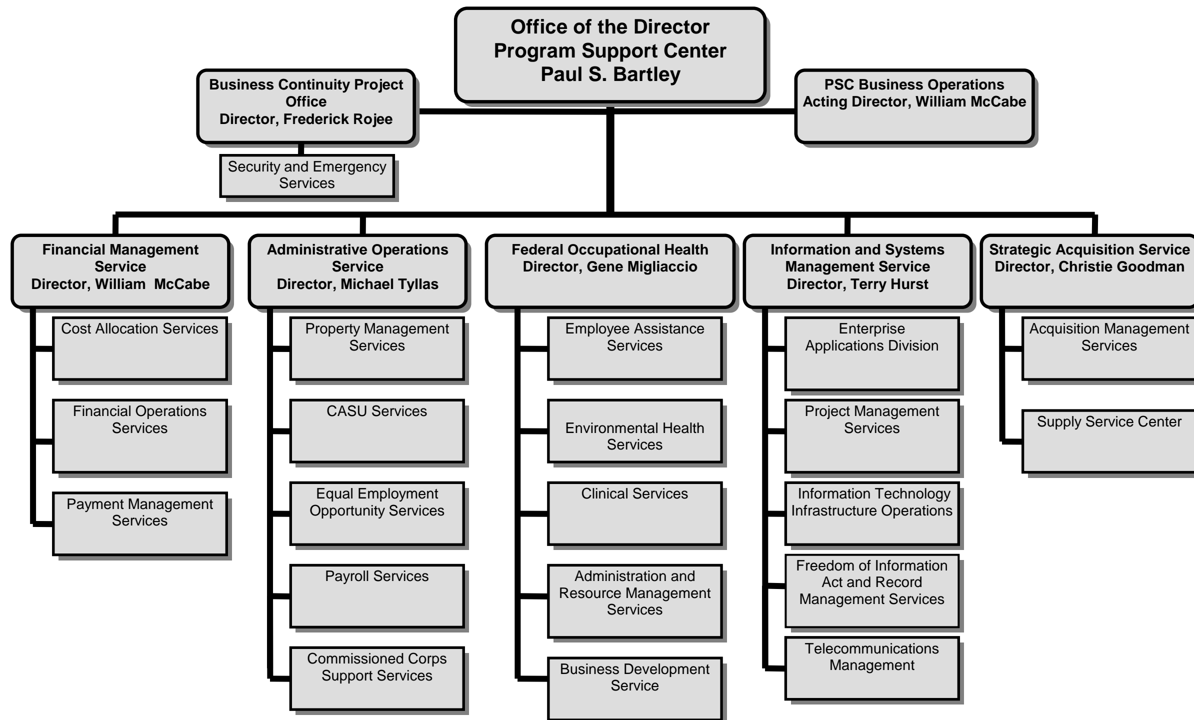
Supplementary Materials

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Non-PSC

Organizational Chart




Office of the Director
Program Support Center
Paul S. Bartley
Business Continuity Project Office
Director, Frederick Rojee
Security and Emergency Services
PSC Business Operations
Acting Director, William McCabe
Financial Management Service
Director, William McCabe
Cost Allocation Services
Financial Operations Services
Payment Management Services
Administrative Operations Service
Director, Michael Tyllas
Property Management Services
CASU Services
Equal Employment Opportunity Services
Payroll Services
Commissioned Corps Support Services
Federal Occupational Health
Director, Gene Migliaccio
Employee Assistance Services
Environmental Health Services
Clinical Services
Administration and Resource Management Services
Business Development Service
Information and Systems Management Service
Director, Terry Hurst
Enterprise Applications Division
Project Management Services
Information Technology Infrastructure Operations
Freedom of Information Act and Record Management Services
Telecommunications Management
Strategic Acquisition Service
Director, Christie Goodman
Acquisition Management Services
Supply Service Center

Department of Health and Human Services
Service and Supply Fund
(Dollars in Thousands)

Service and Supply Fund Activities	FY 2009 Actual	FY 2010 Board Approved	FY 2011 Board Approved	FY 2011+/- FY 2010
PSC				
Administrative Operations Service	259,664	332,841	385,776	52,936
Federal Occupational Health Service	134,171	145,149	149,495	4,346
Financial Management Service	58,402	65,122	66,406	1,284
Info. & Systems Mgmnt Service	162,947	171,717	173,620	1,902
Strategic Acquisitions	122,971	151,318	163,028	11,710
HR Centers & HHS Univ	63,242	67,319	70,239	2,920
PSC Reserves	5,710	23,968	-	-
PSC Subtotal	*807,107*	957,434	*1,008,564*	*51,130*
Non-PSC				
AIM	1,100	1,126	1,127	-
Audit Resolution	1,455	1,356	1,506	151
CCFM	29,845	35,252	23,164	(12,089)
DCIS	892	1,052	1,085	32
HPO & Commercial Services Mgmnt	180	287	287	-
HSPD-12*	6,383	10,218	13,173	2,955
OGC Claims	1,125	1,165	1,202	38
Small Business Consolidation (OSDBU)	2,018	2,692	2,818	126
TAGGS	1,054	1,074	1,125	51
Web Communications	7,427	10,185	10,766	581
Non-PSC Reserves	351	5,491	-	-
Non-PSC Subtotal	*51,830*	*69,898*	*56,253*	*(13,645)*
Total SSF Budget	858,937	1,027,332	1,064,817	37,485

Summary of Changes to SSF Budget by Activity

Most PSC and Non-PSC activities will provide their services at the same rates and budget levels as in FY 2010, but changes to other SSF activity budgets are explained below. No consideration has been made for any FY 2011 Reserves requests or for salary and benefits of Commissioned Corp members detailed to non-HHS agencies.

Administrative Operations Service
The estimated FY 2011 budget for Administrative Operations Service is $385,776,000 to provide administrative operations services. The estimate has changed due to an FY 2009 business growth of $48,000,000 within the CASU. AOS is also expecting an additional growth in CASU of $55,000,000 in FY 2010. However, underlying rates remain largely unchanged. There is an increase of $52,936,000 above the comparable FY 2010 budget request for this activity that is attributable to an increase in new business for the Division of Security and Emergency Services as well as in CASU business. The amount is based on historical patterns supported by discussion with customers and represents a reasonable expectation for responsible growth.

Strategic Acquisition Service
The estimated FY 2011 budget for the Strategic Acquisition Service is $163,028,000 to provide leadership, guidance and fully integrated acquisition and strategic support services to HHS and other Federal agencies. There is and increase of $11,710,000 above the comparable FY 2010 budget request for this activity that is attributable to a $10,000,000 increase in Negotiated Contracts in support of new acquisition business as well as an increase in the Service Supply Center non-Federal business.

OPDIV Share of SSF Budget
(Dollars in Thousands)

	FY 2010			FY 2011			
	PSC	Non-PSC	Total	PSC	Non-PSC	Total	+/- Total FY 2010
ACF	32,235	1,091	33,326	33,556	1,220	34,776	1,450
AoA	2,799	115	2,914	3,367	129	3,496	582
AHRQ	5,956	231	6,187	6,660	253	6,913	726
CDC	71,432	7,366	78,798	72,957	7,956	80,913	2,115
CMS	22,198	2,361	24,559	22,481	2,624	25,105	546
FDA	64,869	6,338	71,207	63,166	6,796	69,962	(1,245)
HRSA	27,812	2,335	30,147	28,190	2,434	30,624	477
IHS	32,929	13,358	46,287	31,287	14,073	45,360	(927)
NIH	53,027	10,081	63,108	54,102	11,238	65,340	2,232
SAMHSA	10,041	738	10,779	10,609	784	11,393	614
OS	84,125	2,308	86,433	86,203	2,462	88,665	2,232
PSC	47,553	997	48,550	48,283	1,181	49,464	914
Non-HHS	478,490	4,768	483,258	547,703	5,103	552,806	69,548
Total Budget			**985,553**			**1,064,817**	**79,264**

Notes for FY 2010 (dollars in thousands):

1) Not included in above table is total amount of $12,320 CCFM for non-HHS agency MOUs.
2) Total use of SSF Reserves (PSC and Non-PSC) is $29,459.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SERVICE AND SUPPLY FUND
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2009 Estimate	FY 2010 Estimate	FY 2011 Estimate
Reimbursable Obligations			
Personnel Compensation and Benefits:			
Personnel Compensation (11)...............................	134,283	144,786	138,738
Personnel Benefits (12)..…	38,693	41,540	40,596
Benefits to Former Employees (13.0)……………......	0	0	247
Subtotal, Pay Costs	**172,977**	**186,325**	**179,581**
Travel (21.0)..…	3,233	4,003	5,001
Transportation of Things (22.0).............................…	3,673	4,278	5,027
Rental Payments to GSA (23)................................	53,599	60,062	64,549
Communications, Utilities, and Misc			
Printing and Reproduction (24.0)...........................…	264	228	910
Other Contractual Services (25)	581,747	724,222	762,290
Supplies and Materials (26.0).................................	35,897	38,306	37,823
Equipment (31.0)...	7,511	9,818	9,544
Other (32)(42)(61)...	36	90	92
Subtotal, Non-Pay Costs…………....................	**685,961**	**841,007**	**885,237**
Total, Reimbursable Obligations……….............	**858,937**	**1,027,332**	**1,064,817**

FY 2011 Budget Submission
Program Support Center
Statement of Personnel Resources

	Total Full-Time Equivalents (Workyears)								
	FY 2009 Actual			**FY 2010 Target**			**FY 2011 Target**		
Reimbursable	Civ	Mil	Total	Civ	Mil	Total	Civ	Mil	Total
PSC Activities:									
Admin. Operations Service	203	10	213	213	8	222	224	8	232
Financial Management Service	192	-	192	202	-	202	212	-	212
Federal Occupational Health	53	63	115	56	53	109	58	53	112
Information Sys. Mgmt Service	120	-	120	126	-	126	132	-	132
Strategic Acquisition Service	100	2	103	105	2	107	110	2	112
Human Resource Activities	433	-	433	455	-	455	478	-	478
Office of the Director	31	-	31	33	-	33	34	-	34
Total, Reim. PSC-SSF FTE	1,132	75	1,207	1,190	63	1,253	1,249	63	1,312
Non-PSC Activities:									
Acquis. Integ. & Mod. (AIM)	-	-	-	-	-	-	-	-	-
Audit Resolution	5	-	5	8	-	8	8	-	8
Comm Corps Force Mgmnt	25	55	80	17	54	71	12	59	71
Dept. Contracts Info. System	1	-	1	1	-	1	1	-	1
HPO & Com. Services Mgmnt	2	-	2	3	-	3	3	-	3
Claims	7	-	7	8	-	8	8	-	8
Small Business Office	9	-	9	12	-	12	13	-	13
TAGGS	1	-	1	2	-	2	2	-	2
Web Communications	19	-	19	25	-	25	25	-	25
Homeland Security Pres Dir - 12	-	-	-	3	1	4	3	1	4
Fund Manager	4	-	4	7	-	7	7	-	7
Total, Reim. Non-PSC-SSF FTE	73	55	128	86	55	141	82	60	142
Total, Reim FTE SSF	1,205	130	1,335	1,276	118	1,394	1,331	123	1,454

SPECIAL REQUIREMENTS

FY 2011 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

Program Support Center Allocation Statement:

The Program Support Center (PSC) will use **$98,950** of its **FY 2011** budget to support HHS-wide enterprise information technology and ongoing government-wide E-government initiatives. The PSC account helps to finance specific HHS enterprise information technology programs and initiatives identified through the HHS Information Technology Capital Planning and Investment Control process. These HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, the entire amount of **$98,950** is allocated to the ongoing E-Gov Initiatives for **FY 2011**. This amount supports these government-wide E-Government initiatives as follows:

FY 2011 Ongoing E-Gov Initiatives*	
Integrated Acquisition Environment	$98,950.00
FY 2011 Ongoing E-Gov Initiatives Total	**$98,950.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Retirement Pay and Medical Benefits for Commissioned Officers

Appropriation Language……………………………………………………..... 304
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Appropriation Language

The Program Support Center has responsibility for the administration of the retirement pay for commissioned officers. The appropriations language for that account follows.

Retirement Pay and Medical Benefits for Commissioned Officers

For retirement pay and medical benefits of Public Health Service Commissioned Officers as authorized by law, for payments under the Retired Serviceman's Family Protection Plan and Survivor Benefit Plan, and for medical care of dependents and retired personnel under the Dependent's Medical Care Act (10 U.S.C. ch. 55), such amounts as may be required during the current fiscal year.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Amounts Available for Obligation

Total, Mandatory Appropriation

	FY 2009 Actual	FY 2010 Omnibus	FY 2011 President's Budget Request
Mandatory Appropriation 1/	$449,907,000	$474,557,000	$517,537,000
Unobligated Balance, start of year			
Unobligated Balance, end of year			
Unobligated Balance, lapsing			
Total Obligations	$449,907,000	$474,557,000	$517,537,000

1/ Includes Retirement Payments, Survivor Benefits, and Medical Care

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Accrued Medical Amount Available for Obligation

Amounts Available for Obligation

	FY 2009 Actual	FY 2010 Omnibus 1/	FY 2011 President's Budget Request
Total, Discretionary Appropriation	$ 34,778,000	$ 35,589,000	$ 37,470,000
Unobligated Balance, start of year			
Unobligated Balance, end of year			
Unobligated Balance, lapsing			
Total Obligations	$ 34,778,000	$ 35,589,000	$ 37,470,000

1/The FY 2010 payment made to the DoD Medicare-eligible Retiree Healthcare Fund was $35,589,000. The *Appendix, Budget of the United States Government, Fiscal Year 2011* includes $37 million, the amount adjusted to reflect the revised on-board projections for FY 2010.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay, Medical Benefits and Accrued Health Care Benefits for Commissioned Officers

Summary of Changes

2010 Appropriation…………………………………………………………..	$510,147,000
2011 Request……………………………………………………………….	$555,007,000
Net change………………………………………………………………..	+44,860,000

	FY 2010 Current Estimate Base		Change from Base	
	FTE	BA	FTE	BA
Changes:				
1. Annualization of the FY 2011 COLA, 2.1% COLA in FY 2010, and for the projected net increase of retirees during FY 2010.	---	$356,455,000	---	+$29,585,000
2. Annualization of the FY 2011 COLA, 2.1% COLA in FY 2010, and projected net increase in average costs per survivor in FY 2010	---	24,592,000	---	+3,295,000
3. Will only cover medical benefits for Officers under age 65. Costs do include a projected increase of 6% in medical care costs for these Officers.	---	93,509,000	---	+10,099,000
4. Will cover Medicare Eligible Accrual Benefits for Officers under age 65.	---	35,589,000	---	+469,000
Net change			---	+$38,900,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Activity

	FY 2009 Actual	FY 2010 Omnibus	FY 2011 President's Budget Request
Retirement payments	$333,318,000	$356,455,000	$386,040,000
Survivors' benefits	24,247,000	24,592,000	27,888,000
Medical care	92,341,000	93,509,000	103,608,000
Total Retired Pay	$449,907,000	$474,557,000	$517,537,000
Medicare Eligible Accruals	34,778,000 1/	35,589,000 2/	37,470,000 3/
Total	$484,685,000	$510,147,000	$555,007,000

1/FY09 – The DoD Office of the Actuary letter dated 7/19/07 set the PHS FY09 per capita amount for the DoD MERHCF at $5560 for full-time members.

2/FY10 – The DoD Office of the Actuary letter dated 7/24/08 set the PHS FY10 per capita amount for the DoD MERHCF at $5642 for full-time members.

3/FY11 – The DoD Office of the Actuary letter dated 8/19/09 set the PHS FY11 per capita amount for the DoD MERHCF at $5673 for full-time members.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Object

	FY 2009 Actual	FY 2010 Omnibus	FY 2011 President's Budget Request	Increase/ Decrease
Benefits for former Personnel	$449,907,000	$474,557,000	$517,537,000	+$42,980,000
Accrued Health Care Benefits	34,778,000	35,589,000	37,470,000	+1,880,000
Total budget authority by object	$484,685,000	$511,557,000	$555,007,000	+$43,450,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Authorizing Legislation

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 President's Budget Request
1. Retirement payments Chapter 6A of Title 42, U.S.C.	Indefinite	$356,455,000	Indefinite	$386,040,000
2. Survivors' benefits Chapter 73 of Title 10, U.S.C.	Indefinite	24,592,000	Indefinite	27,888,000
3. Medical care Chapter 55 Of Title 10 U.S.C., P.L. 89-614; P.L.106-398; P.L. 107-107.	Indefinite	93,509,000	Indefinite	103,608,000
4. Medicare Eligible Accruals, Chapter 55 Of Title 10 U.S.C., P.L. 108-375	Indefinite	35,589,000	Indefinite	37,470,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Appropriations History Table

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2001	219,772,000	219,772,000	219,772,000	245,956,000
2002	242,577,000	242,577,000	242,577,000	273,478,000
2003	251,039,000	251,039,000	251,039,000	291,471,000
2004	308,763,000	308,763,000	308,763,000	321,083,000
2005	324,636,000	324,636,000	324,636,000	343,885,000
2006	363,029,000	363,029,000	363,029,000	363,029,000
2007	377,982,000	377,982,000	377,982,000	406,967,000
2008	439,907,000	439,907,000	439,907,000	438,053,000
2009	469,472,000	469,472,000	469,472,000	484,685,000
2010	510,147,000	510,147,000	510,147,000	
2011	555,007,000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Justification

A. Account Summary

	FY 2009 Actual	FY 2010 Omnibus	FY 2011 President's Budget Request	Increase or Decrease
Retirement payments	$333,318,000	$356,455,000	$386,040,000	+$29,585,000
Survivors' benefits	24,247,000	24,592,000	27,888,000	+3,295,000
Medical care	92,341,000	93,509,000	103,608,000	+10,099,000
Medicare Eligible Accruals	34,778,000	35,589,000	37,470,000	+1,880,000
Total budget authority	$484,685,000	$511,557,000	$555,007,000	+$44,860,000

B. General Statement

This appropriation provides for retirement payments to Public Health Service (PHS) officers who are retired for age, disability, or a specified length of service as well as for payments to survivors of deceased retired officers who had elected to receive reduced retirement payments.

This account also funds the provision of medical care to active duty and retired members of the PHS Commissioned Corps, and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps.

The FY 2011 request is a net increase of $44,860,000 over the FY 2010 level. This amount reflects increased medical benefits costs, an annualization of amounts paid to retirees and survivors in FY 2009, and a net increase in the number of retirees and survivors during FY 2009. The budget request includes a cost-of-living adjustment (COLA) of 2.1 percent.

C. Retirement Payments

Authorizing legislation - Chapter 6A of Title 42 U.S.C.

FY 2009 Actual	FY 2010 Omnibus	FY 2011 President's Budget Request	Increase or Decrease
$333,318,000	$356,455,000	$386,040,000	+$29,585,000

2011 Authorization.......... Indefinite

Purpose and Method of Operation

The purpose of this activity is to provide mandatory payments to Commissioned Officers of the Public Health Service who have been retired for age, disability or specified length of service.

Funding levels for the past five fiscal years were as follows:

2006	268,611,000
2007	292,249,000
2008	303,912,000
2009	333,318,000
2010	356,455,000

Rationale for the FY 2011 Budget Request

The FY 2011 request of $386,040,000 is an increase of $29,585,000 over the FY 2010 level and will support payments to an estimated 5476 annuitants. The increase will fund the annualization costs of the FY 2010 COLA, an FY 2011 COLA of 2.1 percent, and the projected net increase of 159 retirees during FY 2011.

The FY 2011 estimates are based on payments to the following number of retirees:

Period Ending	Total	Net Increase/(Decrease)
September 30, 2009, (act.)	5162	3
September 30, 2010, (est.)	5317	155
September 30, 2011, (est.)	5476	159

D. Survivors' Benefits

Authorizing legislation - Chapter 73 of Title 10 U.S.C.

FY 2009 Actual	FY 2010 Omnibus	FY 2011 President's Budget Request	Increase or Decrease
$24,247,000	$24,592,000	$27,888,000	+$3,295,000

2011 Authorization................................ Indefinite

Purpose and Method of Operation

This activity provides for the payment of annuities to survivors of retired officers who had elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan and Survivor's Benefit Plan. This program is financed by the Federal Government although deductions are made in the retirement payments to the officers who elect the option of survivors' benefits.

Funding levels for the past five years were as follows:

2006………………………………………	16,674,000
2007………………………………………	18,004,000
2008………………………………………	21,400,000
2009………………………………………	24,247,000
2010………………………………………	24,592,000

Rationale for the FY 2010 Budget Request

The FY 2011 request of $27,888,000 is an increase of $3,295,000 from the FY 2010 level and will provide payments for an estimated 950 annuitants. This amount includes funds for the annualization costs of the FY 2010 COLA and the FY 2011 COLA of 2.1 percent, and the projected net increase of 5 annuitants during FY 2011.

The FY 2011 estimates are based on payments to the following numbers of annuitants:

Period Ending	Total	Net Increase/(Decrease)
September 30, 2009, (act.)	940	33
September 30, 2010, (est.)	945	5
September 30, 2011, (est.)	950	5

E. Medical Care

Authorizing legislation - Chapter 55 of Title 10 U.S.C.; P.L. 106-398; and P.L. 107-107.

FY 2009 Actual	FY 2010 Omnibus	FY 2011 President's Budget Request	Increase or Decrease
$92,341,000	$93,509,000	$103,608,000	$10,099,000

2011 Authorization............. Indefinite

Purpose and Method of Operation

This program provides for the cost of medical care rendered in non-Federal and in uniformed service facilities to active duty and retired PHS commissioned officers and dependents of eligible personnel.

This activity fulfills the mandatory medical care obligations of the Public Health Service to Commissioned Officers and their dependents. Medical care to eligible beneficiaries is authorized under the Dependents' Medical Care Act, as amended by P.L. 89-614, which allows for an expanded and uniform program of medical care to active duty and retired members of the uniformed services, and dependents of active duty, retired and deceased members. Health care provided in a uniformed service facility is billed directly to the Public Health Service by that organization. When medical care is provided to dependents or retirees in a private facility, the Civilian Health and Medical Program of the Uniformed Services (TRICARE) acts as the Government's agent to arrange payment and, in turn, bills the Public Health Service for the services rendered. In addition, contract medical care is arranged for active duty officers who are not stationed in an area accessible to uniformed facilities.

Funding levels for the past five years were as follows:

	Total Funding Level
2006	56,754,000
2007	65,998,000
2008	76,100,000
2009	92,341,000
2010	93,509,000

Rationale for FY 2011Budget Request

The request of $103,608,580 will provide medical care for under age 65 beneficiaries. The FY 2011 request reflects increases in the cost of drugs and inpatient and outpatient care for all beneficiaries in Federal and non-Federal facilities.

The FY 2011 estimates are based on payments to the following numbers of active duty officers:

Period Ending	Total	Net Increase/(Decrease)
September 30, 2009, (act.)	6,310	82
September 30, 2010, (est.)	6,558	248
September 30, 2011, (est.)	6,605	47

PREVENTION AND WELLNESS FUND

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget	FY 2011 +/- FY 2010
BA	$0	$700,000,000	$0	$0	$0

Authorizing Legislation…………..…………American Recovery and Reinvestment Act of 2009
Allocation Methods……………..……..Competitive Grants, Cooperative Agreements, Contracts

Program Description and Accomplishments

The American Recovery and Reinvestment Act (Recovery Act) appropriated $700 million in the Prevention and Wellness Fund to the HHS Office of the Secretary. Of this amount, the Recovery Act directed that $50 million be provided to States to execute activities to implement healthcare-associated infections reduction strategies. The Recovery Act also directed the remaining $650 million for evidence-based clinical and community-based prevention and wellness strategies that address chronic disease rates.

Healthcare-Associated Infections (HAI): $50 million

To execute the Recovery Act's healthcare-associated infections activity, HHS allocated $40 million to the Centers for Disease Control and Prevention (CDC) and $10 million to the Centers for Medicare & Medicaid Services (CMS). CDC's and CMS's activities are aligned to the HHS Action Plan to Prevent HAIs and supported by the HHS Steering Committee for the Prevention of Healthcare-Associated Infections.

- CDC is using the $40 million:
  - To fund ten States, for a total of $4 million, to improve and implement HAI surveillance methods, and
  - To fund 49 States, DC, and Puerto Rico, for a total of $36 million, to establish State HAI Programs, enhance HAI surveillance, and establish HAI prevention collaboratives.
- CMS is using the $10 million to work with States to expand the State Survey Agency inspection capability of Ambulatory Surgery Centers nationwide.

Evidence-Based Clinical and Community-Based Prevention and Wellness Strategies: $650 million

The Recovery Act appropriated $650.0 million for evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes. With these funds, HHS is implementing the Communities Putting Prevention to Work Initiative to expand the use of evidence-based strategies and programs, mobilize local resources at the community-level, and strengthen the capacity of States. Key risk factors, such as lack of physical activity,

poor nutrition, and tobacco use, are major contributors to the nation's leading causes of death. This program emphasizes policy and environmental change at both the State and local levels, focused on increasing levels of physical activity; improving nutrition; decreasing obesity rates; and decreasing smoking prevalence, teen smoking initiation, and exposure to second-hand smoke.

The HHS-wide program has four distinct but unified initiatives:

- **Community Initiative**: Approximately $449.4 million supports intensive community approaches to chronic disease prevention and control in selected communities (urban, rural, and tribal). Of this amount, $373 million is competitively awarded to communities to implement evidence-based interventions. The remaining $77 million is allocated for community programmatic support ($27 million), mentoring ($10 million) and evaluation ($40 million).
- **States and Territories Policy and Environmental Change Initiative:** $125 million will support States and Territories in promoting wellness and preventing chronic disease through State-wide policy and environmental change for chronic disease prevention ($75 million) and to increase tobacco cessation through expanded quit lines and tobacco cessation media ($50 million).
- **States Chronic Disease Self Management Initiative:** $32.5 million will support State chronic disease self-management programs. The Administration on Aging and Centers for Disease Control and Prevention will build on an existing partnership to leverage the public health and aging networks at the State and community level to deploy evidence-based prevention programs targeted at the elderly.
- **National Prevention and Media Initiative:** $40 million will establish a National Prevention Media Initiative and a National Organizations Initiative to foster effective and hard-hitting prevention and wellness messages and advertisements, amplified and extended through national organizations, to complement and reinforce community and State activities.
- **Management and Oversight:** $3 million to support management and oversight of the initiative.

Funding History

FY 2009 $700,000,000

Budget Request

There is no FY 2011 funding requested for this activity. The funding will support the CPPW through FY 2012.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROPOSED GENERAL PROVISIONS
FOR FISCAL YEAR 2011

The President's Budget recommends that a number of general provisions be included in the FY 2011 Departments of Labor, Health and Human Services and Education Appropriations Act. These provisions follow appendix schedules for the Department of Health and Human Services (Title II General Provisions) and the Departments of Labor, Health and Human Services and Education (Title V General Provisions). Following is a summary of the proposed provisions:

Title II

Sec. 201. This provision authorizes not to exceed $50,000 in appropriated funds may be used for official reception and representation expenses that are specifically approved by the Secretary.

Sec. 202. This provision enables the Secretary to assign not more than 60 Public Health Service employees to assist in child survival activities and to work in AIDS programs through and with funds provided by the Agency for International Development, the United Nation's International Children's Emergency Fund or the World Health Organization.

Sec. 203. This provision states that no funds appropriated in this Act for the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.

(TRANSFER OF FUNDS)

Sec. 204. This provision allows the Secretary to use not more than 2.9 percent of any appropriations authorized under the Public Health Service Act for evaluation (directly, or by grants or contracts) of the implementation and effectiveness of the Public Health Service Act programs.

(TRANSFER OF FUNDS)

Sec. 205. This section provides that not to exceed 1 percent of discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) appropriated for the current fiscal year for the Department of Health and Human Services in this Act may be transferred between appropriations, with a limitation that no such appropriation may be increased by more than 3 percent, and that an appropriation may be increased by up to an additional 2 percent after notification of the Appropriations Committees in both the House and Senate. The Appropriations Committees of both the House and Senate are to be notified at least 15 days in advance of any transfer.

(TRANSFER OF FUNDS)

Sec. 206. This provision states that the Director of the National Institutes of Health, jointly with the Director of the Office of AIDS Research, may transfer up to 3 percent among institutes and centers from the total amounts identified by these two Directors as funding for research

pertaining to the human immunodeficiency virus, provided that the House and Senate Appropriations Committees are notified at least 15 days in advance of any transfer.

Sec. 207. This section provides that the amount for research related to the human immunodeficiency virus at the National Institutes of Health, as jointly determined by the Director of the National Institutes of Health and the Director of the Office of AIDS Research, shall be available to the "Office of AIDS Research" account and that the Director of the Office of Aids Research shall transfer from the account amounts necessary to carry out section 2353(d)(3) of the Public Health Service Act.

Sec. 208. This provision states that none of the funds appropriated in this Act may be made available to any entity under title X of the Public Health Service Act unless the award applicant certifies to the Secretary of Health and Human Services that it encourages family participation in decisions of minors to seek family planning services and provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

Sec. 209. This section allows that no provider of services under title X of the Public Health Service Act shall be exempt from State laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape or incest.

Sec. 210. This provision provides that none of the funds appropriated by this Act, including trust funds, may be used to carry out the Medicare Advantage program if the Secretary of Health and Human Services denies an otherwise eligible entity participation in the program because the entity informs the Secretary that it will not provide, pay for, provide coverage of, or provide referrals for abortions; provided that the Secretary shall make appropriate prospective adjustments to the capitation payment to such an entity (based on an actuarially sound estimate of the expected costs of providing the service to such entity's enrollees), and provided further that nothing in this section shall be construed to change the Medicare program's coverage for such services and a Medicare Advantage organization described in this section shall be responsible for informing enrollees where to obtain information about all Medicare covered services.

Sec. 211. This provision provides authority to support HHS in carrying out international HIV/AIDS and other infectious disease, chronic and environmental disease and other health activities abroad during fiscal year 2011.

Sec. 212. This provision provides authority for the Office of the Director of the National Institutes of Health (NIH) to enter into transactions (other than contracts, cooperative agreements, or grants) in order to implement the NIH Common Fund, in lieu of the peer review and advisory council review procedures that would otherwise be required. The Director of NIH may utilize such peer review procedures as determined appropriate to obtain assessments of scientific and technical merit.

Sec 213. This provision provides that funds are available for Individual Learning Accounts for employees of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ASTR) and may be transferred to Disease Control, Research

and Training, to be available only for Individual Learning Accounts; provided that the funds are used while such employee is employed by either CDC or ASTR.

Sec. 214. This section allows funds made available in this Act to be used to continue operating the Council on Graduate Medical Education established by section 301 of Public Law102-408.

(TRANSFER OF FUNDS)

Sec. 215. This provision provides authority not to exceed $35,000,000 the amount of funds appropriated by this Act to the Institutes and Centers of the National Institutes of Health that may be used for alteration, repair, or improvement of facilities, as necessary for the proper and efficient conduct of the activities authorized herein, at not to exceed $2,500,000 per project.

Sec. 216. This provision provides that 1 percent of the funds made available for the National Institutes of Health National Research Service Awards (NRSA) will be available to the Administrator of the Health Resources and Services Administration for NRSA awards for research in primary medical care; 1 percent of the amount made available for NRSA is to be available to the Director of the Agency for Healthcare Research and Quality to make NRSA awards for health service research.

Sec. 217. This provision provides that the Health Education Assistance Loan (HEAL) program and the authority to administer such program, shall be permanently transferred from the Secretary of Health and Human Services to the Secretary of Education.

Sec. 218. This provision provides for an additional amount of $7,000,000 for the General Departmental Management account to increase the Department's acquisition workforce capacity and capabilities, provided that such funds may be transferred by the Secretary to any other account in the Department to carry out the purposes provided therein.

Title V

Sec. 501. This provision authorizes the Secretaries of Labor, Health and Human Services, and Education to transfer unexpended balances of prior appropriations to accounts corresponding to those included in this Act as long as the balances are used for the same purpose and the same period of time they were originally appropriated.

Sec. 502. This section states that no appropriation contained in this Act shall remain available for obligation for a period beyond the current fiscal year, unless it is expressly stated in this Act.
Sec. 503. This provision provides that:

(a) Except for normal and recognized executive-legislative relationships, no part of any appropriation in this Act shall be used for publicity or propaganda, preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio or TV broadcast or film presentation designed to support or defeat legislation pending before the Congress or any State legislature, except as a presentation to the Congress or any State legislature itself.

(b) No part of any appropriation in this Act be used to pay the salary or expenses of any grant or contract recipient (or their agent) related to activities designed to influence legislation or appropriations pending before the Congress or any State legislature.

Sec. 504. This provision provides the amounts available to the Secretaries of Labor and Education, the Director of the Federal Mediation and Conciliation Service, and the Chair of the National Mediation Board, from their respective Salaries and Expenses accounts, for official reception and representation expenses.

Sec. 505. This provision provides that no funds appropriated under this Act may be used to carry out a program of distributing sterile needles for the hypodermic injection of any illegal drug.

Sec. 506. This provision provides that all Federal grantees (including State and local governments and recipients of Federal research grants) issuing press releases, requests for proposals and other documents describing projects or proposals supplied with Federal money clearly state the following: (1) the percentage of total costs of the program or project financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) the percentage and dollar amount of the total cost to be financed by non-governmental sources.

Sec. 507. This provision provides that none of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, may be expended for abortion or for health benefits coverage that includes coverage of abortion. The term 'health benefits coverage' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

Sec. 508. The limitations established in the preceding section shall not apply to an abortion:

(a) If the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless the abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

(d) None of the funds may be available to any Federal program, agency or State and local government, if said institution subjects the individual or health care entity to discrimination on the basis that the health care entity does not provide coverage of, or referrals for abortions. Further, the section defines the term "health care entity."

Sec. 509. This section provides that none of the funds made available in this Act to be used for creation of a human embryo, embryos for research, or research in which a human embryo or embryos is destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under the Public Health Service Act. For the

purposes of this section, human embryo or embryos include any organism derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

Sec. 510. This provision provides that none of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or controlled substance except when there is significant medical evidence of therapeutic advantage to the use of such drug or other substance, or Federally-sponsored clinical trials are being conducted to determine therapeutic advantage.

Sec. 511. This provision provides that none of the funds made available in this Act may be used to promulgate or adopt any final standard under section 1173(b) of the Social Security Act providing for, or providing for the assignment of, a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard.

Sec. 512. This provision provides that none of the funds made available in this Act may be used to enter into or renew a contract with a contractor with the U.S. Government who is subject to section 4212(d) of title 38, United States Code, but has not submitted the most recent annual report required by that section to the Secretary of Labor, detailing the employment of certain veterans.

Sec. 513. This provision affects the Department of Education and pertains to a library's eligibility for funding under the Library Services and Technology Act, as amended by the Children's Internet Protections Act.

Sec. 514. This provision prescribes that none of the funds made available to carry out part D of title II of the Elementary and Secondary Education Act of 1965 may be made available to elementary or secondary schools covered by paragraph (1) of section 2441(a), as amended by the Children's Internet Protection Act and the No Child Left Behind Act, unless the local educational agency with responsibility for such covered school has made the certifications required by paragraph (2) of such section.

Sec. 515. This provision provides that none of the funds appropriated in this Act may be expended or obligated by the Commissioner of Social Security for purposes of administering Social Security benefit payments under title II of the Social Security Act, to process claims for credits for quarters of coverage based on work performed under a social security account number that is not the claimant's number and the performance of such work under such number has formed the basis for a conviction of the claimant of a violation of section 208(a)(6) or (7) of the Social Security Act.

Sec. 516. This provision provides that none of the funds made available in this Act may be used for first-class travel by the employees of agencies funded by this Act in contravention of sections 301-10.124 of Title 41, Code of Federal Regulations.

Sec. 517. This provision provides for an additional amount for the “Social Security Administration Limitation on Administrative Expenses account of $1,863,280 to increase the Social Security Administrations acquisition workforce capacity and capabilities provided that such funds may be transferred by the Commissioner to any other account in the Social Security Administration provided herein.