Summary of Performance and Financial Information

Fiscal Year 2009

U.S. Department of Health & Human Services

Message from the Secretary

During FY 2009, the Department of Health and Human Services (HHS) continued to fulfill its charge to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. This *Summary of Performance and Financial Information* presents a synopsis of key past and planned performance of the Department. HHS is making strides in four key areas:

Health Care: HHS has made progress to improve the access to and quality of health care, laying the groundwork for health insurance reform. For example, in FY 2009, the Health Resources and Services Administration supported 180 new or expanded Health Center sites and in FY 2008 provided health care to 17.1 million patients with inadequate access to care. HHS continues to work towards effective health coverage and quality care for beneficiaries of public programs such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Public Health: HHS prevention efforts are an important component of public health protection and span a wide array of activities. To help prevent foodborne illnesses, the Food and Drug Administration participated in the newly formed White House Food Safety Working Group, charged with the goal of upgrading the nation's food safety system which resulted in the cross-government consumer website www.foodsafety.gov. In response to the H1N1 influenza outbreak, HHS worked tirelessly to significantly improve the percentage of State public health agencies prepared to use Strategic National Stockpile materials, achieving the rate of 100 percent (and exceeding the 90 percent target).

Human Services: The economic and social well-being of all Americans continues to be a major issue of concern, especially in light of the current economy. The Child Support Enforcement program seeks to ensure financial and emotional support for children from both parents. In FY 2008, the child support collection rate continued to increase, reaching 62 percent, as compared to 59 percent in FY 2004.

Scientific Research and Development: Basic science is the foundation for improved health and human services. The continuum from basic to applied research to practice is a significant emphasis of our scientific research and development enterprise. The National Institutes for Health (NIH) completed patient follow-ups for a clinical trial evaluating treatment strategies to reduce cardiovascular disease outcomes in patients with type 2 diabetes and/or chronic kidney disease.

The financial and performance data presented in this report is reliable, complete, and provides the latest data available, except where otherwise noted, and demonstrates the Department's commitment to ensuring the highest measure of accountability to the American people. For the eleventh consecutive year, HHS earned an unqualified or "clean" opinion from our independent auditors Ernst & Young LLP on the Department's consolidated financial statements. The Annual Financial Report (AFR) contains more information on our financial condition (http://www.hhs.gov/afr). Additional performance information can be found in the agencies' Online Performance Appendices (http://www.hhs.gov/budget).

Looking toward the future, HHS, along with other Federal agencies, is focusing on a limited number of High Priority Performance Goals which have been incorporated in this document. HHS accomplishments would not have been possible without the dedication and commitment of its employees and partners. They should be proud of the positive impact their contributions have on the lives of Americans. Together, we will continue to strive to enhance the health and well-being of all Americans.

/Kathleen Sebelius/
Secretary Kathleen Sebelius

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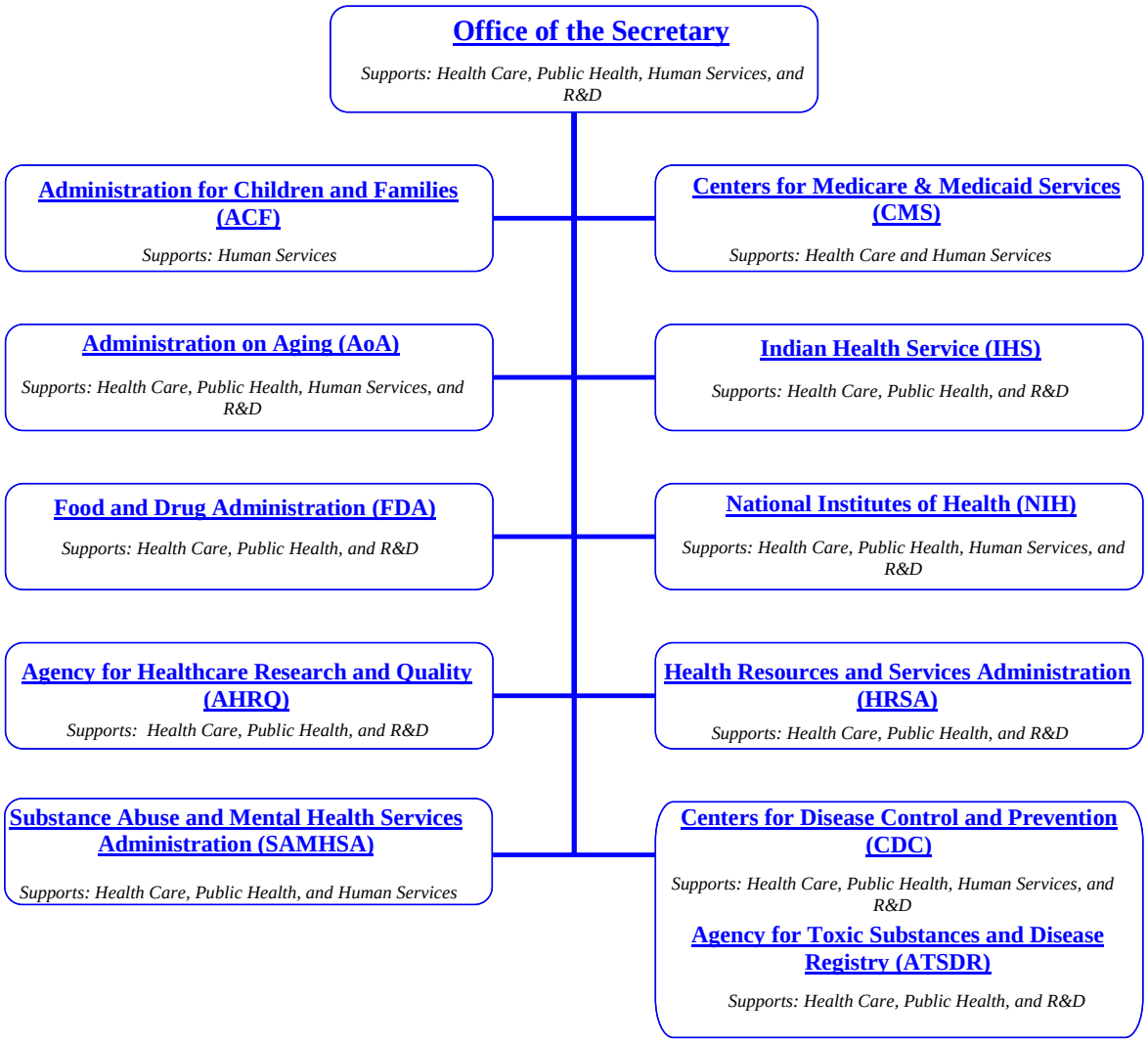
HHS Organization Chart and Agencies by Goal

Mission

The mission of the Department of Health and Human Services is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences, underlying medicine, public health, and social services.

With the Secretary's leadership, direction, and policy and management guidance, the Department carries out its mission through the eleven Operating Divisions and sixteen Staff Divisions. HHS is in the process of updating its Strategic Plan to reflect the priorities of the Obama Administration. This document reports on past performance and is structured by the previous HHS Strategic Plan. The following chart shows both the Department structure and how these Operating Divisions support the four goals in the previous HHS Strategic Plan:

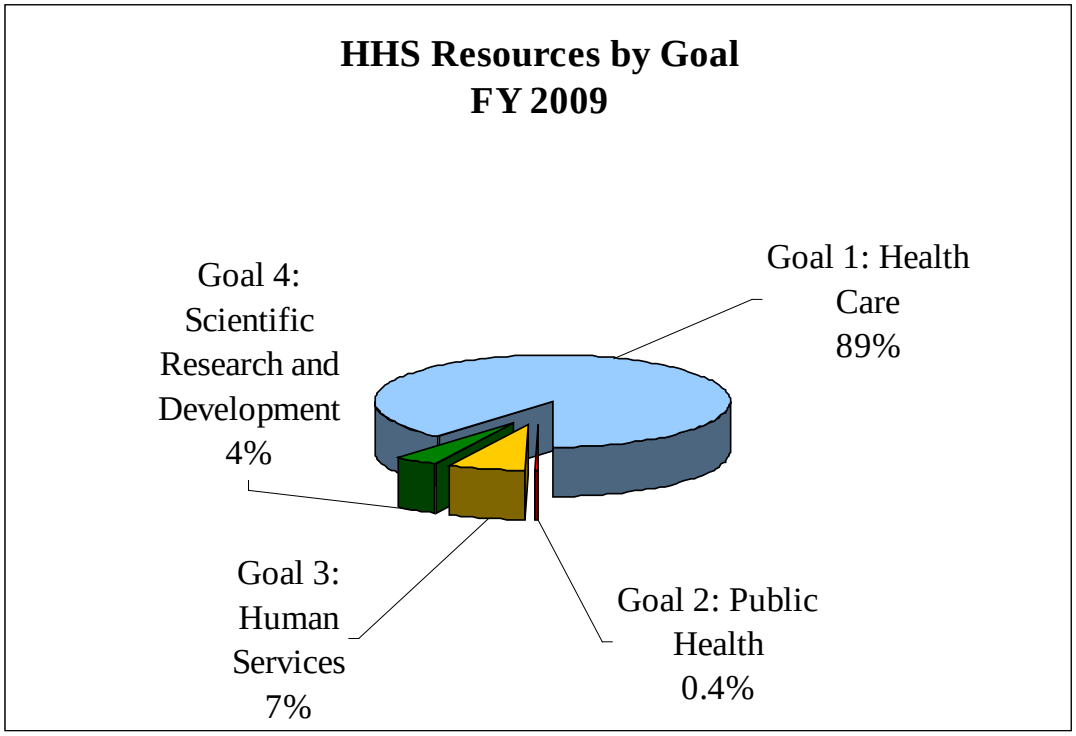
- **Goal One**: Health Care
- **Goal Two**: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness ("Public Health")
- **Goal Three**: Human Services
- **Goal Four**: Scientific Research and Development ("R&D")



HHS Resources by Goal

As a responsible steward of taxpayer dollars, HHS deploys its resources to ensure consistency with the President's goals and invests in health care, disease prevention, social services, and scientific research. These investments will improve the lives of children, families, and seniors by creating a healthy foundation for everyone to fully participate in the American community.

The following chart shows the approximate deployment of HHS resources by goal for FY 2009. HHS Budget Authority for FY 2009 was $834.5 billion, which includes $55.1 billion for the Recovery Act. Additional information on the HHS Budget is available at http://www.hhs.gov/budget.



Overview of Performance

Through its eleven Operating Divisions and sixteen Staff Divisions, HHS implements over 300 programs affecting the health, safety, and welfare of every American. Detailed information about each HHS program and their associated performance measures can be found at: http://www.hhs.gov/budget.

A sampling of HHS performance measures, along with related successes and challenges, is discussed in this document to showcase the breadth of HHS activities. These measures were selected because they represent some of the major contributors to the Department's goals. For more information about any of the programs covered in this document, please see the respective HHS agency website link available at www.hhs.gov/about/index.html.

Success Story: Head Start

Isabel, a Head Start home visitor with Western Community Action in Minnesota, began conducting home visits with a local family. She immediately saw that their 4-year-old girl had serious medical needs that were present at birth but that the family had no resources to address. Isabel worked with the family to have the child seen by a local physician and evaluated for speech services. The child also received needed dental and eye exams. A local optometrist donated eyeglasses and a dentist has agreed to provide ongoing dental care. With help from Head Start, the family completed the paperwork for emergency coverage for the child. The program's health coordinator contacted Shriner's Hospitals about the little girl's situation and her need for surgery. The school and local doctors are continuing to work together to support the family and obtain the necessary care.

The success of HHS programs is gauged through the hundreds of performance measures that the Department tracks. Additional information on HHS performance measures is included in the Online Performance Appendices (available at: http://www.hhs.gov/budget). While this document reports on FY 2009 performance, HHS does not yet have 2009 data for some programs' measures due to data lag. HHS is often challenged with data lag associated with its measures since many programs operate through grants that are directly managed by various organizations and State governments.

The following table shows HHS overall progress in meeting its 1,025 performance measures through 2009. Data for FY 2009 are currently available for 56 percent of HHS performance measures. Out of the 575 targets reported in FY 2009, 82 percent met or exceeded their targets. The continued ability of HHS to meet a large percentage of its targets is notable, considering the size and scope of the Department.

In the pages that follow, HHS has provided the most recent data available for each sample measure, including its targets and results. Some measures are newly developed and may lack established baselines or annual targets. HHS seeks to provide as much information as available to the public and in some instances, provides historical data for newly established measures in order to place these results in context. Where appropriate, an explanation is provided for the missing data and/or targets.

Summary of Performance Targets and Results

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2006	795	781	98%	605	77%
2007	969	931	96%	704	76%
2008	1,049	928	88%	714	77%
2009	1,025	575	56%	469	82%

Goal One: Health Care

Improve the safety, quality, affordability, and accessibility of health care including behavioral health care and long-term care.

The four broad objectives under this goal are:

- Objective 1.1: Broaden health insurance and long-term care coverage;
- Objective 1.2: Increase health care services availability and accessibility;
- Objective 1.3: Improve health care quality, safety, cost, and value; and
- Objective 1.4: Recruit, develop, and retain a competent health care workforce.

Today, disease, illness, and disability can be as much of a threat to Americans' financial well-being as they are to Americans' physical and mental well-being. Medicaid and Medicare spending on health care in America is projected to increase from roughly five percent of Gross Domestic Product (GDP) today to almost 10 percent by 2035.[1] This increase is expected because of the rising health care costs per person as well as the aging of the population.

HHS strives to ensure health care for Americans is available, affordable, portable, transparent, and efficient. HHS efforts include providing consumers with the knowledge they need to make informed choices about their health care spending as well as promoting greater use of health information technology. Improving quality, constraining costs, and providing greater access remain key priorities. HHS is working to increase the rate at which patients receive recommended services and to reduce improper payments, fraud, waste and abuse. The Department is also focusing on eliminating preventable medical errors.

The increasing burden of health spending on the U.S. economy is unsustainable. Higher spending on public programs such as Medicare and Medicaid strain Federal and State budgets. Higher insurance premiums burden workers with higher health costs and pose a challenge to employers. Additionally, 46 million Americans do not have health insurance.[2] These individuals may face barriers to obtaining timely and continuous care. Because of their limited access to the system, their health problems may become more severe.

HHS Goal One addresses the need for people to be able to obtain and maintain affordable health care coverage; receive efficient, high-quality health care services; and access appropriate information for informed choices.

Success Story: Decreasing Physical Restraints in Nursing Homes

With a great deal of Medicare and Medicaid benefit dollars paying for care in nursing homes, CMS measures nursing home quality to protect vulnerable individuals and be good stewards of taxpayer dollars. CMS wants nursing homes to reduce the prevalence of physical restraints because residents who are restrained may suffer from ailments such as incontinence and pressure ulcers. Through intensive education and collaboration with other health organizations, CMS has made exceptional progress and reduced the prevalence of restraints in nursing homes from 17.2 percent in 1996 to 4.0 percent in 2008. CMS will continue to employ energetic interventions to reduce the use of restraints in nursing homes and improve residents' quality of life.

[1] Congressional Budget Office. (2009). The Long-Term Budget Outlook (Summary) Available at http://www.cbo.gov/ftpdocs/102xx/doc10297/SummaryforWeb_LTBO.pdf

[2] United States Census Bureau, Current Population Reports (2009). Income, Poverty, and Health Insurance Coverage in the United States: 2008." Available at http://www.census.gov/prod/2009pubs/p60-236.pdf

The following table shows HHS progress in meeting targets for Goal One in the previous HHS Strategic Plan.

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2006	7	7	100%	6	86%
2007	9	9	100%	7	78%
2008	11	10	91%	7	70%
2009	11	6	55%	4	67%

As part of the Administration's efforts to build a high-performing government, HHS has developed a limited set of High Priority Performance Goals that address key HHS priorities. These goals are included in the Department's FY 2011 Budget and performance plan and will be of particular focus over the next two years:

- ***Medicaid and Children's Health Insurance Program***: HHS will broaden availability and accessibility of health insurance coverage through implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) legislation, by increasing CHIP enrollment by +7 percent over the FY 2008 baseline by the end of FY 2011 (from 7,368,479 children to 7,884,273 children).

  Of the estimated eight million uninsured children in the United States, five million are likely to be eligible for Medicaid or CHIP coverage but not enrolled.[3] CHIP is a State and Federal partnership that provides low-cost health insurance coverage for children in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. CHIP was the largest single expansion of health insurance coverage for children in more than 30 years and has improved access to health care and quality of life for millions of vulnerable children under 19 years of age. Under title XXI, States have the option to expand Medicaid (title XIX) coverage, set up a separate CHIP program, or have a combination of Medicaid expansion and separate CHIP programs. CHIP was reauthorized in 2009 through September 30, 2013, with increased funding to maintain State programs and to cover more uninsured children.

- ***Primary Care***: By the end of FY 2011, increase access to primary health care by increasing the Field Strength of the National Health Service Corps (NHSC) to 8,561[4] primary care providers, an increase over the FY 2008 field strength of 3,601.

  Primary care is an important cornerstone to high-quality and cost-effective health care. Yet, primary care is not readily accessible to all Americans as millions face barriers to quality primary health care because of their income, lack of insurance, geographic isolation, or language and cultural barriers. The National Health Service Corps (NHSC) plays a key role in the safety net for persons who would otherwise lack access to this essential level of care by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities.

- ***Health Information Technology (IT)***: By the end of FY 2011, HHS will establish the infrastructure necessary to encourage the adoption and meaningful use of Health Information Technology, by:
  - Establishing a network of 70 Regional Extension Centers by the end of FY 2010.
  - Registering 30,000 providers to receive services from Regional Extension Centers by end of FY 2010.
  - Registering 100,000 providers to receive services from Regional Extension Centers by end of FY 2011.

[3] The Urban Institute (Updated 12/14/09). "Progress Enrolling Children in Medicaid/CHIP: Who is Left and What are the Prospects for Covering More Children?" (Available at http://www.urban.org/health_policy/url.cfm?ID=411981).

[4] The target of 8,561 assumes the FY 2010 Appropriation figure of $100.797 million for the National Health Service Corps Recruitment line and the FY 2011 President's Budget Request of $122.588 million. If the Congress were to provide less funding in FY 2011, the target would need to be adjusted accordingly.

- Achieving 20% adoption of EHRs among providers working with Regional Extension Centers by end of FY 2011.

One of the main barriers to improving health care quality and reducing overall expenditures stems from the need for real time access to patient data to allow physicians to make better informed decisions. Electronic health records (EHRs) and shared health care information will allow providers to make decisions based on a complete picture of a patient's health. This will reduce the likelihood for medical errors or duplicate tests while providing better overall quality and outcomes for the patient.

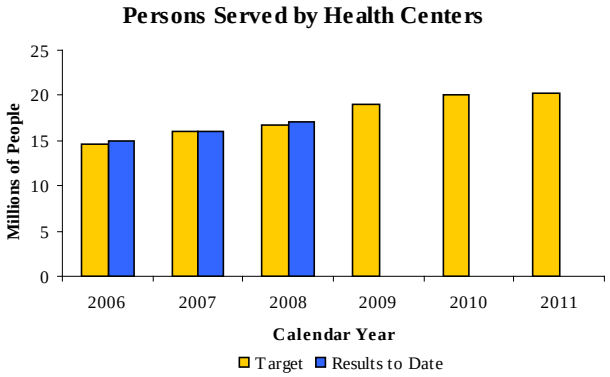
Additional information on the High Priority Performance Goals is available in the Analytical Perspectives volume of the FY 2011 Budget.

Health Care Measures

The following is a sample of measures used by HHS to monitor progress for Health Care.

Measure: Increase the number of patients served by Health Centers.

Performance: The Health Resources and Services Administration's (HRSA) Health Center Program provides grants to community-based organizations to deliver comprehensive, high quality, and cost-effective primary health care to populations in urban and rural areas that lack access to care. These populations include the poor, uninsured, and homeless; minorities; migrant and seasonal farm workers; public housing residents; and people with limited English proficiency.



Since 2002, the number of patients served by Health Centers has increased an average of more than 960,000 per year. This growth was fueled significantly by designated funding increases to support new and expanded Health Center sites. In 2008, 61 new or expanded sites were supported and Health Centers served 17.1 million patients, exceeding the target of 16.75 million and up from 16.1 million in 2007. Additionally, it is estimated that Health Centers will have served 18.95 million patients in 2009 and will serve 20.15 million in 2010. These increases reflect the projected impact of American Recovery and Reinvestment Act of 2009 (Recovery Act) funding for new sites and service areas, and increased demand for services at existing sites. In 2009, 180 new or expanded sites were supported.

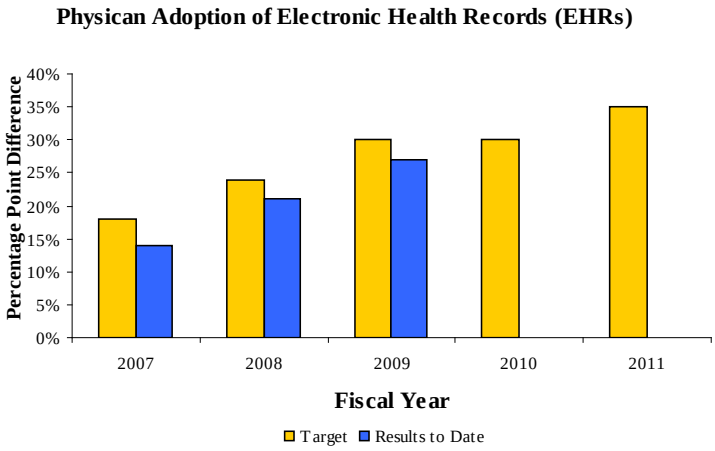
The growth in the number of patients served by Health Centers is also dependent upon the rate of maturation of newly established sites, the efficiency of operations of all centers, policies of the Medicaid program and other State programs that support care to the uninsured, and public awareness of the availability of Health Center services. By providing technical assistance to health center sites on building their organizations, achieving efficiency of operations, improving quality of care, and conducting outreach to the public, the Health Center Program is able to address some of these challenges and contribute to the growth in the number of communities and individuals with access to essential primary and preventive health care.

This measure supports HHS objective 1.2: Increase health care services availability and accessibility.

Data Source: HRSA's Bureau of Primary Health Care Uniform Data System.

Measure: Increase physician adoption of Electronic Health Records (EHR).

Performance: The Office of the National Coordinator for Health Information Technology (ONC) is responsible for supporting and reporting on the adoption of health information technology (HIT) across the United States.



The Recovery Act requires that ONC develop a number of programs that support and increase the adoption and widespread use of HIT, a critical component in improving the quality, safety, cost and value of health care offered to more than 300 million Americans. To further the ability of HIT to improve the quality and efficiency of services, the Recovery Act directed HHS to develop an incentive program for providers who become "meaningful users" of HIT. This definition is to be established by rule making in FY 2010. HHS also established several grant programs to make technical assistance available to providers, support the development of a Health IT workforce, and provide grants to States in support of the electronic exchange of health information.

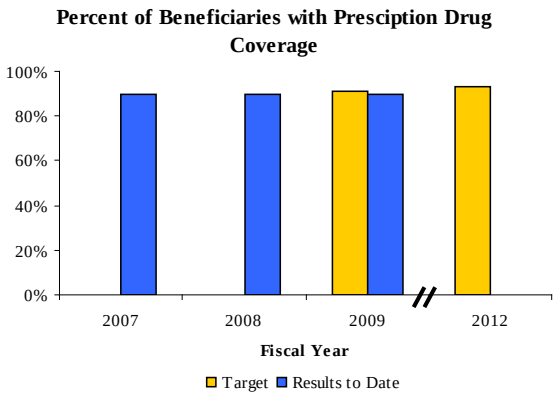
ONC tracks physician adoption of EHRs. Data from FY 2005 established the baseline that 10 percent of physicians had adopted EHRs. Data show that 21 percent of physicians adopted EHRs in FY 2008, an increase from 17 percent in FY 2007. By FY 2010, ONC expects that the physician adoption rate of EHRs will increase to 30 percent. Actions of other HHS entities that collaborate with ONC could affect the physician adoption rate. For instance, the CMS incentive program for meaningful use of EHRs is likely to contribute to a higher level of adoption among Medicare and Medicaid providers. ONC also works with the Centers for Disease Control and Prevention (CDC) and the Department of Education to support a new grant program that will train a workforce in HIT. A large scale pilot announced in December 2009 called "Beacon Communities Pilot Project" is expected to have an impact on adoption with collaboration among ONC and multiple federal partners.

ONC must address the programmatic and management challenges of many barriers that physicians confront in transitioning from paper to EHRs. ONC coordinates with its Federal partners to address these challenges. For instance, ONC and its Federal partners worked to eliminate legal barriers posed by Stark and anti-kickback laws that prevent hospitals from financially contributing towards a physician's purchase of certified EHRs. In addition, ONC is ensuring that certification of HIT products includes the criteria necessary for state of the art interoperability to encourage physicians to buy certified EHR products. ONC is also working with malpractice insurers to potentially lower malpractice insurance premiums for physicians who have adopted certified EHRs.

This measure supports HHS objective 1.3: Improve health care quality, safety, cost, and value.

Data Source: CDC's National Ambulatory Medical Care Survey.

Measure: Implement the Medicare Prescription Drug Benefit – Increase the percentage of Medicare beneficiaries with prescription drug coverage from Part D or other sources.



Performance: Medicare finances health insurance for eligible elderly and disabled individuals. As of January 1, 2006, the Medicare benefit includes outpatient prescription drug coverage (Part D). Following the introduction of the Medicare Part D program in 2006, approximately 90 percent of Medicare beneficiaries had prescription drug coverage from Part D or other sources. Given the initial success of the program, enrollment rate improvements are likely to slow down somewhat because remaining non-enrollees are those who are very hard to reach or who have made a choice not to enroll.

The Centers for Medicare & Medicaid Services (CMS) continues to take steps to educate, inform, and protect beneficiaries. Such steps include: making information available at www.medicare.gov, where beneficiaries can review and compare all of the health and prescription plans available in their area; and ensuring that people who do not have computer access can get the same information 24 hours a day, 7 days a week at 1-800-MEDICARE or by reviewing the information that was included in the Medicare & You handbook that is mailed each Fall. The actual FY 2008 performance (reflecting CY 2007 enrollment) was approximately 90 percent. CMS set the FY 2009 target at 91 percent; however, the FY 2009 enrollment rate remained at 90 percent. Given the high rates of enrollment, it is becoming increasingly challenging to increase the enrollment rates further.

This measure supports HHS objective 1.1: Broaden health insurance and long-term care coverage.

Data Source: CMS's Management Information Integrated Repository; updates from other external data sources.

Goal Two: Public Health Promotion and Protection, 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.

The four broad objectives under this goal are:

- Objective 2.1: Prevent the spread of infectious diseases;
- Objective 2.2: Protect the public against injuries and environmental threats;
- Objective 2.3: Promote and encourage preventive health care, including mental health, lifelong health behaviors, and recovery; and
- Objective 2.4: Prepare for and respond to natural and man-made disasters.

Throughout the 20th century, advances in public health and medicine resulted in reduced mortality and morbidity from infectious diseases. Chronic diseases, such as heart disease, stroke, cancer, and diabetes replaced infectious diseases as the major cause of illness and death in the United States in the latter part of the 20th century. Infectious diseases have reemerged as a priority for public health in the United States. For example, risky behaviors such as unprotected sex and injection drug use continue to result in new HIV/AIDS infections. The proportion of persons with HIV infections diagnosed before progression to AIDS increased from 78.1 percent in 2002 to 82.2 percent in 2007. The percentage of individuals who report having used an illicit drug within the previous 30 days remained at 8 percent in 2008, same as in 2007.

Foodborne diseases cause an estimated 76 million illnesses; 325,000 hospitalizations; and 5,000 deaths in the United States each year. Responding to the President's directive to upgrade the nation's food safety system, the White House Food Safety Working Group, led by Agriculture Secretary Vilsack and HHS Secretary Sebelius, launched a Web site, www.foodsafetyworkinggroup.gov. This site will be an important resource for people who want to stay apprised of the Group's progress, learn about food safety goals and practices, and share views on improving the food safety system. A cross-government consumer website (www.foodsafety.com) has been established as well.

Vaccinations protect individuals, and through herd immunity, vaccinations also protect communities. Ninety percent coverage for early childhood immunizations was met in FY 2008 for most vaccines with the exception of the fourth dose of pneumococcal conjugate vaccine and diphtheria, tetanus toxoids, and acellular Pertussis vaccine. Public health emergencies have become a significant focus for public health at the Federal, State and local levels.

The Strategic National Stockpile (SNS) permits HHS to respond to mass trauma events by delivering medical supplies to any point in the United States within 12 hours. At the end of FY 2009, 100 percent of the States and directly-funded cities demonstrated preparedness to use SNS assets, exceeding the 90 percent target. The primary challenge for this program continues to be recruitment, and training of staff and volunteers to execute a mass prevention plan due to the number of competing priorities and initiatives at the State and local level.

Success Story: Delivering Life-Saving Treatment

The Strategic National Stockpile (SNS) contains medicines and materiel to support State and local public health departments in response to natural and man-made disasters, such as biological outbreaks or chemical exposures. In each case, a subject matter expert at the Centers for Disease Control and Prevention (CDC) carefully reviews the request (for medicines and materiel) and receives release authority from CDC leadership; SNS officials then swiftly deliver the product through contracted aircraft or an expedited delivery system. As a result of this timely intervention, the CDC has delivered life-saving treatment to numerous individuals nationwide, including service members who were suffering severe reactions to smallpox vaccination and patients in Connecticut and Nebraska who were exposed to botulinum toxin.

The following table shows HHS progress in meeting targets for Goal Two in the previous HHS Strategic Plan.

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2006	19	19	100%	8	42%
2007	21	19	90%	10	53%
2008	18	14	78%	10	71%
2009	18	6	33%	4	67%

As part of the Administration's efforts to build a high-performing government, HHS has developed a limited set of High Priority Performance Goals that address key HHS priorities. These goals are included in the Department's FY 2011 Budget and performance plan and will be of particular focus over the next two years:

- ***Food Safety***: By the end of 2011, HHS will decrease by 10% from the 2005-2007 average baseline, all of the following: the rate of sporadic *Salmonella Enteritidis* (SE) illnesses in the population; the number of SE outbreaks; and, the number of SE cases associated with outbreaks.[5]

  Salmonella is a leading cause of foodborne illness in the United States. Over a million illnesses are attributed to *Salmonella*. *Salmonella Enteritidis* (SE) is the second most common type of *Salmonella* in the United States and accounts for approximately 17 percent of all *Salmonella* cases in humans. On July 9, 2009, the FDA published a final rule, "Prevention of *Salmonella Enteritidis* in Shell Eggs During Production, Storage and Transportation" (egg rule), that is expected to reduce SE-associated illnesses and deaths by reducing the risk that shell eggs are contaminated with SE.

- ***Tobacco - Policy and Environments***: By the end of 2011, HHS will increase to 75%[6] the percentage of communities funded under the Communities Putting Prevention to Work (CPPW) program that have enacted new smoke-free policies and improved the comprehensiveness of existing policies.

  For several decades, smoking has been the leading preventable cause of death in the United States. Each year, an estimated 443,000 Americans die from smoking. CDC's Communities Putting Prevention to Work (CPPW) program (funded through the American Recovery and Reinvestment Act of 2009) is one of several efforts within HHS to combat smoking and tobacco use. CPPW will support communities and States to take action to address tobacco use, among other things. Communities and States will address these issues through a package of evidence-based strategies aimed at creating a supportive policy, systems, and environments that will drive changes in tobacco use. Chief among these strategies is implementation and enhancement of comprehensive tobacco bans in communities.

- ***Emergency Preparedness - Incident Command Structure***: By 2011, HHS will increase the percentage of State public health agencies that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners to 96 percent. (CDC, 2007 Baseline: 84 percent).

  A priority for HHS is increasing the Nation's preparedness for a public health disaster. Despite significant progress in improving readiness, challenges and opportunities remain. There is a need to continue to develop preparedness capabilities, sustain improvements in systems and infrastructure, and ensure community resiliency. Considerable gains have been made in ensuring all partners in the public health system are able to implement an incident command system to respond to emergencies; however, some jurisdictions have yet to establish this capability. Similarly, not all public health agencies yet take corrective actions or implement after action findings following an exercise or actual response to an emergency to ensure the appropriate decision making personnel are quickly available to respond to an event.

Additional information on the High Priority Performance Goals is available in the Analytical Perspectives volume of the FY 2011 Budget.

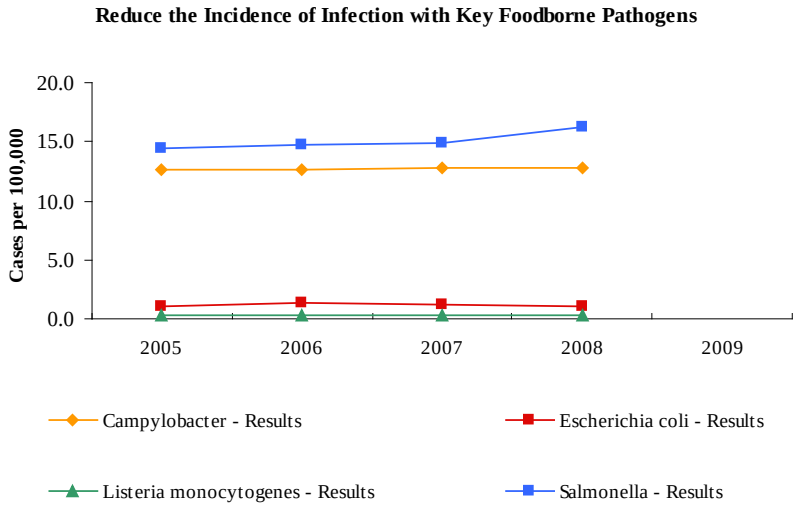
[5] Targets will be reevaluated after actual data is provided for 2009.
[6] This target may be adjusted once the actual CCPW-funded communities have been selected in February 2010.

Public Health Measures

The following is a sample of measures used by HHS to monitor progress for Public Health.

Measure: Reduce the incidence of infection with key foodborne pathogens.

Performance: Federal, Tribal, and State partners have used research, inspections, surveillance, regulation and guidance, standardization and education as strategies to improve food safety. Foodborne illness surveillance information is used to determine what additional food safety strategies are needed and to measure the effectiveness of interventions over time. Incidence of illnesses caused by *Campylobacte*r species, Shiga toxin-producing *Escherichia coli* O157, and *Listeria monocytogenes* decreased significantly between 1997 and 2004, approaching the 50 percent reduction targets. However, the incidence data have not changed significantly between 2005 and 2008, the most recent years for which data are available, and there is concern that some of the original 10-year targets from Healthy People 2010 may not be met, especially with regard to *Salmonella*.



Further investigation is needed to identify sources for emerging *Salmonella* serotypes, since the rate of infection has increased in the past decade. FDA also needs to work closely with CDC and the Food Safety and Inspection Service to develop a more coherent and robust approach to attribute illnesses to FDA-regulated products.

The Nation's challenges to food protection are increasing as consumers buy food from around the globe. FDA features a science and risk-based approach of prevention, intervention, and response to ensure the safety of domestic as well as imported foods. FDA is also playing a key role in the White House Food Safety Working Group, which is working to implement the framework for protecting our nation's food supply.

This measure supports HHS objective 2.1: Prevent the spread of infectious diseases.

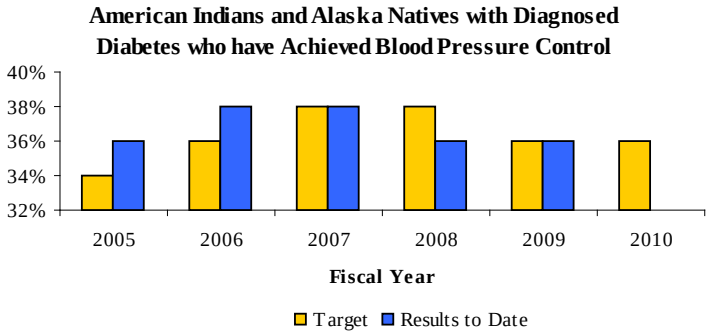
Data Source: CDC's FoodNet and FDA's Healthy People 2010 Food Safety Progress Review.

Measure: Reduce complications of diabetes by increasing the proportion of American Indian/Alaska Native patients with diagnosed diabetes that have achieved blood pressure control (<130/80).

Performance: The mission of the Indian Health Service (IHS) Division of Diabetes Treatment and Prevention Program is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indians and Alaska Natives (AI/AN).

The program met the FY 2009 target of maintaining 36 percent of patients with diabetes demonstrating blood pressure (BP) control for the Diabetes Audit. The program met its annual targets for this measure from

FY 2005 through 2007 but did not meet the target for FY 2008. This measure is designated as high priority by inclusion in the Director's Performance Contract and requires monitoring, frequent visits, and patient compliance in order to achieve an appropriate level of BP control. Patient education and coordination of care continue to be critical strategies to meet targets. Additionally, IHS's new software for integrated case management is used to monitor individualized clinical care.



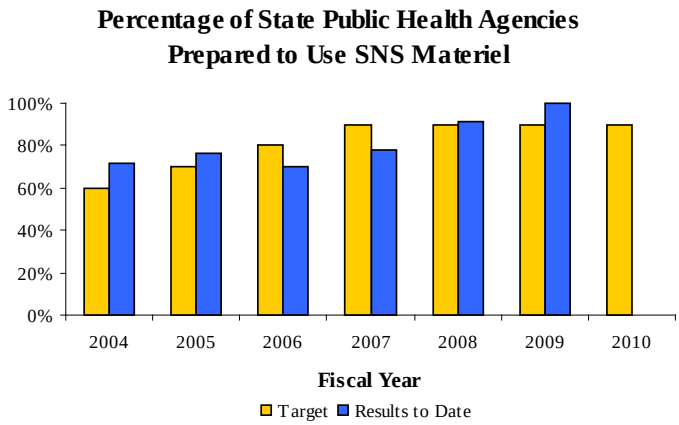
Because this measure is a rate-based treatment measure, meeting targets is a constant challenge. Since 2005, the actual number of AI/AN with diagnosed diabetes has increased by 16,955 people. Although the proportion of people with controlled BP has not increased, 5,604 more AI/AN people with diabetes have achieved BP control. The Division of Diabetes Treatment and Prevention Program faces many challenges in ensuring that patients have achieved BP control, which generally results from blood pressure lowering medications, increased medical visits, and healthy lifestyle practices. Large clinical trials have shown that blood pressure control among diabetics may be more difficult to achieve and can often require 3-5 medications. With the cost of pharmaceuticals increasing each year, many AI/AN patients are unable to achieve the full benefit of BP control.

This measure supports HHS objective 2.3: Promote and encourage preventive health care, including mental health, lifelong health behaviors, and recovery.

Data Source: IHS's Annual Diabetes Care and Outcomes Audit.

Measure: Percentage of State public health agencies prepared to use materiel contained in the Strategic National Stockpile (SNS).

Performance: The Strategic National Stockpile (SNS) is a national repository of life saving pharmaceuticals, medical material, and equipment. The SNS permits HHS to respond to mass trauma events by delivering medical supplies to any point in the United States within 12 hours. In FY 2009, 100 percent (54/54) of the States and directly-funded cities demonstrated preparedness to use SNS assets, a significant achievement accomplished in the partnership between the Centers for Disease Control and Prevention (CDC) and project areas. During FY 2008, 91 percent had demonstrated SNS preparedness, exceeding the 90 percent target for that year. In previous fiscal years, the results of the CDC's assessment of SNS preparedness exceeded performance targets.



During FY 2006, the SNS program revised the standards used annually to assess SNS preparedness, and in FY 2007, the program began conducting more rigorous assessments. These efforts were intended to increase grantee preparedness to effectively manage and use deployed SNS materiel. Enhanced assessments, planning efforts, technical assistance, training, and requirements to demonstrate capability through exercises has contributed to the 100 percent preparedness status today and will continue to help sustain performance during a public health emergency. The recent

2009-H1N1 influenza response validated the preparedness levels of project areas, as each successfully received the 25 percent allocation of SNS pandemic influenza antivirals and personal protective equipment released in the spring of 2009.

The primary challenges for this program continue to be recruitment, recent directed furloughs of public health and other key emergency personnel, and training of staff and volunteers to execute a mass prophylaxis plan due to the number of competing priorities and initiatives at the State and local level. Improved coordination between State and local agencies responsible for disaster preparedness is a continuing challenge.

Although more stringent standards and additional challenges may cause grantee status to fluctuate, the SNS program remains committed to the long-term sustainment of 100 percent of States and directly-funded cities that are prepared to use SNS materiel and the incremental targets to improve preparedness. Appropriated funds allow the SNS program to finance the procurement of critical pharmaceuticals and vaccines needed to protect Americans from threat agents and support the capacity to deliver drugs, vaccines, and supplies anywhere in the Nation within 12 hours. CDC will continue to evaluate the preparedness planning efforts of State and local public health agencies through exercises and reviews of SNS distribution plans.

CDC, in collaboration with the National Association of County and City Health Officials and the Association of State and Territorial Health Officials continues to collect, review, and share State and locally developed tools, templates, processes, plans, and other resources deemed as worthy of promoting as a national best practice. CDC continues to explore partnerships and research alternatives to dispensing medicine such as the Closed Point of Dispensing concept introduced earlier this year. To assist with testing and validating State and local SNS plans, modeling and simulation projects have been made available. Technical assistance and other resources for SNS preparedness include listservs, satellite web casts, extranet site, SNS sponsored training courses and the placement of eight staff in the field.

This measure supports HHS objective 2.4: Prepare for and respond to natural and man-made disasters.

Data Source: CDC's evaluation of standard functions using SNS Assessment Tools.

Goal Three: Human Services

Promote the economic and social well-being of individuals, families, and communities.

The four broad objectives under this goal are:

- Objective 3.1: Promote the economic independence and social well-being of individuals and families across the lifespan;
- Objective 3.2: Protect the safety and foster the well-being of children and youth;
- Objective 3.3: Encourage the development of strong, healthy, and supportive communities; and
- Objective 3.4: Address the needs, strengths, and abilities of vulnerable populations.

Success Story: Unaccompanied Refugee Minors (URM)

ACF's Office of Refugee Resettlement (ORR) administers the URM program, which helps young refugees develop appropriate skills to enter adulthood and achieve success in the United States. Since the Office of Refugee Resettlement's inception in 1980, almost 13,000 minors have entered the URM program, including Lopez Lomong, one of the "Lost Boys" from the Sudan. Lopez made the 2008 U.S. Olympic team for the men's 1,500 meter event and was chosen by his peers to carry the American flag during the opening ceremony. Lomong's athletic achievements in track and field mirror the personal victories he has experienced since resettling in the United States as a Sudanese refugee minor in 2001.

Since the mid-1990s, the employment rates of current and former welfare recipients have risen, and caseloads have diminished dramatically, with a sharp increase in employment rates and fall in caseloads occurring after enactment of the Temporary Assistance for Needy Families (TANF) program in 1996 and major improvements to the Child Support Enforcement program in 1997. Earnings for welfare recipients increased, as did earnings for female-headed households. Child support income also increased substantially for these households. Additionally, child poverty rates declined substantially between 1993 and 2000. Despite this success, employment has fallen and child poverty has risen in recent years. As a result, HHS still has much work to do in FY 2011 to promote the economic and social well-being of individuals, families and communities, especially given the current economic climate.

The needs of vulnerable children continue to be a priority for HHS. For example, HHS will be focusing on improving the quality of and increasing the access to early care and education programs for low-income children. These programs address the importance of early investments in young children as a means to improve children's outcomes and well-being and to also provide critical support for low-income families.

As the American population ages, enhanced efforts are needed to help the growing number of older persons remain active and healthy. The need for long-term care services will also increase, and availability of home and community based services will be increasingly important to help people maintain their independence and quality of life.

People with disabilities, refugees and other migrants, and other vulnerable populations also need assistance and protection to achieve and sustain economic independence and self-sufficiency, as well as social well-being.

The following table shows HHS progress in meeting targets for Goal Three in the previous HHS Strategic Plan.

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2006	16	15	94%	8	53%
2007	17	13	76%	7	54%
2008	18	7	39%	4	57%
2009	18	1	6%	1	100%

As part of the Administration's efforts to build a high-performing government, HHS has developed a limited set of High Priority Performance Goals that address key HHS priorities. These goals are included in the Department's FY 2011 Budget and performance plan and will be of particular focus over the next two years:

- ***Access to Early Care and Education Programs for Low-Income Children***: By the end of FY 2010, HHS will increase the number of low-income children receiving federal support for access to high quality early care and education settings including an additional 64,000 children in Head Start and Early Head Start and an average of 10,000 additional children per month through the Child Care and Development Fund (CCDF) over the number of children who were enrolled in FY 2008.

  Recognizing the importance of early investments in young children both to improve child outcomes and well-being and to provide critical support for families, HHS is committed to providing the support that our youngest children need to prepare for success later in school. HHS supports a seamless and comprehensive set of services and support for children, from birth through age five.

- ***Quality in Early Care and Education Programs for Low-Income Children***: HHS will take actions in FY 2010 and FY 2011 to strengthen the quality of early childhood programs by advancing recompetition, implementing improved performance standards and improving training and technical assistance systems in Head Start; promoting community efforts to integrate early childhood services; and by expanding the number of States with Quality Rating and Improvement Systems that meet high quality benchmarks for Child Care and other early childhood programs developed by HHS in coordination with the Department of Education.

  One of the most critical times to influence learning in a child's life is the period before he or she reaches kindergarten. Early investment in quality care and education programs for young children is essential, both to improve child outcomes and well-being and to provide critical support for families. HHS will coordinate with the Department of Education and others to address this key priority.

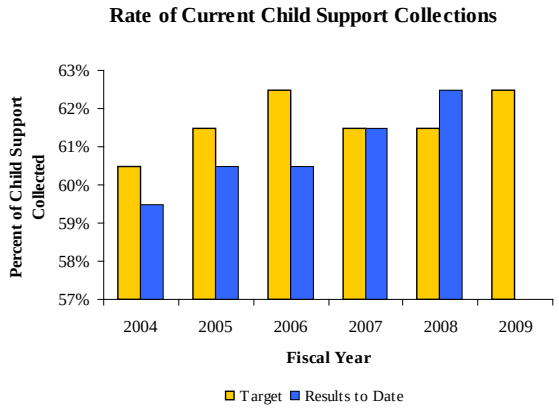
Additional information on the High Priority Performance Goals is available in the Analytical Perspectives volume of the FY 2011 Budget.

Human Services Measures

The following is a sample of measures used by HHS to monitor progress for Human Services.

Measure: Increase the child support collection rate for current support orders.

Performance: The Child Support Enforcement (CSE) program is a joint Federal, State, Tribal, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. Child support is an important resource for children that promotes their self-sufficiency, wellbeing, and health from birth through adulthood. Child support is one of the largest sources of income for poor families with children, and lifts a million people out of poverty every year. By securing reliable support payments from their non-custodial parents until children reach adulthood, the CSE program helps families avoid the need for public assistance.



The Office of Child Support Enforcement (OCSE) has made great strides in expanding the reach of the program through the addition of 36 comprehensive and nine start-up tribal child support programs in FY 2008, negotiations of an international treaty to coordinate enforcement efforts, and work with other stakeholders and partners. FY 2008 data show the total amount of distributed child support was $26.6 billion, of which over 90 percent went directly to families. This total was a seven percent increase over the previous fiscal year, and translates into a current child support collection rate of 62 percent, which exceeded the target (61 percent) for the first time in recent years.

Because child support collections depend upon on non-custodial parents' employment status and are directly related to program expenditures and staffing, the current economic climate is a challenge to program performance. OCSE expects that high rates of unemployment, in combination with program and staffing cutbacks made in 2008 and 2009, could potentially result in a decline in both the actual amount of dollars collected and in collection rates in FY 2009 and FY 2010. Further declines could potentially occur in FY 2010 and beyond when ARRA funding ends.

To overcome these challenges, OCSE will continue to focus on increasing efficiency of State programs through approaches such as automated systems of case management and enforcement techniques, improving collaboration with families and partner organizations, and building on evidence-based innovations. In addition, OCSE will continue to disseminate best practices from a national initiative launched in FY 2007 called PAID: Project to Avoid Increasing Delinquencies. This initiative emphasizes activities that increase current support collections and reduce arrearages, such as setting appropriate orders, employing early intervention, completing order review and modification; improving location and enforcement; and managing existing arrears.

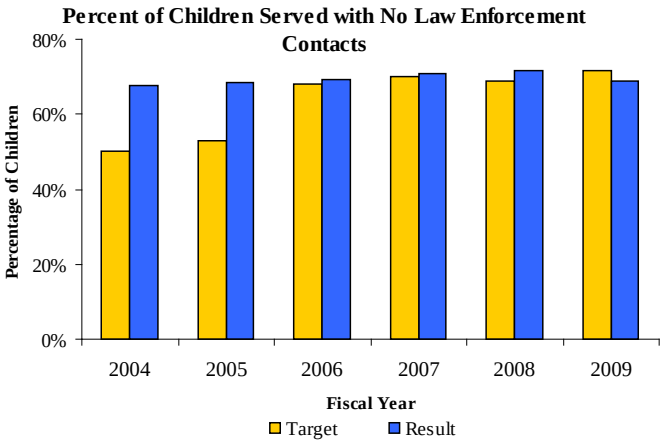
In the coming year, the CSE program will continue this important focus on activities that increase collections and prevent or decrease arrears. Federal technical assistance efforts will focus on efforts that address root causes of nonpayment of support such as establishing appropriate and realistic orders, quickly adjusting orders during unemployment, and intervening early upon nonpayment. The program will also target automation opportunities such as electronic income withholding orders, an employer web-based portal, and a model tribal system. In addition, the program will continue to work with communities and parents to improve child well-being, to align CSE with the broader goals of strengthening families and supporting responsible

fatherhood, and to stimulate economic recovery by providing income to parents caring for children, to help them purchase needed goods and services.

This measure supports HHS objective 3.1: Promote the economic independence and social well-being of individuals and families across the lifespan.

Data Source: ACF's OCSE Form 157

Measure: Increase the percentage of children receiving Children's Mental Health Services who have no interaction with law enforcement in the 6 months after they begin receiving services.



Performance: The Children's Mental Health Services program makes competitive grants to State and local governments to support community mental health services through the development of comprehensive, community-based systems of care for children and adolescents with serious emotional disorders and their families. Children receiving services through these grants experience improved behavioral outcomes, better school performance, and fewer disciplinary and law enforcement encounters.

Although the program did not meet its FY 2009 target (71.7 percent), the proportion of children with no interaction with law enforcement increased from 67.6 percent in FY 2004 to 68.9 percent in FY 2009, an indication of improved behavioral outcomes among program participants. Performance results for this measure are affected by the characteristics of grantees and the individual children served in a given year.

In pursuit of continued performance improvements, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides new grantees with "start up" technical assistance specifically designed to support grantee attainment of performance objectives; conducts site visits to review and give feedback to grantees about their performance; hosts grantee meetings focusing on specific themes related to achieving performance objectives; develops and distributes printed materials related to performance objectives; and connects grantees with specialists who have pertinent expertise.

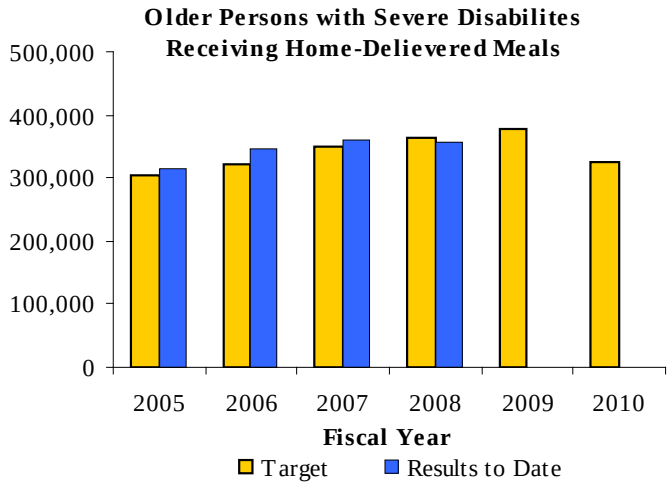
This measure supports HHS objective 3.2: Protect the safety and foster the well-being of children and youth.

Data Source: SAMHSA's Children's Mental Health Initiative.

Measure: Increase the number of older persons with severe disabilities who receive home-delivered meals.

Performance: The Administration on Aging's (AoA) State and Community-Based Services program provides home and community-based support to the elderly so that they may lead healthier and more independent lives. Individuals are considered severely disabled if they have three or more activities-of-daily-living (ADL) limitations, which is a level consistent with nursing home eligibility in most States. These limitations include activities related to personal care such as bathing or eating.

Until 2008, the results of this key performance indicator had trended upward for four years. In FY 2008, the Aging Services Network provided home-delivered meals to 349,934 seniors with severe disabilities of three



or more Activities of Daily Living. This is 4 percent below the 2008 target of 364,590, and a slight decline of 2 percent below the 2007 performance. The decline in performance between 2007 and 2008 is attributed to the current economic downturn.

The program faced several challenges in meeting its goal to annually increase the number of severely disabled clients who receive home-delivered meals, including the accelerating pace of food cost inflation and significant fuel cost increases for delivering meals. However, this indicator is still performing at a level 24 percent higher than the 2003 baseline. AoA is striving to address performance challenges by working closely with States and the Aging Services Network to develop management efficiencies and local community support that will enhance service provision and continue targeting those most in need.

This measure supports HHS objective 3.4: Address the needs, strengths, and abilities of vulnerable populations.

Data Source: AoA's National Aging Program Information System. Available at: http://www.data.aoa.gov/.

Goal Four: Scientific Research and Development

Advance scientific and biomedical research and development related to health and human services.

The four broad objectives under this goal are:

- Objective 4.1: Strengthen the pool of qualified health and behavioral science researchers;
- Objective 4.2: Increase basic scientific knowledge to improve human health and human development;
- Objective 4.3: Conduct and oversee applied research to improve health and well-being; and
- Objective 4.4: Communicate and transfer research results into clinical, public health, and human service practice.

People are living longer as a result of successes in preventing and treating acute and short-term conditions such as heart attacks, stroke, cancer, and many infectious diseases. Additionally, older adults are disproportionately affected by chronic disease and face increased costs for health care and long-term care. The Nation is in a continuous race against the health and economic consequences of disease and human suffering. Therefore, we must utilize research and development to its maximum capacity to transform health care, public health, and human service prevention efforts.

Success Story: Reducing Risks of GI Bleeding

Warfarin (also known as Coumadin®) is a widely prescribed medicine that can save lives by preventing blood clots. However, incorrect use or interaction with drugs and foods could result in serious and possibly life-threatening problems such as gastrointestinal (GI) bleeding. In response, the AHRQ funded the Arizona Center for Education and Research on Therapeutics (CERT) and developed educational tools targeting warfarin patients and prescribers and commissioned a panel of national educational experts to review and assure their quality. Available in English and Spanish, they have been used with the AHRQ booklet, "*Blood Thinner Pills: Your Guide to Using them Safely*," in Arizona CERT patient education interventions. Since 2005, AHRQ has measured a consistent drop in hospitalizations and costs for GI bleeding. Multiple AHRQ-funded initiatives, including CERT's educational efforts, have helped the health care delivery system to reduce the risks of GI bleeding.

Basic science is the foundation for improved health and human services. Once a basic discovery is made, the findings must be applied and translated into practice for health and human service improvement to result. This continuum from basic to applied research to practice is a significant emphasis of HHS scientific research and development enterprise. For example, genomic DNA sequencing has led the way to more powerful approaches to the comprehensive study of normal and disease-associated genetic variation in the human population, which can inform the diagnosis, prognosis, and treatment of diseases. The National Institutes of Health (NIH) conducts basic and applied research in genomic DNA sequencing and supports the development of new technologies and techniques, as well as improvements in sequencing efficiency. The NIH is committed to reducing the cost of genomic DNA sequencing and enabling more studies to be conducted.

Qualified researchers working with or for HHS are needed to make scientific advances. Although the scientific labor market is highly competitive, NIH strives to build and maintain a population of scientists that is well educated, highly trained, and dedicated to meeting the Nation's future health-related research needs primarily through its Extramural Research Training Program, and its Intramural Research efforts. NIH exceeded the training program's annual goals by initiating new research training and fellowship initiatives, and adopting policies to help support early career investigators.

The following table shows HHS progress in meeting targets for Goal Four in the previous HHS Strategic Plan.

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2006	7	7	100%	7	100%
2007	10	10	100%	9	90%
2008	9	9	100%	7	78%
2009	9	8	89%	8	100%

As part of the Administration's efforts to build a high-performing government, HHS has developed a limited set of High Priority Performance Goals that address key HHS priorities. These goals are included in the Department's FY 2011 Budget and performance plan and will be of particular focus over the next two years:

- ***Biomedical Research***: By 2011, HHS will reduce the fully-loaded cost of sequencing a human genome to $25,000.

  NIH conducts research to reduce the cost of genomic DNA sequencing which supports the use of advanced approaches in the comprehensive study of normal and disease-associated genetic variation in people. Research advances have enabled scientists to produce a reference sequence of the human genome (a map containing 99 percent of human genes), and to obtain the genomes of thousands of people to support genomic variation studies. Genomic DNA sequencing has become a core technology in contemporary biomedical research with many different applications. Sequencing the human genome would not have been possible without major reductions in the cost of DNA sequencing during the 1990s. In the 2000s, the continued decline in sequencing costs and the increased flexibility of next-generation technology have allowed many new uses for genomic sequencing in biomedical research. The National Institutes of Health (NIH) is committed to further reducing the cost of genomic DNA sequencing and enabling studies across the spectrum of human disease with the ability to identify important genomic variants underlying disease. This research may also support genome sequencing as a part of individual medical care to understand disease susceptibilities and to optimize treatment.

Additional information on the High Priority Performance Goals is available in the Analytical Perspectives volume of the FY 2011 Budget.

Scientific Research and Development Measures

The following is a sample of measures used by HHS to monitor progress for Scientific Research and Development.

Measure: Through the National Research Service Award Program, increase the probability that newly-trained scientists remain involved in NIH-funded research in the 10 years following their training: a) Postdoctoral fellows; and b) Predoctoral trainees and fellows.

Performance: The overall goal of the National Institute of Health (NIH) Extramural Research Training Program is to build and maintain a population of scientists that is well educated, highly trained, and dedicated to meeting the Nation's future health-related research needs. The extramural grant programs of NIH support a broad range of research education, training, and career development activities that utilize a variety of support mechanisms to meet NIH research training and career development goals.

NIH has routinely met the targets for this training program measure. The success of these efforts is due, in large measure, to NIH's efforts to continually adapt its research training programs to the evolving needs of medical research. By creating new research training and fellowship programs and adopting policies that

support early-stage investigators, NIH fosters competitiveness and prepares its trainees and fellows to initiate and maintain careers in biomedical research. The results demonstrate that those funded by NIH are better able to compete for funding and to stay active as researchers in the years following their training.

In 2009, NIH postdoctoral fellows were 14 percent more likely to remain active in biomedical research than non-NIH fellows; this exceeded the annual target of 12 percent. NIH predoctoral trainees and fellows were also 13 percent more likely to remain active than non-NIH trainees and fellows, exceeding the annual target of 12 percent. Over time, NIH postdoctoral and predoctoral fellows have consistently been approximately 13 percent more likely to remain active in biomedical research than non-NIH fellows.

This measure supports HHS objective 4.1: Strengthen the pool of qualified health and behavioral science researchers.

Data Source: NIH's IMPAC II database and the Doctorate Records File.

Measure: Conduct clinical trials to assess the efficacy of at least three new treatment strategies to reduce cardiovascular morbidity / mortality in patients with type 2 diabetes and/or chronic kidney disease.

Performance: NIH is addressing a significant public health problem by seeking to evaluate approaches for reducing cardiovascular disease (CVD) outcomes, such as heart attacks and strokes, in patients with type 2 diabetes and/or chronic kidney disease for whom premature CVD is the major cause of death. Application of the results of the trials, if favorable, would extend the lifespan and improve the quality of life for persons with type 2 diabetes or kidney disease.

The NIH has been successful in efforts to evaluate approaches to create treatment strategies to reduce CVD outcomes in patients with type 2 diabetes and chronic kidney disease for whom CVD is the major cause of death. The annual targets for this goal were derived from a set of major, multicenter, randomized clinical trials. The set of trials is unparalleled in scope and along with the intense research, could not be replicated by any other organizations. From 2006 to 2008, clinical trial data were collected to evaluate the CVD-prevention potential of using aggressive compared to conventional target levels for controlling blood glucose, blood pressure and blood lipid in patients with type 2 diabetes.

In February 2008, trial results indicated that intensive glycemia lowering with a multicomponent treatment regimen increases all-cause mortality in the participants, all of whom were at substantially elevated risk of a cardiovascular event due to existing disease or multiple risk factors, and had diabetes for an average of 10 years. Subsequently, study participants in the intensive glycemia treatment group were transitioned to the ACCORD standard glycemia treatment approach. In June 2008, the results of the glycemia component of the ACCORD study were published in the New England Journal of Medicine.

The 2009 target was met with each of the 77 clinical sites in the ACCORD trial transitioning participant care to personal physicians and establishing a follow-up strategy. The glycemia component of the trial was terminated early due to higher mortality in the intensive glycemia treatment group compared to mortality in the standard glycemia treatment group. The glycemia results were published in June 2008 (N Eng J Med 2008; 358:2545-59). Study treatment and follow-up for all ACCORD participants was completed by June 30, 2009. All participants are continuing to be followed in a non-treatment observational study for the next 5 years. The lipid and blood pressure results will be published in 2010.

This measure supports HHS objective 4.3: Conduct and oversee applied research to improve health and well-being.

Data Source: NIH's study data.

Measure: Reduce the financial cost (or burden) of upper gastrointestinal (GI) hospital admissions by implementing known research findings.

Performance: The Agency for Healthcare Research and Quality (AHRQ) manages the Effective Health Care Program, which supports the development of new scientific information through research on the outcomes of health care services and therapies by comparing different therapies for the same condition. From FY 2006 through FY 2009, the number of admissions for GI bleeding has generated an annual drop in per capita charges for GI bleeding and targets have consistently been met. In FY 2004, baseline rates were established ($96.54 per capita). In FY 2007, the target was a 4 percent drop ($92.68) and the actual result was a 4.9 percent drop ($91.81 per capita). In FY 2008, the target was a 5 percent drop ($91.71) and the actual result was a 9.8 percent drop ($87.10 per capita).

The most recent results from FY 2009 met and exceeded the target. In FY 2009, the target was a 6 percent drop ($90.75) and the actual result was a 13.2 percent drop ($83.81 per capita). This per capita cost surpasses the absolute target for per capita costs ($86.89) that was set for FY 2012. We do not know the reason for the unexpected steep percentage drop in per capita costs in FY 2008 and FY 2009, and cannot reliably predict that rate of decline will continue in the future. When we reevaluate performance of this measure in 2010, we will examine the additional year of data to assess whether the recent accelerated decline is continuing, has slowed, or has reversed in light of projected factors described below.

Although actual performance has exceeded the anticipated targets for the past two years, AHRQ does not consider these two recent years of data sufficient to predict future trends or to revise the anticipated targets upwards. AHRQ anticipates multiple uncertainties that may challenge its continuing to meet this performance measure. In addition to the external factors that may prevent health care professionals from implementing findings from AHRQ funded research, the recent economic downturn will likely inhibit people from using gastrointestinal protective agents due to the increasing number of unemployed workers who will be unable to afford prescription and over-the-counter proton pump inhibitors and H2 receptor blockers due to job or drug coverage loss and decreased disposable income.

In support of this measure, AHRQ has continued its efforts to educate the public about the safe use of blood thinner pills. In 2009, AHRQ updated and created a Spanish language version of a 24-page booklet, *Blood Thinner Pills: Your Guide to Using Them Safely*, which explains how these pills can help prevent dangerous blood clots from forming and what to expect when taking these pills. Additionally, AHRQ created a 10-minute video (in both English and Spanish), *Staying Active and Healthy with Blood Thinners*, featuring easy-to-understand explanation of how blood thinners work and why it's important to take them correctly. AHRQ is working to disseminate these patient education tools to consumers, hospitals, and other providers. Information on these products, is available at: http://www.ahrq.gov/consumer/btpills.htm#videos#videos

This measure supports HHS objective 4.4: Communicate and transfer research results into clinical, public health, and human service practice.

Data Source: AHRQ's Healthcare Cost and Utilization Project.

Analysis of Financial Statements and Stewardship of Information

For the eleventh consecutive year, HHS obtained an unqualified or "clean" audit opinion on its financial statements. The financial statements were prepared in accordance with Federal accounting standards and audited by the independent accounting firm of Ernst & Young LLP under the direction of the Department's Inspector General. The *Chief of Financial Officers Act of 1990* requires the preparation and audit of these statements, which are part of the Department's efforts for continuous improvement of financial management.

The production of accurate and reliable financial information is necessary for making sound decisions, assessing performance, and allocating resources. Section II of the HHS Annual Financial Report (AFR) presents the Department's audited financial statements and notes and is available at: http://www.hhs.gov/afr.

Financial Condition: The following table summarizes trend information concerning components of HHS financial condition—assets, liabilities, and net position. The Consolidated Balance Sheet presents a snapshot of HHS financial condition as of September 30, 2009, compared to FY 2008, and displays assets, liabilities, and net position.

Financial Condition (Dollars in Billions)	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	Increase (Decrease)	Percent Change
Total Assets	**$428.5**	**$513.9**	**$503.8**	**$529.3**	**$562.8**	**$33.5**	**6.3%**
Fund Balance with Treasury	$99.6	$159.9	$114.8	$124.3	$162.0	$37.7	30.3%
Investments, Net	$300.7	$342.0	$365.9	$385.4	$381.1	$(4.3)	(1.1)%
Other Assets	$28.2	$12.0	$23.1	$19.6	$19.7	$0.1	0.5%
Total Liabilities	**$71.0**	**$78.4**	**$81.9**	**$86.6**	**$94.4**	**$7.8**	**9.0%**
Accounts Payable	$1.1	$1.2	$1.0	$1.0	$1.1	$0.1	10.0%
Entitlement Benefits Due and Payable	$53.8	$61.2	$61.5	$65.9	$72.2	$6.3	9.6%
Accrued Grant Liabilities	$3.8	$3.8	$3.9	$3.9	$4.0	$0.1	2.6%
Federal Employee and Veterans Benefits	$7.2	$7.5	$8.4	$8.8	$9.7	$0.9	10.2%
Other Liabilities	$5.1	$4.7	$7.1	$7.0	$7.4	$0.4	5.7%
Net Position	**$357.5**	**$435.5**	**$421.9**	**$442.7**	**$468.4**	**$25.7**	**5.8%**
Total Liabilities and Net Position	**$428.5**	**$513.9**	**$503.8**	**$529.3**	**$562.8**	**$33.5**	**6.3%**

HHS assets were $562.8 billion at the end of FY 2009, an increase of $33.5 billion or 6.3 percent above the prior year's assets. This increase is largely attributable to the net effect of an increase of $37.7 billion in Fund Balance with Treasury and a decrease of $4.3 billion in Net Investments. The Fund Balance with Treasury increase of $37.7 billion resulted primarily from increases of $46.9 billion in various HHS appropriations offset by a decrease of $9.4 billion in Supplementary Medical Insurance (SMI). Of the $46.9 billion increases in various HHS appropriations, $31.7 billion related to the *Recovery Act*, $6.2 billion to CHIP, $6.0 billion to Public Health and Social Services Emergency Fund, and $2.5 billion to the Low Income Home Energy Program. The majority of the $4.3 billion decrease in Net Investments resulted from a decline of $9.3 billion in Health Insurance (HI) offset by increases in the Medicare SMI Trust Fund of $2.7 billion and CHIP Contingency Fund of $2.1 billion.

HHS liabilities were $94.4 billion at the end of FY 2009, an increase of $7.8 billion, or 9.0 percent above the prior year's liabilities. Entitlement benefits due and payable to the public from the Medicare and Medicaid insurance programs represent 76.5 percent of the liabilities. The $6.3 billion increase in FY 2009 entitlements includes an increase of $1.8 billion related to the Medicare program and an increase of $4.6 billion related to the Medicaid program. Of the $4.6 billion related to the Medicaid program, $3.2 billion related to *Recovery Act* increases.

HHS net position was $468.4 billion at the end of FY 2009, an increase of $25.7 billion or 5.8 percent from the previous year. Of the $468.4 billion, $340.3 billion was for earmarked funds and $128.1 billion was for all other funds. The increase of $25.7 billion was due to the net effect of an increase of $34.0 billion in unexpended appropriations offset by a decrease of $8.3 billion in cumulative results of operations. Further information on HHS financial condition is available at: http://www.hhs.gov/afr.

Net Cost of Operations: Another component of HHS financial picture is HHS Consolidated Statements of Net Cost. HHS net cost of operations represents the difference between the costs incurred by HHS programs less revenues. We receive the majority of HHS funding through Congressional appropriations and reimbursement for the provision of goods or services to other Federal agencies. HHS net cost of operations for the year ended September 30, 2009 totaled $803.9 billion. The majority of HHS FY 2009 net costs relate to Medicare ($430.0 billion) and Health ($320.4 billion) programs, or nearly 93 percent of HHS annual costs.

The following table depicts HHS net cost of operations by major component for the last 5 years. The FY 2009 net cost represents an increase of $94.8 billion or 13.4 percent more than the FY 2008 net cost. Approximately 86 percent of the net cost of operations relates to Medicare, Medicaid, Children's Health Insurance Program (CHIP), and other health programs managed by the Centers for Medicare & Medicaid Services. Further information on the net cost of operations is available at: http://www.hhs.gov/afr.

Net Cost of Operations (Dollars in Billions)	2005	2006	2007	2008	2009	Change	Percent Change
Responsibility Segments							
Centers for Medicare & Medicaid Services (CMS) Gross Cost	$521.7	$574.2	$612.4	$657.9	$749.0	$91.1	13.8%
CMS Exchange Revenue	(38.1)	(49.8)	(50.3)	(54.0)	(57.3)	(3.3)	6.1%
CMS Net Cost of Operations	$483.6	$524.4	$562.1	$603.9	$691.7	87.8	14.5%
Other Segments							
Other Segments Gross Cost of Operations	$100.3	$102.2	$105.4	$108.3	$116.0	$7.7	7.1%
Exchange Revenue	(2.6)	(2.7)	(2.9)	(3.1)	(3.8)	(0.7)	22.6%
Other Segments Net Cost of Operations	$97.7	$99.5	$102.5	$105.2	$112.2	7.0	6.7%
Net Cost of Operations	**$581.3**	**$623.9**	**$664.6**	**$709.1**	**$803.9**	**$94.8**	**13.4%**

Department Management Challenges and High-Risk Areas

The scale, scope, and complexity of the Department's activities result in several management challenges. As shown in the following table, the Office of Inspector General (OIG) published management challenges on November 16, 2009 in the HHS FY 2009 Agency Financial Report (pages I-23 to I-24 and III-39 to III-69). In addition, the Government Accountability Office (GAO) has placed four HHS programs on its "High Risk List," which lists programs that may have greater vulnerabilities to fraud, waste, abuse, and mismanagement, or programs that could benefit from broad-based transformations to address major economic, efficiency, or effectiveness challenges. See details on the actions to address issues in Medicare, Medicaid, food safety, and medical products. As a responsible steward of taxpayer resources, HHS is committed to making improvements related to these challenges and high-risk areas.

Management Challenge	Progress Assessment	Management Response	Future Plans
1. Integrity of Provider and Supplier Enrollment	CMS has made progress in responding to enrollment vulnerabilities, including implementing some measures aimed at enhancing enrollment standards for durable medical equipment (DME) suppliers; additional measures would further improve integrity of provider and supplier enrollment.	We agree with OIG's assessment and are making progress to respond to enrollment vulnerabilities. CMS implemented new durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS) suppliers Accreditation Standards and has also established a surety bond requirement for all DMEPOS suppliers.	Medicare administrative contractors and fiscal intermediaries are being directed to review capital disproportionate share hospital (DSH) payments in support of provider and supplier eligibility. CMS is confident it has the necessary tools to ensure that future DSH payments comply with all applicable Federal provider and supplier requirements.
2. Integrity of Federal Health Care Program Payment Methodologies	CMS is working to ensure that payments are based on accurate data, respond to changes in the marketplace and medical practice, and limit the risk of fraud and abuse; however, many of the payment issues identified by OIG have not yet been resolved.	CMS is making progress on issues with data used in payment methodologies that have affected both Medicare and its beneficiaries. CMS agrees it must be a prudent purchaser of health care and must work to ensure that the Medicare and Medicaid payment methodologies allow access to quality care without wasteful overspending.	The Department is reacting to changes in the marketplace and medical practices so that the programs continue to effectively reimburse for quality care, while ensuring payment incentives limit the risks of fraud and abuse.
3. Promoting Compliance with Federal Health Care Program Requirements	CMS is partnering with providers and suppliers in adopting practices and promoting compliance with program coverage, payment, and quality requirements. This includes education and guidance efforts, including continued participation in the Provider Partnership Program.	CMS continues to participate in the Provider Partnership Program, and is partnering with providers and suppliers in education and guidance efforts.	Medicare and Medicaid providers are being encouraged to implement compliance programs. CMS is creating an education, training, and outreach campaign, which is designed to improve the plan sponsor's compliance with Medicare program requirements.
4. Oversight and Monitoring of Federal Health Care Programs	CMS has efforts underway, including developing oversight tools such as the Integrated Data Repository, to make needed improvements to oversight and monitoring of Federal health care programs.	Progress continues as CMS contracts with outside entities to perform oversight and monitoring functions for both Medicare and Medicaid. Improving the integrity of Medicare fee for service payments is a top priority at CMS.	CMS has plans to enhance data systems available for use by the contractors. CMS is committed to continuously improving the Payment Error Rate Measurement (PERM) program.
5. Response to Fraud and Vulnerabilities in Federal Health Care Programs	HHS is making progress in responding to fraud through law enforcement (through OIG, in partnership with the Department of Justice) and by addressing program vulnerabilities (through CMS). The Heath Care Fraud Prevention and Enforcement Action Team (HEAT) is a collaborative initiative focused on fraud prevention and response.	In conjunction with accurately identified vulnerabilities, CMS revoked suppliers' billing privileges that failed to meet Medicare standards. CMS agrees that responding to fraud and program vulnerabilities requires a high degree of coordination and collaboration between Federal and State agencies.	CMS will continue to work with its partners to respond to health care waste, fraud, and abuse.
6. Quality of Care	CMS has made some progress in ensuring that providers comply with quality standards, developing initiative to protect beneficiaries from abuse or neglect, and implementing payment incentives linked to quality.	CMS continues to operate its Special Focus Facility (SFF) program, monitoring nursing homes with the worst survey performances. CMS agrees that there are significant opportunities for improvement in the Beneficiary Protection Program and has launched a redesign of the program.	Quality Improvement Organizations (QIO) will work with providers on improving their performance on specific clinical measures related to patient safety in all States.

(continued)

Management Challenge	Progress Assessment	Management Response	Future Plans
7. Emergency Preparedness and Response	The Department working with State and local health officials has made progress in preparing for and responding to public health emergencies. They continue to work together in the development of emergency preparedness and detection plans for pandemic influenza, bioterrorist attacks, and natural disasters.	The Department provided guidance to States and localities on the development of a tiered health care response structure, and seamless emergency preparedness plan development and integration for all-hazards health care system preparedness. In addition, an update to the Medical Surge Capacity and Capability Handbook was completed.	Progress continues toward health care system preparedness, which requires exercise and evaluation strategies, including evaluations of all tiers within the health care system.
8. Oversight of Food, Drugs, and Medical Devices	FDA has made progress in ensuring the timely approval and oversight of drugs and medical devices. In FY 2009, the Food Safety Working Group was created to help ensure the safety of our Nation's food supply. However, FDA continues to face challenges in tracing food during food emergencies.	FDA opened field offices in China, India, and Costa Rica to conduct more inspections and work with local officials to improve the safety of foods exported to the United States.	FDA will continue to improve its generic drug approval process in addition to its oversight of clinical trials.
9. Grants Management	HHS made progress in developing consistent policies and procedures to oversee Federal grantees and has taken a key leadership role in the temporary expansion of health and social service programs under the Recovery Act, due to the Department's significant grant expenditures as the largest grant-awarding agency in the Federal Government.	The Department continued to establish practices regarding the integrity of grant data and its use, including grantee reporting and closeout procedures. NIH created a new centralized processing center for the receipt of closeout documents, and reminds grantees of their ability to submit closeout reports in the electronic research administration (eRA) Commons Closeout Module.	Focus will continue on the timely financial closeout of ended projects.
10. *American Recovery and Reinvestment Act*	The *Recovery Act* provided an estimated $167 billion over 10 years to the Department to provide Federal assistance for health care, public health, and human services programs, as well as to invest in research and health information technology (health IT). It is critical that *Recovery Act* funds are used efficiently and effectively and are protected from fraud, waste, and abuse.	HHS established the Office of Recovery Act Coordination (ORAC) for ensuring the appropriate awarding, distributing, use, and reporting of *Recovery Act* funds. In addition, the *Recovery Act* established the Recovery Accountability and Transparency Board (RATB), including the HHS Inspector General, to prevent fraud, waste, and abuse, while promoting accountability and transparency.	The OIG and the Department will work together to ensure we meet our *Recovery Act* responsibilities. In addition, we will continue to prepare for a potential influx of complaints by updating our OIG hotline and tracking systems, and training agents on the evaluation and investigation of such whistleblower complaints.
11. Health Information Technology and Integrity of Information Systems	The Department continues to make progress in ensuring the integrity of the Department's programs to promote health information technology, in addition to ensuring the integrity of information systems through which health information is transmitted and stored.	The Office of the National Coordinator for Health IT (ONC) provided national leadership in health IT adoption and electronic health information exchange. *The Health Information Technology for Economic and Clinical Health (HITECH) Act* highlighted ONC's leadership by providing significant funding and authority for the Department to promote the use of health IT.	Under the guidance of ONC, the Department will continue to improve health care quality, safety, and efficiency by establishing new policies, and fostering the nation-wide health information network (NHIN). The Department will continue to collaborate with partners with regards to privacy, security, and data stewardship for electronic individually identifiable health information.
12. Ethics Program Oversight and Enforcement	NIH and FDA have implemented additional measures to strengthen their processes for reviewing and approving outside activities. The OGC Ethics Division continues its ethics program oversight.	The OGC Ethics Division has responsibility for administering the Department's ethics program as it pertains to HHS employees (including special Government employees). It continued to conduct internal reviews of OPDIV and STAFFDIV ethics programs to ensure that these programs function effectively and that conflicts of interest on the part of HHS employees are identified and resolved.	HHS will adopt a number of model practices to ensure the continued efficacy of the agency's ethics programs, and will continue to work closely with the OIG in the handling of referrals of conflict of interest violations.