# DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR
**2008**

General Departmental Management
Office of Medicare Hearings and Appeals
National Coordinator for Health Information Technology
Public Health and Social Services Emergency Fund
Nonrecurring Expenses Fund
HHS General Provisions

Justification of Estimates for
Appropriations Committees

***Message from the Assistant Secretary for Resources and Technology***

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 initiatives, as well as the Secretary's priorities in guiding the Department of Health and Human Services to fulfil the President's vision of a heathier, safer and more hopeful America.

The DM budget request supports the Secretary in his role as chief policy officer and general manager of HHS. In total, DM activities are requesting $2,306 million and 2,535 full-time equivalent (FTE) staff in FY 2008. These levels will ensure the Secretary's ability to achieve excellence in management throughout the myriad of important programs and activities administered by the Department.

The FY 2008 budget for DM includes significant funding increases for the transformation and expansion of the U.S. Public Health Service Commissioned Corps, and to continue the Department's efforts at strengthening our ability to protect the American people in the event of an influenza pandemic. The request also includes funds to establish the Secretary's new Latin American Health Initiative, and to continue efforts at making secure electronic health records available to most Americans.

In addition, the request increases funding for the Office of Medicare Hearings and Appeals, to ensure its continued ability to provide full access to claimants while also processing cases within legally mandated timeframes. Finally, we are proposing legislation to create a Nonrecurring Expenses Fund as an alternative financing mechanism for one-time costs of Department-wide Secretarial priorities.

The Secretary and I look forward to working with the Congress toward the enactment and implementation of a 2008 budget that continues our progress for the health and well-being of the American people.

Charles E. Johnson
Assistant Secretary for Resources
and Technology

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

# DEPARTMENTAL MANAGEMENT OVERVIEW

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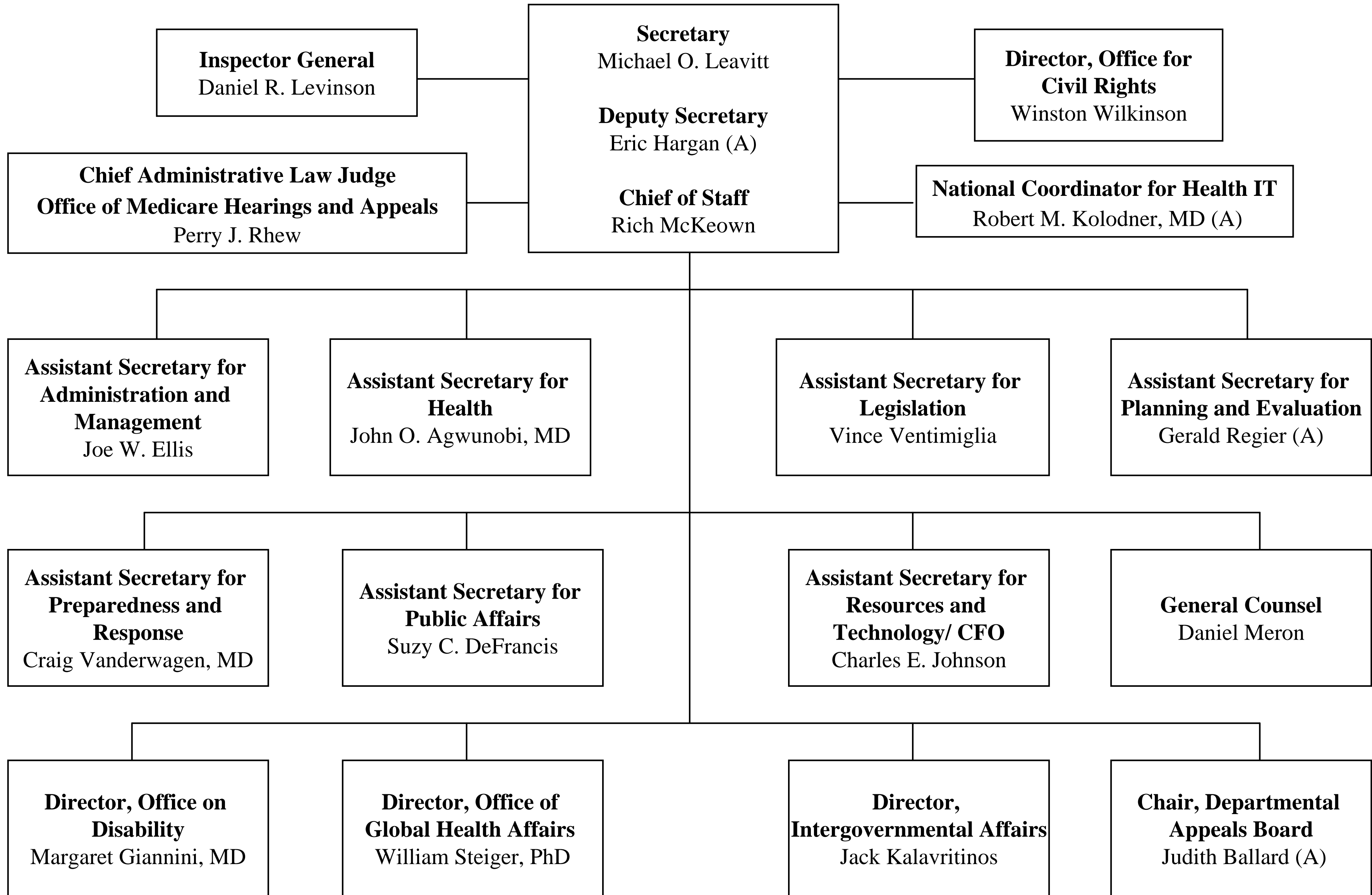
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# OFFICE OF THE SECRETARY



# DEPARTMENTAL MANAGEMENT

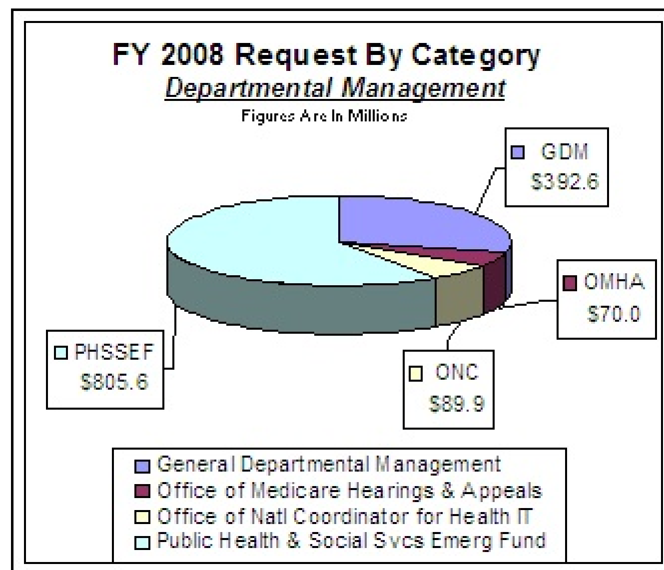
## OVERVIEW

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

- General Departmental Management;
- Office of Medicare Hearings and Appeals;
- Office of the National Coordinator for Health Information Technology; and
- Public Health and Social Services Emergency 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 FY 2008 President's Budget (PB) request for DM – including Pandemic Influenza amounts – totals $2,306,165,000 in appropriated budget authority, and 2,568 full-time equivalent (FTE) positions. When Pandemic Influenza amounts are excluded, the total of $1,358,074,000 is $1,138,074,000 (or 22 percent) and 355 FTE above comparable FY 2007 Continuing Resolution (CR) levels; please see the table on page 5.




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. These activities are carried out through twelve Staff Divisions (STAFFDIVs), including the Immediate Office of the Secretary, the Departmental Appeals Board, and the Offices of: Public Affairs; Legislation; Planning and Evaluation; Resources and Technology; Administration and

Management; Intergovernmental Affairs; General Counsel; Global Health Affairs; Disability; and Public Health and Science.

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 $70,000,000 and 382 FTE in FY 2008.

The **Office of the National Coordinator for Health Information Technology** (ONC) was created in response to Executive Order 13335, signed by President Bush on April 27, 2004. ONC became fully operational on August 19, 2005, and requests $89,872,000 and 38 FTE in FY 2008 to accomplish its mission of expanding the use of health information technology nationwide, by facilitating the development of an interoperable HIT infrastructure. The goal is to reduce medical errors, improve healthcare quality, and produce greater value in healthcare expenditures.

The **Public Health and Social Services Emergency Fund** (PHSSEF) provides resources in support of a comprehensive program to respond to the health and medical consequences of bioterrorism and other public health emergencies, and to continue the Department's cyber-security efforts. The PHSSEF includes all funding for the Office of the Assistant Secretary for Preparedness and Response (ASPR) – formerly known as the Office for Public Health Emergency Preparedness (OPHEP). ASPR directs the Department's efforts in preparing for, protecting against, responding to, and recovering from all acts of bioterrorism and other public health emergencies that affect the civilian population. The PHSSEF also includes the Department's resources for administering its Pandemic Influenza programs.

# DEPARTMENTAL MANAGEMENT

## BUDGET BY APPROPRIATION

(Dollars in thousands)

| | FY 2006 Actual [1] | | FY 2007 CR | | FY 2008 Budget | |
|---|---|---|---|---|---|---|
| | FTE | Amount | FTE | Amount | FTE | Amount |
| General Departmental Management | 1,335 | $358,418 | 1,347 | $358,662 | 1,502 | $392,556 |
| Service and Supply Fund *(OS portion)* | 149 | – | 170 | – | 171 | – |
| Office of Medicare Hearings and Appeals | 274 | $59,359 | 360 | $59,400 | 382 | $70,000 |
| Office of the National Coordinator for Health Information Technology | 6 | $42,343 | 28 | $42,372 | 38 | $89,872 |
| Public Health and Social Services Emergency Fund (PHSSEF): Non-Pandemic Flu portion | 240 | $651,142 | 284 | $651,527 | 451 | $805,646 |
| **Subtotal, Budget Authority** | **2,004** | **$1,111,262** | **2,189** | **$1,111,961** | **2,544** | **$1,358,074** |
| PHSSEF: Pandemic Influenza | 11 | $5,152,000 | 24 | $78,000 | 24 | $948,091 |
| **TOTAL, Budget Authority** | **2,015** | **$6,263,262** | **2,213** | **$1,189,961** | **2,568** | **$2,306,165** |
| [Trust Fund transfers included above for GDM and OMHA] | | [$65,148] | | [$65,193] | | [$75,851] |
| *PHS Evaluation Funds* | | *$58,452* | | *$58,452* | | *$74,756* |
| *HCFAC Funds* | | *$5,268* | | *$5,268* | | *$5,268* |
| ***TOTAL, Program Level*** | | ***$6,326,982*** | | ***$1,253,681*** | | ***$2,386,189*** |

[1] FY 2006 FTE shown here reflect corrections to coding errors contained in the FY 2008 President's Budget Appendix.

# DEPARTMENTAL MANAGEMENT

## PROGRAM ASSESSMENT RATING TOOL (PART) SUMMARY
## CY 2003 – 2006
(Dollars in Millions)

| Program | FY 2007 President's Budget | FY 2008 Budget | FY 2008 +/- FY 2007 | Narrative Rating |
|---|---|---|---|---|
| **2003 PARTs** | | | | |
| Assistant Secretary for Preparedness and Response (ASPR)/Hospital Preparedness | $451.5 | $413.8 | -$37.7 | Results Not Demonstrated |
| **2004 PARTs** | | | | |
| Adolescent Family Life (AFL) | $30.3 | $30.3 | +$0 | Results Not Demonstrated |
| Office on Women's Health (OWH) | $28.4 | $27.4 | -$1.0 | Results Not Demonstrated |
| **2005 PARTs** | | | | |
| Office of Disease Prevention and Health Promotion (ODPHP) | $7.5 | $7.5 | $0 | Results Not Demonstrated |
| Office of Minority Health (OMH) | $46.8 | $43.8 | -$ 3.0 | Results Not Demonstrated |
| Office of Global Health Affairs (OGHA)/ Afghanistan Health Initiative | $6.0 | $6.0 | $0 | Results Not Demonstrated |
| OGHA/ US-Mexico Border Health Commission (USMBHC) | $3.5 | $3.9 | +$0.4 | Results Not Demonstrated |
| **2006 PARTs** | | | | |
| Office of Medicare Hearings and Appeals (OMHA) | $74.2 | $70.0 | -$4.2 | Results Not Demonstrated |
| Commissioned Corps (CC): Readiness and Response | $18.6 | $50.5 | +$31.9 | Adequate |
| Office of the National Coordinator for Health Information Technology (ONC) | $89.9 | $89.9 | $0 | Results Not Demonstrated |

**2003 Narrative:**

- ASPR/Hospital Preparedness – Assessment of this program identified lack of performance data. To address this weakness, the program is developing new measures to reflect the direction and focus of current and future proposed preparedness efforts.

**2004 Narrative:**

- Office of Public Health and Science (OPHS)/ AFL – The assessment of this program found AFL's purpose, design, and management strong; however, strategic planning efforts were limited. AFL is developing performance baselines, measures and targets to address this deficiency; these will be completed in 2007.

- OPHS/ OWH – The assessment of this program found OWH's purpose, design, and management strong; however, strategic planning efforts were limited. OWH developed new annual and long-term outcome measures, and a draft 5-year performance plan.

**2005 Narrative:**

- OPHS/ ODPHP – The assessment of this program identified a lack of long-term outcome measures. As a result, ODPHP developed recommendations to address weaknesses identified in the assessment.

- OPHS/ OMH – The results from this assessment focused attention on developing annual performance measures and long-term goals that indicate achievement. As a result, OMH developed recommendations to address these and other weaknesses identified in the assessment.

- OGHA/ Afghanistan – The assessment of this program identified a lack of performance data. To address this weakness, the program established baselines and targets to show progress.

- OGHA/ USMBHC – The assessment of this program identified a lack of performance data. To address this weakness, USMBHC has established baselines and targets to show progress.

**2006 Narrative:**

- OMHA – The assessment of this program focused attention on developing long-term and annual performance measures that reflect achievement.

- ONC – The overall assessment for this program focused attention on developing measures to monitor performance results.

- OPHS/ CC Readiness and Response – This program received a rating of Adequate, reflecting strong program purpose and design, and program management.

# DEPARTMENTAL MANAGEMENT

## FULL COST SUMMARY TABLE
Estimated Full Cost By Program
($000)

| Performance Program Area | FY 2006 | FY 2007 | FY 2008 |
|---|---|---|---|
| Planning and Evaluation | $41 | $41 | $42 |
| Resources and Technology | 29 | 29 | 30 |
| Administration and Management | 16 | 15 | 16 |
| Disability | 1 | 1 | 1 |
| Legislation | 3 | 3 | 4 |
| Public Affairs | 4 | 4 | 4 |
| Global Health Affairs | 10 | 10 | 12 |
| Departmental Appeals Board | 9 | 10 | 12 |
| General Counsel | 42 | 43 | 44 |
| National Coordinator for Health IT | 61 | 61 | 118 |
| Medicare Hearings and Appeals | 59 | 59 | 70 |
| Public Health and Science | 166 | 164 | 194 |
| Preparedness and Response | 632 | 632 | 751 |
| TOTAL, Program Performance Area | $1,073 | $1,072 | $1,298 |
| Other Activities (including Pandemic) | 5,257 | 173 | 1,092 |
| TOTAL | $6,330 | $1,245 | $2,390 |

| Funding Sources | FY 2006 | FY 2007 | FY 2008 |
|---|---|---|---|
| GDM + OMHA + ONC budget authority | $460 | $448 | $552 |
| PHS Evaluation funds | 62 | 62 | 79 |
| HCFAC funds | 5 | 5 | 5 |
| PHSSEF budget authority[1] | 5,803 | 730 | 1,754 |
| TOTAL Program Level | $6,330 | $1,245 | $2,390 |

[1] FY 2006 reflects Emergency Supplemental funding for Pandemic Influenza.

# DEPARTMENTAL MANAGEMENT

## SUMMARY OF MEASURES AND RESULTS TABLE

| FY | Total Measures in Plan 1/ | Results Reported | | Targets | | | |
|---|---|---|---|---|---|---|---|
| | | Number | % | Met | Not Met | | % Met |
| | | | | | Total | Improved | |
| 2003 | 110 | 73 | 66% | 70 | 3 | | 64% |
| 2004 | 80 | 72 | 89% | 70 | 2 | | 79% |
| 2005 | 72 | 72 | 100% | 70 | 1 | 1 | 97% |
| 2006 | 79 | 79 | 100% | 75 | 4 | 4 | 95% |
| 2007 | 88 | | | | | | |
| 2008 | 104 | | | | | | |

1/ FY 2008 reflects new and/or developmental measures.

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

# GENERAL DEPARTMENTAL MANAGEMENT

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## FY 2008 PROPOSED APPROPRIATION LANGUAGE

*For necessary expenses, not otherwise provided, for general departmental management, including hire of six sedans, and for carrying out titles III, XVII, XX, and XXI of the Public Health Service Act, the United States-Mexico Border Health Commission Act, and research studies under section 1110 of the Social Security Act, $386,705,000, together with $5,851,000 to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Hospital Insurance Trust Fund and the Supplemental Medical Insurance Trust Fund, and $46,756,000 from the amounts available under section 241 of the Public Health Service Act to carry out national health or human services research and evaluation activities: Provided, That of the funds made available under this heading for carrying out title XX of the Public Health Service Act, $13,120,000 shall be for activities specified under section 2003(b)(2), all of which shall be for prevention service demonstration grants under section 510(b)(2) of title V of the Social Security Act, as amended, without application of the limitation of section 2010(c) of said title XX: Provided further, That of this amount, $51,891,000 shall be for minority AIDS prevention and treatment activities; and $5,941,000 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 up to $4,000,000 may be used by the Secretary of Health and Human Services to meet unanticipated needs of Departmental programs.*

## LANGUAGE ANALYSIS

| Language Provision | Explanation |
|---|---|
| "*and up to $4,000,000 may be used by the Secretary of Health and Human Services to meet unanticipated needs of Departmental programs*" | This language will permit the Secretary to fund a necessary activity under any of the Department's authorities, by providing specific authority to augment appropriations. |

## AMOUNTS AVAILABLE FOR OBLIGATION[1]

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| General funds: | | | |
| Annual appropriation | $352,703,000 | $349,176,000 | $386,705,000 |
| Rescissions pursuant to PL 109-149 | -3,527,000 | – | – |
| *Subtotal* | *349,176,000* | | |
| Section 202 transfer to CMS | -240,000 | – | – |
| Subtotal | 348,936,000 | 349,176,000 | 386,705,000 |
| Comparable transfers from: | | | |
| PHSSEF, for Commissioned Corps Transformation and Training function | 2,926,000 | 2,926,000 | – |
| OPDIVs for five former Taps being converted to GDM budget authority | 287,000 | 287,000 | – |
| NIH for transfer of PHS Historian function | 480,000 | 480,000 | – |
| Subtotal, adjusted general funds | 352,629,000 | 352,869,000 | 386,705,000 |
| Trust funds: | | | |
| Annual appropriation | 5,851,000 | 5,793,000 | 5,851,000 |
| Rescission pursuant to PL 109-149 | -58,000 | – | – |
| *Subtotal* | *5,793,000* | | |
| Secretary's 1% Transfer to CMS | -4,000 | – | – |
| Subtotal, adjusted trust funds | 5,789,000 | 5,793,000 | 5,851,000 |
| Subtotal, adjusted budget authority | 358,418,000 | 358,662,000 | 392,556,000 |
| Unobligated balance lapsing | -474,000 | – | – |
| Total obligations | $357,944,000 | $358,662,000 | $392,556,000 |

[1] Excludes the following amounts for reimbursable activities carried out by this account: FY 2006 – $221,645,000; FY 2007 – $229,336,000; FY 2008 – $231,662,000.

# SUMMARY OF CHANGES

| | | |
|---|---|---|
| 2007 | General funds adjusted Continuing Resolution | $352,869,000 |
| | HI/SMI adjusted trust funds transfer | 5,793,000 |
| | Total adjusted budget authority | 358,662,000 |
| 2008 | Request – General funds | 386,705,000 |
| | Request – HI/SMI trust funds transfer | 5,851,000 |
| | Total estimated budget authority | 392,556,000 |
| | Net change | +$33,894,000 |

| | 2007 Current Estimate Base | | Change from Base | |
|---|---|---|---|---|
| | (FTE) | Budget Authority | (FTE) | Budget Authority |
| Increases: | | | | |
| A. Built-in: | | | | |
| 1. Annualization of January 2007 pay raise (2.2%) | (1,347) | $129,913,000 | (–) | +$715,000 |
| 2. Effect of January 2008 pay raise (3.0%) | (1,347) | 129,913,000 | (–) | +2,939,000 |
| 3. Within-grade increases and career ladder promotions | (1,347) | 129,913,000 | (–) | +1,299,000 |
| 4. Total Common Expenses/ Service and Supply Fund payments | (–) | 26,297,000 | (–) | +3,366,000 |
| 5. Total Rent/ Operations & Maintenance payments | (–) | 22,120,000 | (–) | +1,248,000 |
| 6. Total Rent-Related Services | (–) | 2,980,000 | (–) | +218,000 |
| Subtotal | | | | +9,785,000 |
| B. Program: | | | | |
| 1. Office of Public Health and Science, Commissioned Corps Transformation and Training – new programs | (6) | 4,157,000 | (+118) | +34,282,000 |
| 2. Departmental Appeals Board – new workload | (65) | 9,714,000 | (+10) | +1,163,000 |
| 3. Secretary's Discretionary Fund | ( – ) | – | (–) | +4,000,000 |
| 4. Latin American Health Initiative | (–) | – | (–) | +1,500,000 |

# SUMMARY OF CHANGES
(Cont.)

| | 2007 Current Estimate Base | | Change from Base | |
|---|---|---|---|---|
| | (FTE) | Budget Authority | (FTE) | Budget Authority |
| 5. Net of increases for new FTE and for non-salary administrative costs | (1,276) | $358,662,000 | (+27) | +$1,217,000 |
| Subtotal | | | (+155) | +42,162,000 |
| Total increases | | | (+155) | +51,947,000 |
| Decreases: | | | | |
| B. Program: | | | | |
| 1. UFMS Payment | (–) | 2,614,000 | (–) | -927,000 |
| 2. One-time project included in FY 2007 CR for Office of Minority Health | (–) | 7,400,000 | (–) | -7,400,000 |
| 3. Office of Assistant Secretary for Planning and Evaluation – transfer of funding to PHS Evaluation | (–) | 6,726,000 | (–) | -6,726,000 |
| 4. Office of Minority Health – grants reductions | (66) | 46,593,000 | (–) | -3,000,000 |
| Total decreases | | | (–) | -18,053,000 |
| Net change | | | (+155) | +$33,894,000 |

## BUDGET AUTHORITY BY ACTIVITY
(Dollars in Thousands)

| | FY 2006 Actual | | FY 2007 CR | | FY 2008 Budget | |
|---|---|---|---|---|---|---|
| | FTE | Amount | FTE | Amount | FTE | Amount |
| Immediate Office of the Secretary | 65 | $8,728 | 68 | $9,427 | 74 | $14,331 |
| Public Affairs | 29 | 3,931 | 30 | 4,099 | 30 | 4,215 |
| Legislation | 24 | 3,110 | 24 | 3,180 | 26 | 3,546 |
| Planning and Evaluation | 108 | 6,726 | 108 | 6,726 | 108 | – |
| Resources and Technology | 136 | 18,943 | 137 | 19,365 | 138 | 20,380 |
| Administration and Management | 122 | 15,644 | 127 | 15,854 | 129 | 16,418 |
| Intergovernmental Affairs | 36 | 5,931 | 36 | 6,064 | 36 | 6,270 |
| General Counsel | 379 | 36,729 | 377 | 37,715 | 381 | 38,779 |
| Departmental Appeals Board | 63 | 8,691 | 65 | 9,714 | 75 | 11,967 |
| Disability | 4 | 643 | 4 | 658 | 4 | 661 |
| Global Health Affairs | 52 | 9,690 | 52 | 9,803 | 54 | 11,339 |
| Public Health and Science | 303 | 151,406 | 303 | 149,531 | 431 | 174,544 |
| President's Council on Bioethics | 10 | – | 10 | – | 10 | – |
| Center for Faith-Based Initiatives | 4 | – | 6 | – | 6 | – |
| Rent/Operations & Maintenance [1] | – | 14,752 | – | 15,249 | – | 16,850 |
| Common Expenses/SSF Payment [1] | – | 13,160 | – | 14,792 | – | 17,698 |
| UFMS Payment | – | 3,530 | – | 2,614 | – | 1,687 |
| Embryo Adoption Awareness Campaign | –- | 1,979 | – | 1,980 | – | 1,980 |
| One-Time Projects | – | 2,970 | – | – | – | – |
| Minority HIV/AIDS | – | 51,855 | – | 51,891 | – | 51,891 |
| Subtotal | 1,335 | $358,418 | 1,347 | $358,662 | 1,502 | $392,556 |
| OS Service and Supply Fund | 149 | – | 170 | – | 171 | – |
| Total budget authority | 1,484 | $358,418 | 1,517 | $358,662 | 1,673 | $392,556 |
| [Trust Fund transfers included above] | | [$5,789] | | [$5,793] | | [$5,851] |
| [Evaluation Funds; non-add] | | [$39,552] | | [$39,552] | | [$46,756] |

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

## BUDGET AUTHORITY BY OBJECT

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Full-time equivalent employment | 1,347 | 1,502 | +155 |
| Average SES salary | $139,838 | $142,635 | +$2,797 |
| Average GS grade | 12.2 | 12.2 | – |
| Average GS salary | $71,219 | $73,356 | +$2,137 |
| Personnel compensation: | | | |
| Full-time permanent | $96,558,000 | $96,450,000 | -$108,000 |
| Other than full-time permanent | 3,447,000 | 3,553,000 | +106,000 |
| Other personnel compensation | 1,851,000 | 1,902,000 | +51,000 |
| Military personnel | 3,602,000 | 13,993,000 | +10,391,000 |
| Special personnel services | – | – | – |
| Subtotal, Personnel compensation | 105,458,000 | 115,898,000 | +10,440,000 |
| Civilian personnel benefits | 23,422,000 | 23,411,000 | -11,000 |
| Military personnel benefits | 1,033,000 | 3,128,000 | +2,095,000 |
| Benefits to former personnel | – | – | – |
| Subtotal, pay costs | 129,913,000 | 142,437,000 | +12,524,000 |
| Travel | 2,490,000 | 2,906,000 | +416,000 |
| Transportation of things | 162,000 | 165,000 | +3,000 |
| Rental payments to GSA | 20,095,000 | 21,996,000 | +1,901,000 |
| Rental payments to others | 155,000 | 155,000 | – |
| Communications, misc charges | 2,162,000 | 2,380,000 | +218,000 |
| Printing and reproduction | 992,000 | 1,003,000 | +11,000 |
| Other contractual services: | | | |
| Advisory and assistance services | 1,974,000 | 2,084,000 | +110,000 |
| Other services | 36,747,000 | 50,966,000 | +14,219,000 |
| Purchases of goods and services from Government accounts | 35,211,000 | 36,965,000 | +1,754,000 |
| Operation and maintenance of facilities | 2,607,000 | 2,827,000 | +220,000 |
| Research and development contracts | 250,000 | 255,000 | +5,000 |
| Medical care | – | – | – |
| Operation and maintenance of equipment | 1,913,000 | 2,706,000 | +793,000 |
| Subsistence and support of persons | – | – | – |
| Subtotal, other contractual services | 78,702,000 | 95,803,000 | +17,101,000 |

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Supplies and materials . . . . . . . . . . . . . . . . | 2,000,000 | 2,678,000 | +678,000 |
| Equipment . . . . . . . . . . . . . . . . . . . . . . . . | 769,000 | 10,820,000 | +10,051,000 |
| Grants, subsidies and contributions . . . . . . | 121,222,000 | 112,213,000 | -9,009,000 |
| Subtotal, Non-pay costs . . . . . . . . . . . . . | 228,749,000 | 250,119,000 | +21,370,000 |
| Total, Budget Authority . . . . . . . . . . . . . . | $358,662,000 | $392,556,000 | +$33,894,000 |

# SALARIES AND EXPENSES
(Budget Authority)

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Personnel compensation: | | | |
| Full-time permanent | $96,558,000 | $96,450,000 | -$108,000 |
| Other than full-time permanent | 3,447,000 | 3,553,000 | +106,000 |
| Other personnel compensation | 1,851,000 | 1,902,000 | +51,000 |
| Military personnel | 3,602,000 | 13,993,000 | +10,391,000 |
| Special personnel services | – | – | – |
| Subtotal, Personnel compensation | 105,458,000 | 115,898,000 | +10,440,000 |
| Civilian personnel benefits | 23,422,000 | 23,411,000 | -11,000 |
| Military personnel benefits | 1,033,000 | 3,128,000 | +2,095,000 |
| Benefits to former personnel | – | – | – |
| Subtotal, Pay costs | 129,913,000 | 142,437,000 | +12,524,000 |
| Travel | 2,490,000 | 2,906,000 | +416,000 |
| Transportation of things | 162,000 | 165,000 | +3,000 |
| Rental payments to others | 155,000 | 155,000 | – |
| Communications, misc charges | 2,162,000 | 2,380,000 | +218,000 |
| Printing and reproduction | 992,000 | 1,003,000 | +11,000 |
| Other contractual services: | | | |
| Advisory and assistance services | 1,974,000 | 2,084,000 | +110,000 |
| Other services | 36,747,000 | 50,966,000 | +14,219,000 |
| Purchases of goods and services from Government accounts | 35,211,000 | 36,965,000 | +1,754,000 |
| Operation and maintenance of facilities | 2,607,000 | 2,827,000 | +220,000 |
| Medical care | – | – | – |
| Operation and maintenance of equipment | 1,913,000 | 2,706,000 | +793,000 |
| Subsistence and support of persons | – | – | – |
| Subtotal, other contractual services | 78,452,000 | 95,548,000 | +17,096,000 |
| Supplies and materials | 2,000,000 | 2,678,000 | +678,000 |
| Total, Salaries and Expenses | $216,326,000 | $247,272,000 | +$30,946,000 |

## SIGNIFICANT ITEMS IN APPROPRIATIONS COMMITTEE REPORTS

### FY 2007 House Appropriations Committee Report Language (H. Rpt 109-515)

Item

***Cardiovascular Disease and Women*** – The Committee is concerned that there continues to be a lack of awareness among health care providers that cardiovascular disease is the leading killer of women in the United States. The Committee encourages the Secretary to conduct an education and awareness campaign for physicians and other health care professionals relating to the prevention, diagnosis, and treatment of heart disease, stroke and other cardiovascular diseases in women. (p. 166)

Action Taken or To Be Taken:

*The Heart Truth* is a national awareness and prevention campaign about heart disease in women sponsored by the National Heart, Lung, and Blood Institute (NHLBI), part of the National Institutes of Health, U.S. Department of Health and Human Services. The Office on Women's Health (OWH) has collaborated with the NHLBI to address the continuing education and training needs of health professionals about heart disease in women. A team of national experts from the National Centers of Excellence in Women's Health and the National Community Centers of Excellence in Women's Health developed an array of educational materials for use by educators, practicing health professionals and students. These materials include self study modules offering free continuing medical education (CME)/continuing education units (CEU) credits.

*The Heart Truth* Professional Education Website provides information for clinicians and educators about the prevention of heart disease in women including:

- Links to consumer information and patient education materials, including fact sheets, tools and guides;
- Links to evidence-based references for clinical decision making, including downloads for Palm and PocketPC;
- Educational materials suitable for medical and nursing students, physician assistant students, primary practice physicians, and other health care providers; and
- Links to web-based CME learning modules about heart disease and women

More than 6,000 primary care providers (physicians, cardiologists, OB/GYNs, nurses, nurse practitioners, nurse midwives, residents, fellows, and medical and nursing students) attended continuing education presentations or trainings using these materials over the last two years. These presentations were made to health care providers in urban and rural academic and community hospitals and community health centers by physicians and nurses at the National Centers of Excellence in Women's Health (CoEs) and the National Community Centers of Excellence in Women's Health (CCoEs). Preliminary results show statistically significant knowledge gains were made by those attending the lectures as measured by pre-tests and post-tests.

The campaign learning objectives are based on the American Heart Association's Evidence-Based Guidelines for Heart Disease Prevention in Women. The materials are

being evaluated for their effectiveness over the next few months before being widely advertised and distributed. Four self study case-based modules will be released in February 2007. These modules will provide free continuing medical education units to health care providers and will be housed on the Medscape web site.

Item

***Report on Sodium and Hypertension*** – High sodium diets are strongly correlated with hypertension, heart attack, and stroke. The National Heart, Lung, and Blood Institute's working group on hypertension has called for a fifty percent reduction in salt consumption over ten years. The Committee encourages the Surgeon General to issue a report on salt and hypertension within one year of the passage of this bill. (p. 166)

Action Taken or To Be Taken:

The Office of the Surgeon General (OSG) has a strong working relationship with the National Heart, Lung, and Blood Institute (NHLBI). Over the past year, OSG has worked with Dr. Elizabeth Nabel and a leadership team of the NHLBI on a Surgeon General's workshop on Deep Vein Thrombosis, and recently received a draft version of a Surgeon General's Call to Action on Deep Vein Thrombosis. Senior Science Advisors from the OSG have recently been in contact with the same leadership team of the NHLBI and have begun discussing the possibility of another collaboration between the OSG and NHLBI/NIH.

Item

***Sleep Disorders*** – At the National Institutes of Health's Frontiers of Knowledge in Sleep and Sleep Disorders conference in March, 2004, the U.S. Surgeon General reported on the profound impact that chronic sleep loss and untreated sleep disorders have on Americans of all ages and that the public health model is well suited to translate these essential health messages to society. The Committee continues to urge the Surgeon General to develop a Surgeon General's Report on Sleep and Sleep Disorders and requests a report regarding progress made on this initiative. (p. 166)

Action Taken or To Be Taken:

The Office of the Surgeon General (OSG) has this subject under study as a potential topic for a Surgeon General's workshop or conference. As noted, the Surgeon General made comments during the March 2004 conference on "Sleep and Sleep Disorders" and also provided information regarding healthy sleep habits in a December 29, 2005, press release, "Tips for Parents on Teenagers" as part of The Year of the Healthy Child. In March 2006, OSG staff attended a workshop entitled "A Scientific Workshop on Sleep Loss and Obesity: Interacting Epidemics" to gather information and to identify leaders in the field. In addition, in April 2006 OSG staff met with leadership representatives from the Committee of Interns and Residents to discuss the prolonged work hours of this population, and the potential impact on patient safety brought about by the stress of sleep loss in this population. In September 2006, OSG staff members were invited to attend the National Sleep Awareness Roundtable Meeting. Subsequent discussions between OSG staff and participants of this meeting have been useful in highlighting key areas of importance. Should a Surgeon General's Workshop be held, proceedings from the workshop would be published as an accurate report containing viewpoints and recommendations of the participants. Depending on the level and depth of information

gathered, a consensus document, "The Surgeon General's Call to Action" (a brief, scholarly publication intended to mobilize health care providers and society to take immediate action in addressing an urgent public health concern) could be a next logical step. Either or both of these communications venues, the "Surgeon General's Workshop" and/or "Surgeon General's Call to Action," could lead to a "Surgeon General's Report" which is a very thorough, scholarly review, of the state of the science and medicine.

FY 2007 Senate Appropriations Committee Report Language (H. Rpt 109-287)

Item

***Chronic Fatigue*** – The Committee appreciates the work of the Department's Chronic Fatigue Syndrome Advisory Committee [CFSAC]. However, the Committee is concerned that it took the Department almost one year to appoint new members to replace in March 2006 the five CFSAC appointees whose terms expired in September 2005. The Committee directs the Department to ensure a timely nomination and appointment process to replace the remaining CFSAC members whose terms will expire in 2006, and to ensure that the appointment process does not disrupt the committee's schedule of meetings. (p. 215)

Action Taken or To Be Taken:

The terms of five CFSAC members expired in the fall of 2006, including that of the immediate past chair of the Committee. In January 2007, five new members were nominated to serve on CFSAC, including one as Chair; these nominations are currently being reviewed in the Office of the Secretary. These new members will be in place for the next full Committee meeting in April 2007.

Item

***Health Disparities*** – The Committee is committed to ensuring the overall improved health of the American people, and strongly urges the Secretary to continue to intensify his efforts in implementing recommendations developed by the Institute of Medicine's "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" study. The recommendations offer significant guidelines and opportunities for eliminating health disparities and improving health across all populations. The Committee expects the Secretary to report on the progress of this action during next year's appropriations hearings. (p. 216)

Action Taken or To Be Taken:

The Institute of Medicine's (IOM) "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" study was an important report that outlined recommendations for the nation on eliminating racial and ethnic disparities. As such, a number of recommendations are legal, regulatory, and statutory interventions that fall outside of the purview and scope of HHS' policies and programs. However, HHS Secretary Leavitt has reaffirmed HHS' commitment to eliminating racial and ethnic disparities in healthcare, and the Department has moved forward on a number of IOM's recommendations.

*IOM urged increasing awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders.*

OMH has developed a national strategy aimed at: increasing awareness of health disparities; strengthening leadership at all levels; improving patient/provider interactions; improving cultural and linguistic competency; and improving the coordination of health disparities research efforts, the availability of sub-population data, and the utilization of evaluation outcomes in health systems planning and policy development. This national strategy is consistent with, and complementary to, the following IOM recommendations:

*Increasing outreach and education to assist racial and ethnic minorities in taking charge of their health and adopting healthy behaviors.*

A primary objective for OMH is to increase awareness and understanding of the major health problems of racial and ethnic minorities in the US through a wide range of informational and educational efforts aimed at individuals and their families, communities, health care decision-makers, and health professionals. OMH is accomplishing this through a number of campaigns, efforts of the Office of Minority Health Resource Center, OMH funded projects, and its partnerships with a number of national organizations.

HHS has continued its successful Celebra La Vida Campaign. This campaign brings health information directly to Hispanics through a traveling health fair that takes place in 14 select cities across the United States. Approximately 1,500 participants attended each fair this past year. Evaluation has shown that the majority of Hispanic persons who attended each fair followed up with a health professional in their community for additional screenings, risk assessments, and other appropriate services.

*Enhancing community focused partnerships.*

Partnerships with national, community and faith-based organizations are a cornerstone of the OMH national strategy to address health disparities. In addition, OMH is working to strengthen the capacity of HHS grantees to raise awareness of disparities through sound and strategic actions. OMH is also working to strengthen the justification for its grant programs and enhance their evaluation efforts as a means of documenting and communicating progress in reducing disparities.

Through established partnerships with national minority-serving organizations, State departments of health, institutions of higher education in the Gulf Coast, and community-based organizations, OMH was able to contribute to the HHS Katrina response and support activities that could more rapidly connect minority communities with available services. Since those events, organizations representing minority communities have continued to reach out to OMH to assist in filling emergency preparedness gaps for their communities.

*Increasing the capacity of States and Tribes to Address Health Disparities.*

OMH continues to work closely with nearly 40 State Offices of Minority Health to develop state-based policies and programs to eliminate health disparities. In FY 2006, OMH launched an effort to assist seven additional States to build infrastructure to establish an Office of Minority Health. OMH has also undertaken an effort aimed at assisting tribes in improving coordination of health promotion programs that will impact disparities. An example of this effort is the new FY 2006 initiative aimed at reducing

methamphetamine use among American Indian/Alaska Natives. With support from HHS, four tribes and two national American Indian/Alaska Native-serving organizations will develop a national information and outreach campaign and a culturally specific methamphetamine abuse education kit, document and evaluate promising practices in education on meth use, and create meth awareness multi-disciplinary education teams.

*Expanding partnerships with the media.*

Recognizing the important role media plays in how consumers receive and process information, OMH has initiated steps to encourage national and minority media outlets to play a more participatory role in raising awareness of disparities and providing key information to consumers on important steps one should take to improve their health outcomes.

*The Institute of Medicine recommended collection and reporting of data by race/ethnicity in order to measure health care quality and access.*

The HHS Data Council is developing a comprehensive strategy focused on increasing the collection and reporting of data by race/ethnicity. HHS has launched a minority health web data portal that is designed to enhance the availability of racial and ethnic data. This data portal can be accessed at http://www.hhs-stat.net/OMH. OMH is also engaged in a project to evaluate existing methods for sampling racial and ethnic minority populations to identify a cost effective, statistically reliable technique to fill gaps in national data systems as an alternative to over sampling for racial and ethnic populations. Upon completion of this project, the findings will be made available to assist researchers in using sampling and analytic techniques to calculate estimates of minority populations and to increase understanding of the advantages and limitations of these techniques in practical applications.

*The IOM urged efforts to enhance patient-provider communication and trust.*

OMH has elevated the importance of patient/provider communications. On January 9-11, 2006, OMH convened the National Leadership Summit on Eliminating Racial and Ethnic Disparities. Patient/Provider communication was a reoccurring theme that was addressed in a number of plenary sessions. OMH is also continuing a project to determine how to enhance effective communication between researchers/research volunteers and health care providers/health consumers to facilitate a climate of trust in research and medical care. A national invitational meeting of stakeholders (including researchers, consumers, and other healthcare professionals) was convened at Tuskegee University to share promising practices and to identify future opportunities to strengthen the informed consent process.

*The IOM urged efforts to integrate cross-cultural education into the training of all current and future health professions.*

OMH has developed curriculum modules aimed to effectively equip family practitioners with cultural and linguistic competencies. These modules are based on principles in the National Standards for Cultural and Linguistically Appropriate Services (CLAS). Entitled “A Family Physician’s Practical Guide to Culturally Competent Care,” the curriculum utilizes the case study approach, drawing from real-life clinical settings. In

the past year, these modules have been nationally recognized and accredited for continuing medical education from the American Medical Association, the American Association of Family Practitioners, and the Quality Improvement Organizations in Centers for Medicare and Medicaid Services. OMH continues to explore other ways to increase the utilization of these modules. Curriculum modules for nurses are under development and will be available in the near future.

Item

***HIV Rapid Testing Initiative*** – The Committee commends the Secretary for the HHS initiative on increased rapid HIV testing for HIV/AIDS. The Committee is aware that wide-scale bulk deployment of new oral fluid rapid HIV testing for HIV is a significant step towards helping citizens throughout the United States, to know their HIV status. The Committee urges the Secretary to significantly increase the use of bulk purchasing and wide-scale deployment of FDA-approved oral fluid HIV rapid tests for all domestic HIV prevention initiatives. (p. 216)

Action Taken or To Be Taken:

This response will to be submitted to the Committee under separate cover.

Item

***Health Disparities*** – The Committee expects OMH and the National Center for Minority Health and Health Disparities at NIH to play a joint role in coordinating and monitoring the implementation of the Department's elimination of health disparities initiatives and strategic plans. The Committee expects the Secretary to report to Congress on the progress and implementation of the strategic plans in general and as related to the IOM's assessment and recommendations regarding the strategic plan during next year's appropriations hearings, and to include a progress update in the Department's Budget Justification. (p. 217)

Action Taken or To Be Taken:

The Office of Minority Health (OMH) in the Office of Public Health and Science provides leadership and guidance to HHS in improving minority health and eliminating health disparities. As such, OMH works closely with all of the HHS operating divisions to ensure a coordinated departmental response to health disparities. In 2006, OMH convened the National Leadership Summit on Eliminating Racial and Ethnic Disparities. With more than 2,000 participants, this Summit was designed to promote best practices and collaborative actions that are vital to improving minority health. OMH has and will continue to partner with the NCMHD in implementing initiatives and developing strategic plans. OMH and NCMHD have shared responsibility for monitoring plans and are working closely to ensure progress. OMH and NCMHD joined together to lead a departmental effort aimed at providing needed services to racial and ethnic minorities impacted by Hurricane Katrina. OMH and NCMHD continue to further efforts to ensure access to critical information, facilitate rapid connections and communications between Federal leaders and key leaders in minority communities, and develop strategies prior to and following a public health or emergency event. In FY 2006, OMH and NCMHD have also worked collaboratively in helping to strengthen Historically Black Medical Schools.

Item

***Historically Black Medical Schools*** – The Committee continues to be concerned about the diminished partnership between OMH and our Nation's historically black medical schools. Consistent with the fiscal year 2006 conference report, the Committee encourages OMH to: (1) Re-establish its unique cooperative agreement with Meharry Medical College, (2) develop a formal partnership with the Morehouse School of Medicine and its National Center for Primary Care, and (3) coordinate a response to the challenges facing the Charles R. Drew University of Medicine and Science, including expanded opportunities for biomedical research and support for residency training faculty. The Committee requests an update on the status of these activities in the Department's Budget Justification. (p. 218).

Action Taken or To Be Taken:

OMH recognizes the important role which Historically Black Colleges and Universities play in increasing minority representation in the healthcare workforce, as well as in providing needed services to the communities in which they reside. In FY 2006, OMH developed a formal relationship with the Morehouse School of Medicine (MSM) National Center for Primary Care. An umbrella cooperative agreement between OMH and MSM was established, focusing on healthcare workforce diversity. The umbrella cooperative agreement is a funding mechanism which allows OMH to provide support to projects conducted by MSM, other historically black health professions schools, and other organizations in their efforts to address racial/ethnic health disparities. The ultimate goal of this cooperative agreement is to improve the health status of minorities and disadvantaged people, and increase the diversity of the health-related workforce. MSM is responsible for implementing and providing oversight for all projects conducted under this cooperative agreement. Currently, three projects are being implemented, involving Morehouse School of Medicine, Meharry Medical College, and Charles R. Drew University.

# AUTHORIZING LEGISLATION

| | 2007 Amount Authorized | 2007 CR | 2008 Amount Authorized | 2008 Budget Request |
|---|---|---|---|---|
| General Departmental Management, except accounts below: | | | | |
| Reorganization Plan No. 1 of 1953 | Indefinite | $209,131,000 | Indefinite | $217,765,000 |
| Office of Public Health and Science: | | | | |
| Public Health Service Act, | | | | |
| Title III, Section 301 | Indefinite | 50,756,000 | Indefinite | 85,923,000 |
| Title XVII, Section 1701 (ODPHP) | [1] | 7,402,000 | [1] | 7,499,000 |
| Title XVII, Section 1707 (OMH) | [2] | 53,993,000 | [2] | 43,775,000 |
| Title XX, Section 2010 (AFL) | [3] | 30,307,000 | [3] | 30,307,000 |
| Title XXI (NVPO) | [4] | 7,073,000 | [4] | 7,287,000 |
| Subtotal | | 149,531,000 | | 174,791,000 |
| Total appropriation | | $358,662,000 | | $392,556,000 |

[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 2010 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.

APPROPRIATIONS HISTORY TABLE
(Non-Comparable)

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| FY 1999 | | | | |
| Appropriation | $154,092,000 | $166,662,000 | $168,309,000 | $189,051,000 |
| Rescission | – | – | – | -341,000 |
| Trust Funds | 5,851,000 | 5,851,000 | 5,851,000 | 5,851,000 |
| FY 2000 | | | | |
| Appropriation | 185,561,000 | 171,936,000 | 193,203,000 | 207,051,000 |
| Rescission | – | – | – | -1,478,000 |
| Trust Funds | 6,851,000 | 5,851,000 | 6,517,000 | 5,851,000 |
| FY 2001 | | | | |
| Appropriation | 223,741,000 | 206,780,000 | 204,266,000 | 285,224,000 |
| Rescission | – | – | – | -438,000 |
| Trust Funds | 5,851,000 | 5,851,000 | 5,851,000 | 5,851,000 |
| 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 |

APPROPRIATIONS HISTORY TABLE
(Cont.)

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 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 | – | – | |
| KLL Supplemental | 13,512,000 | | | |
| Trust Funds | 5,851,000 | – | – | |
| FY 2008 | | | | |
| Appropriation | 386,705,000 | | | |
| Trust Funds | 5,851,000 | | | |

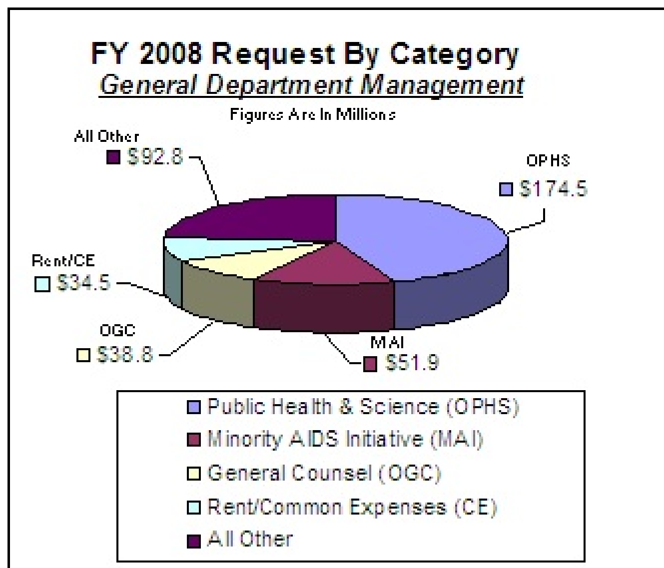
# GENERAL DEPARTMENTAL MANAGEMENT

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $358,418,000 | $358,662,000 | $392,556,000 | +$33,894,000 |
| FTE (including reimbursables) | 1,335 | 1,347 | 1,502 | +155 |

## GENERAL STATEMENT

The FY 2008 budget request for General Departmental Management (GDM) includes $392,556,000 in appropriated funds and 1,502 full-time equivalent (FTE) positions. This request is $33,894,000 (9.5 percent) and 155 FTE higher than the comparable FY 2007 Continuing Resolution (CR) level.

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




The Office of Public Health and Science (OPHS) – the largest GDM STAFFDIV – 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 twelve cross-cutting program offices, including: Surgeon General, HIV/AIDS Policy, Adolescent Family Life, 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.

The FY 2008 request for GDM reflects the following significant changes from previous years:

- Funding for **Transformation and Training of the Commissioned Corps** ($38,439,000) has been transferred to GDM from the Public Health and Social Services Emergency Fund (PHSSEF), in order to centralize funding for all Commissioned Corps Initiatives in one location. Please see page 177 for additional information.

- Funding for the **Office of the Assistant Secretary for Planning and Evaluation** has been transferred from GDM direct budget authority to reimbursable authority under PHS Evaluation funds ($7,104,000). Please see page 226 for additional information.

- Funding is requested for a new **Secretary's Discretionary Fund**, to provide the Secretary with the flexibility necessary to respond quickly to unanticipated issues and opportunities ($4,000,000). Please see page 38 for additional information.

- Funding is requested for a new **Latin American Health Initiative**, to be coordinated by the Office of Global Health Affairs ($1,500,000). Please see page 126 for additional information.

- Funding for four former **Centrally-Managed Projects** has been transferred to GDM direct budget authority from reimbursable authority contributions by the Department's Operating Divisions ($287,000). Please see pages 42, 84 and 265 for additional information.

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, as required by the Government Performance and Results Act (GPRA). Performance objectives and measures for activities in ASAM, ASL, ASPA, ASPE, ASRT, DAB, OGC, OGHA, OPHS and Disability are located in their individual budget narrative sections.

Non-comparable appropriated funding for GDM during the last five years, including amounts available for obligation from both general funds and trust fund transfers, has been as follows:

| Fiscal Year | Funds | FTE |
|---|---|---|
| 2003 | $356,512,000 | 1,324 |
| 2004 | $360,000,000 | 1,408 |
| 2005 | $423,849,000 | 1,499 |
| 2006 | $354,725,000 | 1,335 |
| 2007* | $354,969,000 | 1,347 |

** Full-year Continuing Resolution, rather than appropriation.*

In addition to appropriated funds, the GDM budget uses other sources and types of funding, including: transfers from the Health Insurance and Supplementary Medical Insurance trust funds; inter-departmental delegations of authority; inter-agency reimbursements; and funds from the Health Care Fraud and Abuse Control (HCFAC) account. GDM also conducts centrally-managed projects which benefit the Department's OPDIVs and STAFFDIVs, under the authority of the Economy Act (31 USC 1535) or other specific statutes. Costs for these activities are distributed among the OPDIVs and STAFFDIVs on a proportional basis, using established cost distribution formulas.

The DM FY 2008 budget request includes a total of $457,285 to support the Department's **Enterprise Information Technology (EIT) initiatives**, including the Expanding E-Government initiatives from the President's Management Agenda (PMA). Contributions from all OPDIVs

are combined to create an EIT Fund, which finances both the PMA initiatives and specific EIT initiatives identified through the HHS IT Capital Planning and Investment Control process. Such initiatives must meet cross-functional criteria and be approved by the Department's IT Investment Review Board, based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals to produce common technology, promote common standards, and enable data and system interoperability. The HHS initiatives also position the Department to have a consolidated approach, ready to join in PMA initiatives.

Of the amount specified above, $173,985 is allocated to support the PMA **Expanding E-Government initiatives** for FY 2008, as follows:

| PMA e-Gov Initiative | FY 2007 Allocation | FY 2008 Allocation |
|---|---|---|
| Business Gateway | $9,543 | $5,759 |
| E-Authentication | 0 | 0 |
| E-Rulemaking | 0 | 0 |
| E-Travel | 0 | 15,492 |
| Grants.gov | 69,958 | 72,056 |
| Integrated Acquisition Environment | 17,622 | 18,160 |
| Geospatial LOB | 821 | 846 |
| Federal Health Architecture LoB | 44,832 | 46,625 |
| Human Resources Management LoB | 3,686 | 3,686 |
| Grants Management LoB | 3,691 | 7,288 |
| Financial Management LoB | 1,103 | 1,890 |
| Budget Formulation and Execution LoB | 992 | 1,125 |
| IT Infrastructure LoB | 1,058 | 1,058 |
| TOTAL | **$153,306** | **$173,985** |

Prospective benefits from these initiatives are:

- **Business Gateway:** Provides cross-agency access to government information including: forms; compliance assistance resources; and, tools, in a single access point. The site offers businesses various capabilities including: "issues based" search and organized agency links to answer business questions; links to help resources regarding which regulations businesses need to comply with and how to comply; online single access to government forms; and, streamlined submission processes that reduce the regulatory paperwork burdens. HHS's participation in this initiative provides HHS with an effective means to communicate its regulations, policies and forms applicable to the business community in a business-facing, single-access point.
- **E-Travel:** Provides a standard set of travel management services government-wide. These services leverage administrative, financial and information technology best practices. By the end of FY 2006, all but one HHS OPDIV had consolidated services to GovTrip, and the legacy systems were retired. By May 2008, all HHS travel will be conducted through this single system and the last remaining legacy functions will be retired.
- **Grants.gov:** Allows HHS to publish grant funding opportunities and application packages online while allowing the grant community (state, local and tribal governments, education and research organizations, non-profit organization, public housing agencies and individuals) to search for opportunities, download application forms, complete applications locally, and electronically submit applications using common forms,

processes and systems. In FY 2006, HHS received over 56,000 electronic applications from the grants community via Grants.gov.

- **Integrated Acquisition Environment:** Eliminates the need for agencies to build and maintain their own agency-specific databases, and enables all agencies to record vendor and contract information and to post procurement opportunities. Allows HHS vendor performance data to be shared across the Federal government.
- **Lines of Business – Geospatial One-Stop:** 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 – Federal Health Architecture:** Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.
- **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 – 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. An HHS agency, 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 and has applied to be a GMLOB consortia lead. 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.
- **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.
- **Lines of Business – IT Infrastructure:** A recent effort, this initiative provides the potential to leverage spending on commodity IT infrastructure to gain savings; to promote and use common, interoperable architectures that enable data sharing and data

standardization; secure data interchanges; and, to grow a Federal workforce with interchangeable skills and tool sets.

The GDM FY 2007 budget request also includes funding to continue support for the **Unified Financial Management System (UFMS)**, which was created to replace five legacy accounting systems in the Department and integrate the Department's financial management structure. UFMS was implemented in GDM on October 16, 2006. UFMS will now provide HHS leaders with a more timely and coordinated view of critical financial management information, facilitate shared services among the OPDIVs, and help management substantially reduce the cost of providing accounting services throughout HHS. Similarly, by generating timely, reliable and consistent financial information, UFMS will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. GDM requests a total of $1,687,000 to support these efforts in FY 2007. (See the separate UFMS narrative section in this GDM justification.)

The President's FY 2008 appropriation request of $392,556,000 for the GDM account represents current law requirements. No proposed law amounts are included.

## IMMEDIATE OFFICE OF THE SECRETARY

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $8,728,000 | $9,427,000 | $14,331,000 | +$4,904,000 |
| FTE | 65 | 68 | 74 | +6 |

### Statement of the Budget Request

The FY 2008 request for the Immediate Office of the Secretary (IOS) is $14,331,000, an increase of $4,904,000 above the FY 2007 Continuing Resolution (CR) level. Of this amount, $4,000,000 is for a new Secretary's Discretionary Fund.

### Program Description

IOS provides leadership, direction, policy, and management guidance to the Department, and support for the Secretary and Deputy Secretary in their roles as representatives of both the Administration and HHS. IOS serves as the nucleus for HHS activities.

The responsibilities associated with policies and issues that the Secretary and HHS must confront daily include more than 300 programs, covering a wide spectrum of activities. Some of these issues include: pandemic and public health emergency preparedness; health information technology; health care quality and transparency; biomedical research; pharmaceutical innovation; food and drug safety; Medicare and Medicaid; HIV/AIDS; women's health; public health; Head Start; teen pregnancy; youth substance abuse; and many other critical Federal responsibilities.

Other IOS activities include:

- Providing advisory assistance and executive level staff support essential for the Secretary to manage and direct the myriad of programs mandated to the Department.
- 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.
- Providing assistance, direction and coordination to the White House and other Cabinet agencies on HHS issues.
- Setting the Department's regulatory agenda and review of all new regulations and regulatory changes to be issued by the Secretary; performing an on-going review of regulations which have already been published, with particular emphasis on reducing the regulatory burden.
- Increasing the efficiency and cost-effectiveness of the Department through improved management of resources, operations and implementation of the President's Management

Agenda; evaluating the potential for cost savings through the introduction of centralized approaches to developing, operating and maintaining automated administrative systems.

- Overseeing the operations and functions of IOS entities, including Scheduling and Advance, Executive Secretariat, and White House Liaison.

- Providing continuing Departmental leadership in implementing the Medicare Modernization Act of 2003, which is the largest program expansion of Medicare since its inception in 1965.

Performance Analysis

In order to provide a framework for prioritizing the Department's agenda, Secretary Leavitt has set forth a 500-Day Plan and identified 20 Department-wide objectives to complement the HHS Strategic Plan. These objectives include, but are not limited to, the following:

- Transforming the healthcare system;
- Modernizing Medicare and Medicaid;
- Advancing medical research;
- Securing the Homeland by increasing the capacity of the health care system to respond to public health threats from both bio-terrorism and natural causes, and by increasing the nation's preparedness for a potential disease pandemic;
- Protecting life, family and human dignity;
- Broadening health insurance and long-term care coverage;
- Emphasizing healthy living and the prevention of disease, illness and disability; and
- Improving the human condition around the world.

This expanded responsibility will also address: strategically managing human capital; competitive sourcing programs; improving financial performance; expanding electronic government; improving budget and performance integration; implementing a real property asset management program; and eliminating improper payments – among others.

Rationale for the Budget Request

The FY 2008 request for IOS is $14,331,000, an increase of $4,904,000 above the FY 2007 CR level. In order for the Department to meet the critical objectives spelled out above, IOS must provide expanded leadership, increased direction, broader policy guidance, extensive management support, and stronger engagement with State and local leaders across the country and abroad. The budget request will enable IOS to continue and expand its strong leadership role in administering and overseeing the organization, programs and activities of HHS.

The requested amount will cover increased personnel costs, such as the annualization of the January 2007 pay raise and the anticipated January 2008 pay raise, as well as 6 additional FTE.

The $4,000,000 requested for a new **Secretary's Discretionary Fund** will provide the Secretary with the flexibility necessary to respond quickly to unanticipated issues and opportunities. It is critical that the Secretary have the capacity to respond quickly to emerging issues. Therefore, this request is patterned after the discretionary funds included in the FY 2008 budgets for CDC and NIH. Some recent examples where the Secretary's Discretionary Fund could have been used include:

- NIH has initiated a new genomics effort. With a Discretionary Fund, the Secretary could have considered co-funding some of the startup costs for this effort.
- The Secretary held Pandemic Influenza summits in almost every State over the last year. With a Discretionary Fund, the Secretary could have done more on this effort.
- The Secretary has concluded that it is essential to reinvent the Commissioned Corps into a rapid response force.
- The President has issued directives to improve security procedures government-wide (HSPD-12). With a Secretary's Discretionary Fund, HHS could have quickly provided a number of one-time services to help the HHS Operating Divisions come into compliance with the significant and unanticipated expenditures required by HSPD-12.

# ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $3,931,000 | $4,099,000 | $4,215,000 | +$116,000 |
| FTE (including reimbursables) | 29 | 48 | 49 | +1 |

## Statement of the Budget Request

The FY 2008 request for the Office of the Assistant Secretary for Public Affairs (ASPA) is $4,215,000, an increase of $116,000 over the comparable FY 2007 Continuing Resolution (CR) level.

## Program Description

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 general public. ASPA plays an important role by:

- conducting Department-wide public affairs programs;
- synchronizing Departmental policy and activities with communications;
- overseeing the planning, management and execution of communication activities throughout HHS; and
- administering the Freedom of Information Act (FOIA) and Privacy Act programs on behalf of the Department.

ASPA provides communications support for Secretarial initiatives which cut across program and operating agency lines within the Department. Among these initiatives are public affairs campaigns to support the following: Health Care Value Incentives, Health Information Technology, Medicaid Modernization, Medicare Rx, rebuilding of the New Orleans Health Care System, Personalized Health Care, Obesity Prevention, Protecting and Preparing the Nation for Pandemic Influenza, and Emergency Preparedness and Response.

ASPA also continues to lead the development of a consolidated, U.S. government-wide public Web portal to provide citizens with access to timely information on how to prepare for a possible outbreak of avian influenza. In addition, Web staff are upgrading, modernizing, and enhancing the Department's internal and external Web presence, to allow Web access to the vital health and human service programs that reside within HHS. This has necessitated establishing a governance organization to evaluate the content and timeliness of agency Websites, and to coordinate them with the Department presence.

Other ASPA activities include:

- Strengthening and improving the day-to-day management of news and communication with the news media throughout the Department. Maintaining the system for clearance and issuance of press releases, streamlining the process where possible.

- Providing important health information to the public through news releases, interviews

with HHS spokespersons, press conferences, op/eds, and letters to the editor.

- Expanding production and distribution of health promotion and disease prevention messages to television and radio broadcasters, with a special emphasis on reaching disadvantaged and minority populations.
- Producing satellite news conferences and media tours that bring health information directly to English and Spanish-speaking TV affiliates around the country.
- Strengthening communication capabilities for public health crises, including bioterrorism and infectious disease outbreaks.
- Improving the effectiveness of the various education and marketing campaigns currently being conducted throughout the Department, beginning with stronger coordination among agencies and better front-end planning and execution.
- Producing speeches, statements, articles, editorials, video scripts and other written materials for Departmental officials.
- Reviewing Departmental requests for clearance of printed publications and audio-visual materials, with the goal of eliminating wasteful spending, improving communications to the public, and exploring more modern methods of convergence technology to reach audiences through alternative means.
- Continuing technical support and maintenance of the FOIA tracking system, processing increasingly complex FOIA requests, and upgrading the FOIA office, which is facing new demands and workload increases due to the implementation of new privacy regulations.

<u>Performance Analysis</u>

ASPA continues to improve Department-wide communications with the public through vigorous monitoring of the media, and rapid response to new developments in the news. ASPA's efforts to strengthen the Department's Web-based messaging and use of new convergence technologies have greatly improved HHS's ability to convey video and audio news to all generations of Americans.

ASPA has also coordinated health promotion and disease prevention public awareness programs, through interviews, press conferences, and public service announcements.

ASPA continues to provide technical support and maintenance for the Department's FOIA office.

Finally, ASPA has used Public Health and Social Services Emergency Fund (PHSSEF) monies from the Office of the Assistant Secretary for Preparedness and Response (ASPR) to complete a multi-year redesign and modernization of the HHS studio. The Department now has the ability to reach the American public with emergency preparedness television and live-feed programming any time such communications are deemed necessary.

Rational for the Budget Request

The FY 2008 request for ASPA is $4,215,000, an increase of $116,000 over the comparable FY 2007 CR level. The requested amount will cover increased personnel costs, including annualization of the January 2007 pay raise and the anticipated January 2008 pay raise. It also includes $74,000 for the former Media Outreach tap, which will now be funded from GDM direct budget authority instead of from reimbursable authority contributions by other OPDIVs.

# ASSISTANT SECRETARY FOR PUBLIC AFFAIRS
## Detailed Performance Analysis

| **Long Term Goal:** Improve Department-wide communication with the public | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Improve the effectiveness of Departmental education and marketing campaigns for the public relating to important health issues. | 2008<br>2007<br>2006<br>2005<br>2004 | See Narrative | Objective Met<br>Objective Met<br>Objective Met |
| Maintain and enhance the Department's Web portal. | 2008<br>2007<br>2006<br>2005<br>2004 | See Narrative | Objective Met<br>Implemented<br>Dec. 2005 |
| Improve the efficiency of processing Freedom of Information Act (FOIA) request. | 20082<br>007<br>2006<br>2005<br>2004 | See Narrative | Objective Met<br>Nov. 2005 |
| **Data Source:** | | | |
| **Data Validation:** | | | |
| **Cross Reference:** PMA, HHS Strategic Goal | | | |

Performance Narrative

Performance Measure 1: Improve the effectiveness of Departmental education and marketing campaigns currently being conducted with emphasis on preventive health care messages and other high priority initiatives of the Department and the President.

*Performance Objective:* Strengthen communication with the public on vital health issues by providing news releases, Web-based materials, speeches, rapid response and other materials to the national and regional media, including minority media. Establish standard methods for sharing public relations information with all agency public affairs representatives to achieve consistency, reduce redundancy, and heighten the Department's outreach to the American public. Ensure that the overall goals of the Department are accurately represented in materials for public release across all operating divisions. Continue to enhance the efforts toward a smooth consolidation of public affairs functions for the Department.

*Performance Report:* ASPA contributed significantly to the successful enrollment of more than 38 million seniors during the initial enrollment of the Medicare Part D prescription drug plan. Employing coordinated messaging and outreach to the media, APSA met weekly (or more often) with staff from the Centers for Medicare & Medicaid Services (CMS), produced monthly reports from the Secretary detailing progress about the plan, as well as coordinated and assisted in the press coverage during the six-month enrollment period. In addition, ASPA planned, and carried out press operations for more than 50 state summits on pandemic influenza.

ASPA has consistently processed requests to clear print productions, employing methods for decreasing the number of steps needed to clear operating division documents.

*Performance Target:* Produce and distribute news to print, television and radio station reporters which results in media coverage that is factual, timely and reflects messaging in support of the Department. Objective met in FY 2005 and 2006.

Performance Measure 2: Maintain and enhance the Department's Web portal.

*Performance Objective:* Create a one-stop shop for all information available to the public from HHS, thereby reducing the time and effort required to access information available on the HHS Website. ASPA will provide day-to-day management and operation of content on the Website, to ensure that HHS is speaking with one voice on the Web.

*Performance Report:* APSA created a comprehensive Web portal on Avian Influenza (AI) Preparedness – the first U.S. government-wide Web presence on any topic. Traffic to the site was measured following a related television program and public service announcement promoting the Website. Traffic to the Website surged to more than three times the normal daily average, and traffic to the Frequently Asked Questions section of the Website was viewed at 13 times higher than normal.

Major improvements were made to the design and functionality of the Department's internal Website and search capability and RSS feeds were added to the public site.

*Performance Target:* Work on the HHS Website will continues with major design rk to be accomplished and increased functionality to allow for Webcasts and downloadable information as well as online chat capability.

Performance Measure 3: Improve the efficiency of processing Freedom of Information Act (FOIA) requests.

*Performance Objective:* ASPA will continue to provide technical support and maintenance for the FOIA tracking system, in addition to the processing of increasingly complex FOIA requests.

*Performance Report:* The FOIA office is meeting new demands and workload increases due to the implementation of new privacy regulations. ASPA is focusing on streamlining and upgrading the FOIA office by examining the procedures used in processing clearances and issuance of press releases. Changes are being made as required in efforts at producing more rapid response and completions of requests submitted.

*Performance Target:* Progressing.

# ASSISTANT SECRETARY FOR LEGISLATION

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $3,110,000 | $3,180,000 | $3,546,000 | +366,000 |
| FTE | 24 | 24 | 26 | +2 |

## Statement of the Budget Request

The FY 2008 request for the Office of the Assistant Secretary for Legislation (ASL) is $3,546,000 – an increase of $366,000 and 2 FTE above the FY 2007 Continuing Resolution (CR) level. These increases will allow ASL to effectively implement a new responsibility: as overall liaison for HHS with the Government Accountability Office (GAO). This responsibility will be transferred from the Office of Inspector General (OIG) to ASL in FY 2007, and then expanded.

## Program Description

ASL performs the following activities: 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, GAO, non-governmental organizations and associations, and selected legislative programs.

ASL is also responsible for the development and implementation of the Department's legislative agenda. The office provides advice on legislation, and facilitates communication between the Department and Congress. It also informs the Congress of the Department's views, priorities, actions, grants and contracts. ASL is the Departmental liaison with Members of Congress, Congressional staff and Committees, and GAO.

Other ASL activities include:

- Developing, transmitting, providing information about, and working to enact the Department's legislative and administrative agenda;
- Supporting implementation of legislation passed by Congress;
- Working closely with the White House to advance Presidential initiatives relating to health and human services;
- Responding to Congressional inquiries and notifying Congressional offices of grant awards (GrantsNet, TAGGS) made by the Department;
- Providing technical assistance regarding grants and legislation to Members of Congress and their staffs, and facilitating informational briefings relating to Department programs and priorities;
- Managing the Senate confirmation process for the Secretary and the 14 other Presidential appointees in HHS who must be confirmed by the Senate;
- Preparing witnesses and testimony for Congressional hearings;
- Coordinating meetings and communications of the Secretary and other Department

officials with Members of Congress;
- Notifying and coordinating with Congress regarding the Secretary's travel and event schedule;
- Coordinating Department response to Congressional oversight and investigations;
- Acting as HHS's liaison with GAO and coordinating responses to GAO inquiries; and
- Serving as liaison to external organizations, including public and private interest groups, with respect to the legislative agenda.

Performance Analysis

ASL continues to effectively manage, communicate and implement the Secretary's legislative agenda by working with Congress to pass legislation such as the Deficit Reduction Act of 2006 (DRA), the Ryan White HIV/AIDS Treatment Modernization Act of 2006, and the Pandemic and All-Hazards Preparedness Act, as well as to ensure that bills moving through authorizing committees are consistent with the views of the Secretary and the Administration.

ASL also continues to work with Congress to coordinate Medicare Part D outreach events, to improve Congressional awareness of issues relating to pandemic influenza and emergency preparedness, to implement legislation consistent with legislative intent (e.g., DRA), and to advise the Congress on the status of key HHS priority areas, such as health information technology and value-driven health care.

Rationale for the Budget Request

The FY 2008 request for ASL is $3,546,000, an increase of $366,000 and 2 FTE above the FY 2007 CR level. This amount will cover increased personnel costs, such as annualization of the January 2007 pay raise, and the anticipated January 2008 pay raise. At this funding level, ASL will also be able to take on its new responsibility as the Department's designated liaison with GAO, including the costs of the two additional FTE.

Centralizing HHS responses to GAO is vital to the Department's ability to ensure adequate protection of sensitive information from improper release, and to coordinate overall Departmental responses to GAO inquiries. The transfer of this function from OIG will allow ASL to build on its existing relationships with the Congress, and should result in a smoother exchange of information between the Department and GAO.

# ASSISTANT SECRETARY FOR LEGISLATION
## Detailed Performance Analysis

| **Long Term Goal:** Advocate the Administration's health and human services legislative agenda before the Congress. | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Secure the necessary legislative support for Department's initiatives. | 2008<br>2007<br>2006<br>2005<br>2004 | See Narrative | Objective Met<br>Objective Met<br>Objective Met |
| Provide guidance on the development and analysis of Departmental legislation and policy. | 2008<br>2007<br>2006<br>2005<br>2004 | See Narrative | Objective Met<br>Objective Met<br>Objective Met |
| **Data Source:** | | | |
| **Data Validation:** | | | |
| **Cross Reference:** PMA, HHS Strategic Goal | | | |

Performance Narrative

The Assistant Secretary for Legislation (ASL) serves as the chief HHS legislative liaison and principal advisor to the Secretary and the Department on Congressional activities.

Performance Measure 1: Secure the necessary legislative support for Department's initiatives.

*Performance Objective:* ASL will work to foster all of the Department's program objectives by securing the necessary legislative support for Department's initiatives. Secure legislative authority to advance initiatives for Avian Flu Pandemic preparedness, Biodefence, and the Ryan White Care Act.

*Performance Report:* ASL continues to effectively manage, communicate and implement the Secretary's Congressional agenda by working with Congress to pass legislation such as the Deficient Reduction Act, the Ryan White HIV/AIDS Treatment Modernization Act of 2006, and the Pandemic and All-Hazards Preparedness Act, as well as to ensure that bills moving through authorizing committees are consistent with the Secretary's and the Administration's views.

*Performance Results:* Continues to meet objectives.

Performance Measure 2: Provide guidance on the development and analysis of Departmental legislation and policy.

*Performance Objective:* Develop and execute Departmental legislative and regulatory activities by providing effective guidance to, and increasing participation with other Executive Branch officials and the Department's STAFFDIVs and OPDIVs. Provide quality service and

information to Members of Congress and staff concerning HHS programs, grants, and initiatives.

*Performance Report:* Coordinated Departmental participation in Congressional hearings, mark-ups and conference committee meetings. This includes arranging briefing sessions, identifying witnesses, supervising, drafting and clearing testimony and position papers, communicating the Administration's positions to Congress, and advising Department officials of the results of Congressional actions.

*Performance Results:* Continues to meet objectives.

# ASSISTANT SECRETARY FOR RESOURCES AND TECHNOLOGY

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $18,943,000 | $19,365,000 | $20,380,000 | +$1,015,000 |
| FTE (including reimbursables) | 136 | 137 | 138 | +1 |

## Statement of the Budget Request

The FY 2008 request for the Office of the Assistant Secretary for Resources and Technology (ASRT) is $20,380,000, an increase of $1,015,000 over the comparable FY 2007 Continuing Resolution (CR) level. This amount will support the direction of budget, grants, financial management, and information technology activities throughout the Department.

## Program Description

ASRT advises the Secretary on all aspects of budget, grants, financial management and information technology, and provides for the direction of these activities throughout the Department. ASRT embraces budget formulation and execution, financial policy and accountability, information resources management, and grants administrative policy and oversight. In carrying out these functions, the Assistant Secretary has several formal and informal roles, including Chief Financial Officer, Chief Infrastructure Assurance Officer, the Department's audit follow-up official, and leading officials for budget and grants. The ASRT is also a close advisor to the Secretary on all policy issues. The work of the ASRT is accomplished through four offices:

Office of Budget (OB) – The OB manages the preparation of the Department's annual performance budget, and prepares the Secretary to present and defend the budget to the public, the media, and Congressional committees. The Office prepares analyses, options, and recommendations on all budget and management issues for the Department and works with OMB and Congress to accomplish his priorities. The OB serves as Departmental liaison with central agencies on budget execution. Finally, the Office manages the implementation of the Government Performance and Results Act (GPRA) and the Budget and Performance Integration initiative under the President's Management Agenda (PMA). This involves preparing the HHS Annual Plan, working on the Performance and Accountability Report, managing OPDIV development of integrated performance budgets, coordinating performance measurement information as well as additional performance management products.

Office of Finance (OF) –The Office of Finance (OF) provides financial management leadership to the Secretary through the Assistant Secretary for Resources and Technology/Chief Financial Officer and the Operating Division CFOs. The OF manages and directs the development of financial policies and standards consistent with major financial management legislation, the Federal Accounting Standards Advisory Board (FASAB), and the new requirements of OMB Circular A-123. The OF prepares the annual HHS Performance and Accountability Report (PAR) which includes the HHS annual financial statements and auditor's opinion, as well as the report on performance, as required by GPRA.

The OF develops department-wide policies and standards for financial and mixed financial systems, including participation in the Capital Planning and Investment Control process and development of business cases for departmental financial efforts. OF is leading the development and implementation of the Unified Financial Management System (UFMS) replacing the Department's five legacy systems. The OF is the lead office in coordinating the HHS activities related to the PMA initiatives to improve financial performance and eliminate improper payments in Federal programs.

For the audit resolution function, OF resolves systemic and monetary issues of a cross-cutting nature in A-133 single audits of State and local governments, Indian tribes, colleges and universities and non-profit organizations. In addition, OF provides management and technical assistance to the OPDIVs and works with the IG on audit resolution issues.

Office of the Chief Information Officer (OCIO) – The OCIO provides leadership and oversight in the use of information technology (IT)-supported business process re-engineering, investment analysis, performance measurement, strategic planning, and development and application for information systems and infrastructure. The OCIO coordinates enterprise-wide programs such as IT Capital Planning and Investment Control (CPIC) and Enterprise Architecture (EA) that support the HHS IT Budget data collection, analyses and presentation and manages and maintains requirements under the Paperwork Reduction Act and the Clinger-Cohen Act as defined in OMB Circular A-130. The OCIO also provides liaison with OMB and other Federal Departments, as well as internal coordination in connection with the fulfillment of the PMA objectives relating to citizen-centered government. In addition, the Office has operational responsibility for Departmental IT Services that include Enterprise Email, Security and Capital Planning systems, and information collection tracking systems. Finally, the Office develops policy to provide improved management of information resources and technology, and to provide better, more efficient service to HHS clients and employees.

Office of Grants (OG) – The OG advises the Secretary on all aspects of grants administration, HHS' primary line of business. The OG develops and promulgates policy regarding pre-award and post-award financial and administrative management for the over $241 billion awarded annually by the various HHS Operating Divisions (OPDIVs). In consultation with OPDIV management, OG policy formulation and implementation takes into consideration the need for consistent adherence to all statutory and regulatory requirements while ensuring the means of meeting such requirements is appropriately managed directly by the OG or more appropriately delegated to OPDIVs. In addition to grants policy, the OG administers the HHS-wide Grants Officer Training and Certification Program, Grants Policy Oversight and Evaluation Program, and works to develop modern business models and the functional requirements for supporting information technologies (IT). The OG provides the interface with HHS IT groups and contract support to develop OG/OPDIV systems support. The OG administers the Tracking Accountability in Grants Systems (TAGGS) award reporting system, leads the consolidation of administrative management functions in the areas of grants management and policy administered by Grants.Gov and provides leadership on P.L. 106-107 projects government-wide. Under the guidance of the Deputy Assistant Secretary for Grants, the OG works to ensure HHS meets all strategic goals in the PMA and the GPRA annual plan that fall under the OG mission. The OG also reviews and coordinates cost policy issues with OMB, the IG and other central agencies as well as the HHS regional Divisions of Cost Allocation related to recipients of Federal financial assistance under HHS programs.

Rationale for the Budget Request

The FY 2008 request for ASRT of $20,380,000 is an increase of $1,015,000 and 1 FTE over the comparable FY 2007 Continuing Resolution (CR) level. At the requested level, ASRT will be able to maintain support of its ongoing responsibilities, which include improving financial management, expanding electronic government, improving budget and performance integration, improving grants management and operations oversight, and eliminating improper payments.

In addition, the request will provide increased support for financial reporting needs under the PMA "Improving Financial Performance" initiative, such as resolving outstanding audit findings relating to the accurate and timely preparation of financial statements, and the resolution of auditor material weaknesses and reportable conditions related to required financial reconciliations.

The request will also provide increased support for the implementation of revised OMB Circular A-123 Internal Control over Financial Reporting (ICOFR) requirements in the Office of Finance, by addressing any outstanding management and/or auditor identified reportable conditions or material weaknesses resulting from implementation of ICOFR in FY 2006 and FY 2007.

Performance Analysis

Office of Budget (OB) – The OB continues to meet the standards of quality and timeliness established by the ASRT, OMB, Congress and oversight agencies for submission of the annual performance budget. The OB plans and coordinates all HHS events for the Departmental performance budget including reviewing OPDIV requests, developing alternative recommendations, and ensuring timely submission to the President and the Congress. The OB prepares the HHS Annual Plan and provides guidance and direct assistance in implementing the PMA, especially budget and performance integration. The FY 2006 budget submission fully integrated budget and performance. The OB continues to meet the performance goals associated with this activity. Finally, the OB coordinates the Program Assessment Rating Tool (PART) process under budget and performance integration which annually assesses a substantial portion of HHS Programs.

Office of Finance (OF) – In fulfilling the leadership responsibility for financial management policies and activities throughout HHS, OF has set eight (8) performance goals. They are:

- Submit HHS Performance and Accountability Report (PAR), including consolidated audited financial statements, on time.
- Retain an unqualified (clean) audit opinion on HHS consolidated financial statements.
- Improve HHS financial management systems to provide uniform, integrated financial information for all of HHS.
- Maximize the use of electronic payments.
- Complete timely vendor payments.
- Collect debt owed to HHS.
- Complete the resolution of all non-Federal audits within the statutory 6-month time-frame.
- Strengthen the Department's Internal Control Structure by institutionalizing the process for meeting OMB Circular A-123 requirements.

For all the goals, OF has been successful in meeting the performance targets for several years.

For a full discussion on the targets, performance progress and results, see the Detailed Performance Analysis of each goal that follows. All goals and targets relate to the fulfillment of the PMA initiatives of Improved Financial Performance and Eliminate Improper Payments.

Office of the Chief Information Officer (OCIO) – The OCIO aligns its organization structure and goals to bring all HHS OPDIVs together in terms of IT. In particular, OCIO provides leadership and oversight in the design and implementation of infrastructure upgrades necessary to improve IT security in HHS. As one of the five key elements outlined in the PMA, Electronic government (e-Gov) focuses on reforming the Federal government so that it is citizen-centered. The OCIO e-Gov mission is to establish, support and maintain a Departmental e-Gov program that coordinates and makes visible current and future efforts between the OPDIVs and Federal, State, and local governments, business entities, and the public, as well as act to improve internal efficiencies and effectiveness. The IT Strategic Goals are:

- Provide a secure and trusted IT environment.
- Enhance the quality, availability, and delivery of HHS information and services to citizens, employees, businesses, and governments.
- Implement an enterprise approach to information technology infrastructure and common administrative systems that will foster innovation and collaboration.
- Enable and improve the integration of health and human services information.
- Achieve excellence in IT management practices.

Office of Grants (OG) – P.L. 106-107 calls for government-wide reform of grants management and oversight to improve the efficiency and accessibility of Federal assistance for the grants community. The OG continues to meet these objectives as outlined in our Program Activities and measured by our performance goals.

# ASSISTANT SECRETARY FOR RESOURCES AND TECHNOLOGY
Detailed Performance Analysis

Office of Budget

| **Long Term Goal: Manage the preparation and execution of the Department's Performance Budget** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Meet the standards of quality and timeliness established by the ASRT, OMB, Congress and oversight agencies for the annual Budget and performance plan submission. Prepare clear, concise assessments that articulate HHS OPDIV priorities and meet Department requirements in preparation of the Department's budget. | 2008<br>2007<br>2006<br>2005<br>2004<br>2003 | Develop FY10 Budget<br>Develop FY 2009 Budget<br>Develop FY 2008 Budget<br>Develop FY 2007 Budget Develop FY 2006 Budget Develop FY 2005 Budget | 2/2009<br>2/2008<br>2/2007<br>Target met<br>Target met<br>Target met |
| Provide timely and useful assistance and guidance to OMB and committee staffs and monitor effective implementation of authorizing and other legislation and regulations for Federal budget and management functions; identify and coordinate the resolution of serious issues. | 2008<br>2007<br>2006<br>2005<br>2004<br>2003 | <br><br>Oversee FY 2006 Budget<br>Oversee FY 2005 Budget<br>Oversee FY 2004 Budget<br>Oversee FY 2003 Budget | <br><br><br>Target met<br>Target met<br>Target met |
| Professional management of the appropriations process. Provide high-quality budget justifications to the Appropriations Committees in time for hearings. | 2008<br>2007<br>2006<br>2005<br>2004<br>2003 | <br><br>Submit FY 2007 Budget<br>Submit FY 2006 Budget<br>Submit FY 2005 Budget<br>Submit FY 2004 Budget | <br><br>Target met<br>Target met<br>Target met<br>Target met |
| Provide Department-wide guidance and assistance in implementation of GPRA and Budget and Performance Integration under the President's Management Agenda. (Revised) | 2008<br>2007<br>2006<br>2005 | Submit FY 2009 Performance Budget<br>Submit FY 2008 Performance Budget<br>Submit FY 2007 Performance Budget<br>Revised Measure | <br>Feb. 2007<br>Target met<br> |
| **Data Source:** Performance Budget | | | |
| **Data Validation:** OMB and Congressional verification of submission receipt | | | |
| **Cross Reference:** President's Management Agenda- Budget and Performance Integration | | | |

## Performance Narrative

Performance Measure 1: Meet the standards of quality and timeliness established by the ASRT, OMB, Congress and oversight agencies for annual performance budget submission. Prepare clear, concise assessments that articulate HHS Operating Division (OPDIV) priorities and meet Department requirements in preparation of the Department's budget.

*Performance Target:* The Budget Office plans and coordinates all HHS activities for the Departmental budget. This includes the review of OPDIV performance and budget requests;

developing alternative recommendations; and ensuring timely submission to the President and Congress.

*Performance Result:* During FY 2006, the Budget Office consistently provided timely, accurate, and innovative analysis and information in an environment characterized by competing priorities and non-negotiable deadlines. The Budget Office provided policy and technical guidance for OPDIVs' performance budgets in May for the Department submission, in August for the OMB submission, and in December for the Congressional submission. The Budget Office also makes available guidance in July and December for the Department-level HHS Annual Plan. Briefing materials were succinct, and questions from the Secretary and his staff were answered quickly and accurately. Budget and performance materials were carefully reviewed for quality and completeness and distributed to OMB and Congress on time or ahead of schedule.

Performance Measure 2: Provide timely and useful assistance and guidance to OMB and committee staffs and monitor effective implementation of authorizing and other legislation and regulations for Federal budget and management functions; identify and coordinate the resolution of serious issues.

*Performance Target:* The Budget Office provides timely information to the Secretary and his staff in support of compelling justifications to committee staffs in time for their hearings.

*Performance Result:* During FY 2006, the Budget Office provided the Secretary and his staff with all budget-related materials and information necessary for presentation to any audience. This assists the Secretary's success in budget presentations in support of the programs of the President.

Performance Measure 3: Professional management of the appropriation process. Provide high-quality budget justifications to the Appropriations Committees in time for hearings.

*Performance Target:* The Budget Office develops and implements strategies for a timely and effective presentation and defense of the Department's budget during the appropriations process.

*Performance Result:* The Budget Office successfully managed the major workloads required in support of the annual performance budget and other program budget analysis and estimates that occurred throughout the year. Guidance and technical assistance were provided in a timely manner. Budget and performance justifications were carefully reviewed and distributed in a timely manner prior to hearings.

Performance Measure 4: Provide Department-wide guidance and assistance in implementation of Government Performance and Results Act and Budget and Performance Integration under the President's Management Agenda.

*Performance Target:* This measure was revised in FY 2005 to provide a broader sense of deliverables under the PMA relating to the Budget and Performance Integration initiative.

*Performance Result:* The FY 2007 HHS Annual Plan was submitted on time to OMB and Congress. The FY 2008 Congressional Justifications report all of the Department's performance goals including outcome and efficiency measures. The target for FY 2006 was to submit on time to OMB and Congress the FY2007 budget integrating performance information.

Office of Finance

| **Performance Goal: Submit HHS Performance and Accountability Report (PAR), including consolidated audited financial statements, on time. [Output]** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Submit HHS Performance and Accountability Report (PAR), including consolidated audited financial statements to OMB by the due date. | 2008 | November 15, 2008 | |
| | 2007 | November 15, 2007 | |
| | 2006 | November 15, 2006 | Nov. 15, 2006 |
| | 2005 | November 15, 2005 | Nov. 15, 2005 |
| | 2004 | November 15, 2004 | Dec. 8, 2004 |
| | 2003 | November 15, 2003 | Nov. 15, 2003 |
| **Data Source:** Transmittal memo and report from HHS to OMB. | | | |
| **Data Verification and Validation:** The OMB verification of timely receipt of HHS submission. | | | |
| **Cross Reference:** PMA: Improved Financial Performance | | | |

## Performance Narrative

Performance Goal 1. Provide a Timely Performance and Accountability Report, including Audited Financial Statements.

*Performance Targets:* The Reports Consolidation Act of 2000 authorizes agencies to consolidate financial, performance and other management information into a single annual report. Consolidated reporting is intended to improve information quality and enhance agency coordination and efficiency in preparing, reporting and using this information. OMB Circular A-136 requires that agencies prepare a combined Performance and Accountability Report (PAR) and institute a progressively accelerated preparation and submission schedule. This schedule culminates in a November 15 submission deadline (45 days after fiscal year end) beginning for the FY 2004 PAR and beyond.

*Performance Results:* HHS met the submission deadline and performance target for FY 2006, and consistently met or exceeded targets from FY 1999 through FY 2005, with the exception of FY 2004.

| **Performance Goal: Retain an unqualified (clean) opinion on HHS consolidated financial statements. [Output]** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Results of audit opinion. | 2008 | Unqualified | |
| | 2007 | Unqualified | |
| | 2006 | Unqualified | Unqualified |
| | 2005 | Unqualified | Unqualified |
| | 2004 | Unqualified | Unqualified |
| | 2003 | Unqualified | Unqualified |
| **Data Source:** Financial Statement Auditors Opinion and Date of the Opinion. | | | |
| **Data Verification and Validation:** Copies of these reports are provided by the Inspector General and are kept on record. | | | |
| **Cross Reference:** PMA: Improved Financial Performance | | | |

Performance Goal 2. Clean Audit Opinion

*Performance Targets:* The independent auditor's opinion determines whether the statements present fairly the financial condition of an entity in conformity with generally accepted

accounting principles (GAAP). When they do, an "unqualified" or "clean" opinion is rendered. If not, either a qualified opinion (one or more serious findings of deviations from accounting principles) or a disclaimer (not auditable) is given. HHS continues to set its goal to obtain a "clean audit opinion" on the consolidated financial statements.

*Performance Results:* HHS has earned unqualified (clean) audit opinions on its consolidated financial statements for FY's 1999 through 2006. We will strive to meet our goals in retaining a clean audit opinion for the consolidated financial statements for FY 2007 and beyond. Actual performance will be available in November of each year.

| **Performance Goal: Improve HHS financial management systems to provide uniform, integrated financial information for all of HHS. [Outcome]** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Implement an integrated Department-wide financial system that complies with Federal financial management systems requirements. | 2008 | Meet FY 2008 milestones identified in the detailed implementation plan. | |
| | 2007 | Meet FY 2007 milestones identified in the detailed implementation plan. | |
| | 2006 | Meet FY 2006 milestones identified in the detailed implementation plan. | Milestones met |
| | 2005 | Meet FY 2005 milestones identified in the detailed implementation plan. | Milestones met |
| | 2004 | Meet FY 2004 milestones identified in the detailed implementation plan. | Milestones met |
| | 2003 | Meet FY 2003 milestones identified in detailed implementation plan. | Milestones met |
| **Data Source:** Annual audit work and resulting opinions on the financial statements rendered by the Department's auditor(s). | | | |
| **Data Verification and Validation**: Data verification and validation are determined by the successful execution of project tasks to satisfy established milestones. The UFMS Program Management Office (PMO) is utilizing a third-party contractor to provide "arm's length" IV & V support. | | | |
| **Cross Reference:** PMA: Improved Financial Performance | | | |

<u>Performance Goal 3.</u> Unified Financial Management System (UFMS)

*Performance Targets:* Like other Federal agencies, HHS is moving forward in enhancing its electronic business (E-business) capabilities. A major driver in this effort is addressing satisfactorily the Department's leaders and managers' requirements for reliable, relevant and timely financial information upon which to make operational and strategic decisions. Also, the Department must be able to furnish its customers and service benefactors quality information regarding the Department's operational performance and its stewardship of financial resources entrusted to it.

One of the Department's objectives is to design and implement an integrated, automated financial management system that provides complete, consistent, reliable and timely financial information. This system must support the preparation of the HHS annual financial statements and other financial reports. In short, the system is being designed to integrate the Department's

financial management systems network and fulfill the requirements stipulated in the Federal Financial Management Improvement Act of 1996 (FFMIA). The FFMIA requires each Federal agency to implement and maintain financial management systems that comply substantially with: Federal financial management systems requirements; applicable Federal accounting standards; and the U.S. Standard General Ledger (SGL) at the transaction level.

In the past, HHS has operated five core accounting systems that did not adequately satisfy the FFMIA requirements. Furthermore, these systems were designed to operate on varying technological "platforms" at various locations. The outdated technologies are not readily capable of being modified to operate efficiently with modern integrated database systems. Upon consolidating these existing systems into a unified system, HHS will achieve greater financial economies of scale, eliminate duplicative systems and processes, and provide better service delivery. The Unified Financial Management System (UFMS), when fully implemented, will provide uniform, integrated financial information for HHS management and decision-makers.

Related to UFMS, the Department is consolidating accounting services and streamlining its financial infrastructure. Such consolidation and streamlining will enhance the Department's ability to achieve greater operational efficiencies and at the same time deliver high quality, timely services to its customers and the American public.

Consistent with the President's Management Agenda (PMA) under the Improving Financial Performance initiative, HHS has instituted a "One Department" approach to modernizing its financial systems. This approach impacts all of HHS' information technology by emphasizing management of resources on an enterprise-wide basis with a common technical infrastructure.

In FY 2001, HHS initiated a six-year project to implement UFMS and replace the existing five core accounting systems. The UFMS will consist of two major system sub-components. One sub-component – the Healthcare Integrated General Ledger and Accounting System (HIGLAS) – will serve CMS and its Medicare Contractors; the other sub-component will serve the remaining HHS agencies. Both sub-components will be integrated for Department-wide financial reporting capability. This unified system is designed to automate internal and external financial reporting requirements. The NIH Business Systems (NBS) replaces the NIH administrative and financial core operations systems, including the general ledger, finance, budget, procurement, supply, travel, and property management systems. UFMS, HIGLAS and NBS are HHS' FMFIA and FFMIA compliant systems.

For FY 2002 and beyond, HHS established goals to meet each year's Project Plan milestones. This includes developing a detailed implementation plan to guide the remaining "life" of the project.

During FY 2006, in addition to the PSC deployment, UFMS released 2.2 in April 2006, which delivered Common Accounting Number (CAN) Realignment at the General Ledger level and the interface to eTravel, an e-Gov initiative.

In February 2007, NBS will upgrade general ledger from Oracle 11.5.7 to 11.5.9 and deploy Supply and Replenishment functionality using PRISM, iProcurement, Warehouse Management and Oracle Purchase Order module.

In March 2007, UFMS will include code freeze for Indian HS PRISM and Sunflower interfaces; it will also fully deploy iProcurement for the Indian HS as part of their "go live" in October.

In May 2007, NBS will deploy Acquisition and Property management with full deployment of iProcurement, PRISM and Sunflower interfaces.

The UFMS schedule calls for an October 2007 implementation for the Indian Health Service. In January 2008, UFMS will transition to O&M support at the PSC. This will complete implementation of UFMS.

*Performance Results:* In FY 2002, the UFMS Program team completed the planning phase of the project, with the Departmental approval in September 2002 of the UFMS detailed implementation plan.

During FY 2003, the Program team executed the implementation plan and met all critical milestones and deliverables, including: development of the initial baseline requirements; critical evaluation of identified requirements and development of the final baseline requirements; conduct of the global fit/gap analysis and production of the global fit/gap summary and production of the initial global process designs. The team successfully completed the CDC initial process designs and conducted conference room pilot 1.

During FY 2004, the program team conducted a Shared Services Study to determine the feasibility of, and a plan for, implementing a shared services environment. Additionally, the program team met all its remaining critical milestones including: conducting Conference Room Pilots (CRPs) at FDA, CDC, and the PSC; completing Mock Data Conversions 1, 2, and 3 at CDC; began end user training at CDC; and conducted system and integration testing leading up to Go-Live efforts for April 2005.

During FY 2005, the UFMS Program deployed full financial capability at the CDC and the FDA in April 2005 and full implementation at those OpDivs in May 2005. With this deployment the program delivered 86% of the Department's original functional requirements. The PSC implementation began in June 2005 and completed full deployment in October 2006.

In FY 2006, CDC and FDA successfully closed FY 2005 in UFMS, meeting all year-end deadlines. Also, in October 2005, Release 2.1 was delivered to production which includes IVR and Grants. In May 2006 code freeze was met for the PSC, on schedule for October 2006 deployment and Mock 3.5 was also completed out of 6 planned for data conversion for the PSC. Release 3.0 was successfully deployed for PSC, OS, AHRQ, AoA, ACF, HRSA, and SAMSHA. Delivered federally mandated reports for PSC, using ORACLE Discoverer and successfully completed all month-end, quarter-end, and year-end processing activities.

| **Performance Goal: Maximize the use of electronic payments. [Outcome]** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Percentage of payments transferred electronically (Electronic Funds Transfer). | 2008 | 96% Vendor - 96% Travel | Nov., 2008 |
| | 2007 | 96% Vendor - 96% Travel | Nov., 2007 |
| | 2006 | 96% Vendor - 96% Travel | 91% V - 96% T |
| | 2005 | 96% Vendor - 96% Travel | 89% V - 97% T |
| | 2004 | 95% Vendor - 100%Travel | 88% V - 96% T |
| | 2003 | 95% Vendor - | 90% V - 97% T |
| **Data Source:** Quarterly EFT Reports and Treasury Guidelines | | | |
| **Data Verification and Validation:** Each OPDIV has an automated process for tabulating the number and types of payments made; this information is used to compile the quarterly statistics. The data is validated and verified via Treasury which tabulates the number and types of payments made based on the Agency Location Codes. | | | |
| **Cross Reference:** PMA: Improved Financial Performance | | | |

Performance Goal 4. Electronic Funds Transfer (EFT)

*Performance Targets:* OMB has developed a government-wide Metric Tracking System (MTS) that captures and reports key financial management indicators across the Federal Government. In FY 2006, HHS' goal for EFT payments was aligned with the goal identified in MTS.

The FYs 2006 through 2008 vendor and travel payment goals are set at 96% to coincide with the MTS goal. The HHS travel payment target will be adjusted when OMB sets the travel payment goal.

*Performance Results:* The FY 2006 HHS actual performance for vendor payments was -91%. In FY 2006, the HHS OPDIVs correctly classified vendor payments due to the refinement and implementation of Treasury's EFT Reporting guidelines for payment classification. As a result, HHS' EFT percentage increased to 91%. Staff in the Office of Finance worked with the OPDIVs to verify how vendor payments were being classified and also ensured that all administrative contracts, training programs, leases, space and building rental services, equipment and contractors were being correctly classified as vendor payments. The FY 2006 actual performance for travel was reported at 96%. Actual performance will be available in November of each year.

| **Performance Goal: Timely vendor payments. [Outcome]** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Percentage of vendor payments made on time. | 2008 | 98% | Nov., 2008 |
| | 2007 | 98% | Nov., 2007 |
| | 2006 | 98% | 97.5% |
| | 2005 | 98% | 97.1% |
| | 2004 | 97% | 97.1% |
| | 2003 | 97% | 97.4% |
| **Data Source:** Quarterly HHS Component Prompt Pay reports. | | | |
| **Data Verification and Validation:** OPDIV's verify by different methods. | | | |
| **Cross Reference:** PMA: Improved Financial Performance | | | |

Performance Goal 5. Timely Vendor Payments

*Performance Targets:* Timely payment by HHS of bills owed to vendors will avoid late fees and interest penalties as mandated under the Prompt Pay Act. HHS' previous goal of 97% for timely vendor payments was changed beginning with FY 2005 to align with the 98% goal identified in MTS.

The FY's 2006 through 2008 targets are set at 98% to coincide with the MTS goal.

*Performance Results:* HHS' rates of on-time payments have increased from 91% for FY 1998 to 97.4% for FY 2003, with a slight decrease to 97.1% for both FY's 2004 and 2005. HHS is in the process of implementing a new financial system, throughout the Department. The implementation process may have a short-term impact on performance; however, no projections can be made at this time. Actual performance will be available in November of each year.

| Performance Goal: Collect debt owed to HHS. [Output] | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Percent increase in total collections over prior year. | 2008<br>2007<br>2006<br>2005<br>2004<br>2003 | 5% above FY 2007 collections<br>5% above FY 2006 collections<br>5% above FY 2005 collections, $17.7B<br>5% above FY 2004 collections, $15.8B<br>10% above FY 2003 collections, $17.7B<br>10% above FY 2002 collections, $15.8B | Dec. 1, 2008<br>Dec. 1, 2007<br>$24.6B<br>$16.9B<br>$15.1B<br>$16.1B |
| **Data Source**: Treasury Report on Receivables (formerly Schedule 9s). | | | |
| **Data Verification and Validation:** The HHS Deputy Chief Financial Officer (DCFO) certifies annually to Treasury that the amounts reports on the receivables report are correct and will be used to monitor compliance with the Debt Collection Improvement Act. In addition the DCFO verifies that the report has been reconciled to the HHS audited financial statements and submits this verification to Treasury by March 31. (Note - Beginning in FY 2004 the verification became a combined certification/verification due to Treasury in December.) | | | |
| **Cross Reference:** PMA: Improved Financial Performance | | | |

Performance Goal 6. Collection of Debts

*Performance Targets:* The target is the increase in dollars collected over the prior fiscal year for debts owed to HHS.

The FY 2007 and 2008 targets will be 5% above the dollars collected for FY's , 2006, and 2007, respectively. Because of the reduction in receivables available for collection, effective with FY 2005, HHS reduced the target for increased collections from 10% to 5%. This percentage will be adjusted pending further reduction of the available receivable pool.

*Performance Results:* HHS greatly exceeded the FY 2006 target of $17.7 billion with actual collections of $24.6 billion, as 45% increase over FY 2005 collections. The huge increase in collections was due primarily to a massive increase in the Accounts Receivable for Payment from States Medicare Prescription Drug account. These receivables were first reported in Q3 of FY 2006. The Department's overall collection rate is 71.4%, an improvement over the last two years' rates of 68.1% in FY 2005 and 57.4% in FY 2004. This demonstrates that HHS' collection actions are very effective. Actual performance data will be available in December of each year.

| Performance Goal: Complete the resolution of all non-Federal audits within the statutory 6-month time-frame. (Revised) [Efficiency] | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Percent of non-Federal audits resolved within 6 months of receipt. | 2008<br>2007<br>2006<br>2005<br>2004<br>2003<br>2002 | 96%<br>96%<br>95.5%<br>95%<br>94.5%<br>94%<br>132.9 days | Oct., 2008<br>Oct., 2007<br>97.8%<br>95.2%<br>96.9%<br>93.6%<br>146.4 days |
| **Data Source:** Division of Financial Systems Policy, Payment Integrity and Audit Resolution (DFSPIAR) formerly Office of Audit Resolution and Cost Policy (OARCP). | | | |

| **Performance Goal: Complete the resolution of all non-Federal audits within the statutory 6-month time-frame. (Revised) [Efficiency]** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| **Data Verification and Validation:** Office Director reviews and approves the system's input and analysis by the senior audit resolution staff. | | | |
| **Cross Reference:** PMA: Improved Financial Performance | | | |

Performance Goal 7. Complete the Resolution of All Non-Federal Audits Within the Statutory 6-Month Time-frame (Revised)

*Performance Targets:* OMB Circulars A-50 and A-133 require the Federal Awarding Agency to, "Issue a management decision on audit findings within six months after receipt of the audit report and ensure that the recipient takes appropriate and timely corrective action." To appropriately reflect performance of the Office in relation to the requirements of the Circulars, a new baseline was introduced in FY 2003 to measure the number of non-Federal audits resolved within 6 months of receipt.

As discussed in the previous paragraph, the baseline for this goal was changed beginning with FY 2003. Subsequent targets reflect a 0.5% yearly increase through FY 2007. Beginning in FY 2008, the baseline will remain at 96% to represent an increase in the complexity of non-Federal audits.

*Performance Results:* In FY 2006, the Division of Financial Systems Policy, Payment Integrity and Audit Resolution (DFSPIAR) resolved 97.8% of non-Federal audits within 6 months of receipt exceeding the FY 2006 performance target. In FY 2005, DFSPIAR resolves 95.2% of non-Federal audits within 6 months of receipt. Actual performance will be available in October of each year.

| **Performance Goal: Strengthen the Department's Control Structure by fully implementing OMB Circular A-123, Appendix A requirements. [Outcome]** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Completion of OMB Circular A-123, Appendix A, assessments of internal controls over financial reporting (ICOFR) and submission of related assurance statements to meet required submission dates. | 2008 | Complete ICOFR assessments and meet FY 2008 reporting requirements. | |
| | 2007 | Complete ICOFR assessments and meet FY 2007 reporting requirements. | |
| | 2006 | Complete ICOFR assessments and meet FY 2006 reporting requirements. | |
| **Data Source:** OPDIV assurance statement submissions to the Department and the Department's Assurance Statement Included in Performance and Accountability Report (PAR). | | | |
| **Data Verification and Validation:** Data verification and validation are determined by the successful completion of A-123, Appendix A ICOFR assessments and timely submission of assurance statements. | | | |
| **Cross Reference:** PMA: Improved Financial Performance | | | |

Performance Goal 8. Implementation of OMB Circular A-123, Appendix A

*Performance Targets:* OMB Circular A-123, Appendix A requires that managers of Federal agencies take responsibility for conducting a rigorous assessment of internal controls over financial reporting and report on the results of these assessments in assurance statements. Assurance statements are required to be included in the Performance and Accountability Report (PAR).

HHS performance targets correlate with the OMB PAR submission deadlines.

*Performance Results:* This was a new requirement for FY 2006. The Department fully implemented the A-123 requirements during FY 2006 and submitted the required A-123 assurance statements by the OMB reporting dates.

Office of the Chief Information Officer

| **Performance Goal: Provide a secure and trusted Information Technology (IT) environment.** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| 1.1. Enhance confidentiality, integrity, and availability of IT resources.<br><br>1.1.1. Improve reliability of critical IT infrastructure. | 2008<br>2007<br>2006<br>2005<br>2004<br>2003<br>2002 | 99.5%<br>99.5%<br>99.5%<br>99.5%<br>99.4%<br>99.2% | <br><br>99.8%<br>99.9%<br>99.4%<br>99.7% |
| 1.2. Ensure the availability and dissemination of information in preparation of or in response to local and national emergencies or other significant business disruptions.<br><br>1.2.1. Maintain the reliability of HHS IT systems. | 2008<br>2007<br>2006<br>2005<br>2004<br>2003<br>2002 | 99.8%<br>99.8%<br>99.8%<br>99.8%<br>99.8%<br>99.7% | <br><br>99.8%<br>99.9%<br>99.4%<br>99.97% |
| **Data Source:**. ITSC Availability Statistics | | | |
| **Data Verification and Validation:** | | | |
| **Cross Reference:** | | | |

## Performance Narrative

Performance Goal 1. Provide a secure Information Technology (IT) environment.

*Performance Target*: Enhance confidentiality, integrity, and availability of IT resources.

PG 1.1.1: Improve reliability of critical IT infrastructure services. This performance goal/measure was identified as 1.9 in the FY 2004 performance plan.

*Performance Result:*

*In FY 2003:* The Departmental level security oversight role has expanded to include formal, periodic review of OPDIV security programs, and facilitate the dissemination of information regarding new security mandates and legislation through on-going education programs. From FY 2003 through FY 2005, the Critical Infrastructure Protection (CIP) contract will provide

Certification and Accreditation (C&A) and reduce FISMA (formerly GISRA) corrective action items for all CIP and Presidential Decision Directive 63 assets. HHS intends to continue in its endeavor to achieve the established C&A goals for major IT systems by the end of FY 2003.

*In FY 2004:* HHS is continuing to develop its *Secure One HHS* program, the Department's integrated, proactive, enterprise-wide IT Security Program. *Secure One HHS* aims to address OPDIV security needs, meet departmental security responsibilities, and implement oversight recommendations through specific initiatives including coordination activities, system-specific security initiatives, contractual arrangements, security policy and guidance development, and IT security training and awareness activities. Specifically, the Department is continuing its C&A efforts requiring that all OPDIVs develop and submit a detailed C&A plan for all Department IT systems that have not yet undergone C&A. HHS will closely monitor the OPDIVs' progress in C&A throughout the year to ensure that the Department is meeting its established goals. In addition, the Department has been involved in outreach and coordination with the OPDIVs on IT security issues. For example, HHS is planning to establish Secure One Support, an email-based interactive tool designed to provide support and assistance for IT security issues. A strong partnership has been developed between the Secure One and HHS Enterprise Architecture programs resulting in the development of a security architecture that is integrated with the overall enterprise architecture. This will provide a framework for consistent implementation of security controls that are in compliance with HHS policy.

*In FY 2005:* HHS continued to ensure that the appropriate security considerations were addressed by maintaining focused attention on the completion of C&As for all IT systems. This focus has resulted in the completion of C&As for 99% of systems, with the remaining two scheduled for completion in FY 2006. This has been coupled with a program to ensure that all systems have a tested contingency plan so that once the secure systems are in place they continue to be available for use and that the business processes that they support are not adversely affected. This has resulted in an increase to over 81% of tested contingency plans. HHS has completed the implementation of the first phase of an automated Department-wide network and security monitoring system that will allow HHS to be proactive in identifying and resolving issues before they become system failures. This capability has already been instrumental in the identification and remediation of emergent virus attacks. This capability will also allow HHS to monitor compliance with security policies and configurations.

*In FY 2006:* HHS continued efforts to mature its security program and enhance the security posture of the Department. The satisfaction of multiple FISMA requirements was achieved during FY 2006, with many required elements, such as security certifications and accreditations and privacy impact assessments, completed at the 100% level. HHS anticipates that this will result in a much improved FISMA score once the details of the FISMA evaluation have been completed. HHS implemented a Department level scanning program that proactively scans the HHS network environment to identify potential vulnerabilities and to prioritize their remediation, and track that remediation to completion. HHS has also enhance its computer forensics capability to allow the Department to not only identify a vulnerability but track it back to its root cause, to prevent the vulnerability from occurring in the future.

*In FY 2007:* HHS will continue efforts to mature its security program and enhance the security posture of the Department. This will be pursued through a team approach that includes representation from across the Operating Divisions that compose HHS. This will be coupled with the continued evolution of the HHS shared network capability to ensure that effective security practices are coupled with the ability to rapidly respond to any perceived threats. Using

this model, HHS plans to advance the automated use of security tools in developing and implementing an increasingly effective security architecture that mitigates known risks and strives to proactively monitor for and identify those that may be lesser known as targets for exploitation.

*Performance Target:* Ensure the availability and dissemination of information in preparation of or in response to local and national emergencies or other significant business disruptions.

PG 1.2.1: Maintain the reliability of HHS IT systems. This performance goal/measure was identified as 1.10 in the FY 04 performance plan.

*Performance Result:*

*In FY 2003:* The Department established a target success rate of 99.7% for FY 2003, and achieved an actual performance rate of 99.97%.

*In FY 2004:* The Department established a target success rate of 99.8% for FY 2004. From FY 2003 through FY 2006, the Managed Security Services contract will establish 24/7 monitoring and response for security alerts and incidents. HHS is also in the process of implementing an integrated Network Operations Center (NOC) and a Security Operations Center (SOC) that will greatly enhance the ability to monitor both the health of the HHS network and the health of the HHS security posture, which will allow a more proactive approach to maintaining a healthy, reliable and available infrastructure.

*In FY 2005:* The HHS IT Security Program implemented the first phase of a security monitoring capability that has a close functional integration with the HHS Network Operations Center (NOC). The implementation of automated tools that continuously measure the HHS compliance with its established security policy, and that expose variances from those policies, eliminated the requirement to have this monitoring capability co-located with the NOC. The ability to monitor in real time the health and security of the HHS network has enhanced the reliability and availability of HHS systems.

*In FY 2006:* HHS implemented a monitoring program that provides enhanced situational awareness. HHS implemented a robust privacy and confidentiality program that monitors for any exposure of sensitive information and coordinates the response to any such exposures. HHS continues to increase its ability to proactively discover and remediate network and application vulnerabilities through the use of advanced automated tools that scan both areas for vulnerabilities for rapid remediation to improve reliability and availability of systems and which strengthens the overall security posture of the Department.

*In FY 2007:* The HHS IT Security Program will continue to improve the Departmental security and network monitoring capability. A primary area of focus this upcoming year will be to continue to perform due diligence in the identification of areas to be enhanced in support of the HHS ability to ensure the availability of digital assets in the event of any pandemic, public health emergency or HHS continuation of operations events. Testing of capabilities and capacities in this arena is planned that will allow HHS to expose areas of need in a simulated exercise to prevent unforeseen issues arising during a real event.

| Performance Goal: Implement an enterprise approach to information technology infrastructure and common administrative systems that will foster innovation and collaboration. | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| 2.1. Establish a basis for consolidated infrastructure to achieve interoperability and communication among OPDIVs (Enterprise Architectures (EA)).<br><br>2.1.1. Establish and maintain OPDIVs' and Department EAs for use in evaluating IT investments as a criterion for approval. | 2008<br>2007<br>2006<br>2005<br>2004<br>2003 | 100%<br>100%<br>100%<br>100%<br>100%<br>100% | <br><br>100%<br>100%<br>100%<br>100% |
| 2.2. Maximize the value of technology investments through enterprise-wide procurement and licensing.<br><br>2.2.1. Executive enterprise licensing to consolidate duplicative efforts. | 2008<br>2007<br>2006<br>2005<br>2004<br>2003 | 100%<br>100%<br>100%<br>100%<br>95%<br>90% | <br><br>80%<br>80%<br>80%<br>80% |
| **Data Source:**. Consolidated Enterprise Licensing and Competitive Sourcing | | | |
| **Data Verification and Validation:** | | | |
| **Cross Reference:** | | | |

Performance Goal 2. Implement an enterprise approach to information technology infrastructure and common administrative systems that will foster innovation and collaboration.

*Performance Target:* Establish a basis for consolidated infrastructure to achieve interoperability and communication among OPDIVs (Enterprise Architectures (EA)).

PG 2.1.1: Establish and maintain OPDIVs' and Department EAs for use in evaluating IT investments as a criterion for approval. This performance goal/measure is a modification to 1.2 in the FY 2004 performance plan.

*Performance Result:*

*In FY 2003:* The HHS Enterprise Architecture Group (EAG) revised the HHS Information Technology Architecture (ITA) document in September 2002 to include reformatting the ITA for consistency with the Federal EA (FEA) document structure and realigning the original ITA Lines of Business with the OMB FEA Business Reference Model. During FY 2003, significant progress has been made in program management, program resource management, HHS EA development, and EA training. There has been continued participation by HHS as full members of the Architecture and Infrastructure Committee components and governance subcommittees. The EA Program has focused on providing assistance and support to the HHS OPDIVs as well as making a contribution to the FEA initiative. HHS has installed the EA Management System tool and will continue to leverage its use for EA development. Also, HHS has formed an EA project team to facilitate the EA development at HHS and its OPDIVs.

*In FY 2004:* During FY 2004, with the Enterprise Architecture (EA) Program Management Office (PMO) in place, the first iterations of the baseline EA and the target EA were developed. The Enterprise Architecture Program Team (EAPT) focuses on providing architectural perspectives into the E-Government initiatives, HHS-wide IT initiatives, creating increased alignment with the Federal Enterprise Architecture (FEA) initiative and evolving the HHS EA

program toward greater levels of architectural maturity, as measured by the General Accounting Office (GAO) Enterprise Architecture Management Maturity Framework (EAMMF). This HHS EA program evolution will involve the continued participation of the OPDIVs in keeping with the vision of "One HHS." This program will soon provide an enterprise technical standards profile, an integrated security architecture and accomplish the implementation of a Department-wide implementation of an EA repository, modeling and analysis tool.

*In FY 2005:* During FY 2005, the Enterprise Architecture (EA) Program successfully met the level three (3) of architectural maturity, as measured by the OMB Enterprise Architecture Assessment Tool.

HHS has now begun the architectural inspection of priority business domain areas that will allow the Department to make strides toward greater interoperability, data sharing, efficiency and effectiveness. As each of these domain areas are addressed HHS will develop transition strategies that will allow the Department to move closer toward a set of share infrastructure and administrative system services.

*In FY 2006:* During FY 2006, the Enterprise Architecture (EA) Program will once again be challenged to successfully meet the level three (3) of architectural maturity, as measured by the OMB Enterprise Architecture Assessment Tool. This accomplishment will be measured against the new OMB Enterprise Architecture Assessment Tool Version 2.0, which significantly raises the performance levels to be met.

HHS implemented a comprehensive segmented approach to its enterprise architecture that allows common business process needs to be addressed across organizational boundaries and which identifies communities of interest that strive for enhanced interoperability and data sharing within each architectural segment. This model has provided perspectives that allow for focused attention to each of the major architectural segments in developing strategic, investment and performance plans that inform business and investment decision making within the context of a mature IT governance process.

*In FY 2007:* During FY 2007, the Enterprise Architecture (EA) Program will be challenged to successfully meet the level four (4) of architectural maturity in the 'Completion' capability area, as well as a three (3) in both the 'Use' and ' Results' capability areas of the OMB Enterprise Architecture Assessment Tool Version 2.1. The elevation of the scores to be achieved in all areas and the new OMB Enterprise Architecture Assessment Tool Version 2.1 criteria, once again, significantly raises the performance levels to be met.

*Performance Target:* Maximize the value of technology investments through enterprise-wide procurement and licensing.

PG 2.2.1: Execute enterprise licensing to consolidate duplicative efforts. This performance goal/measure was identified in 1.5 in the FY 2004 performance plan. (NOTE: Based on the implementation of "One HHS," this measure is now interpreted to cover IT investments in which HHS is afforded better prices through volume discounts).

*Performance Result:*

*In FY 2003:* During FY 2003 HHS achieved $41 million in gross cost avoidance for software licensing as a result of aggregated requirements for 17 software manufacturers. Resellers

servicing these agreements are providing account management and reporting functions for HHS, resulting in more efficient commercial activities for both the government and the commercial sectors.

*In FY 2004:* During FY 2004 HHS continued to pursue enterprise licensing agreements on all contracts where such efforts are deemed cost-effective. The Department is anticipating additional licensing guidance from the General Services Administration (GSA) during FY 2004, specifically on the SmartBUY interagency initiative that is currently under consideration. This guidance could have substantial impact on the Department's future licensing activities. HHS has continued to leverage enterprise contracts for purchases and licenses for tools that provide shared services across the Department, such as, a portfolio management tool, a EA tool and the development of a contract for enterprise purchases of personal computers and computer peripherals.

*In FY 2005:* During FY 2005 HHS implemented a contract for enterprise purchases of personal computers and computer peripherals, developed an enterprise license for Oracle, and has begun the enterprise deployment of a standard network and security monitoring tool, all of which allowed for significant cost savings through the leveraging of volume purchases. HHS will continue to look for such opportunities as the HHS enterprise architecture work exposes areas where these same types of cost savings may be available.

*In FY 2006:* HHS continued to leverage the benefit of competitive and strategic sourcing as evidenced by the negotiation of enterprise licenses for data encryption and web application security scanning tools. HHS also negotiated purchase and support agreements for various types of computer servers within the context of a comprehensive computer support contract.

*In FY 2007:* HHS will continue to look for opportunities in competitive and strategic sourcing as the HHS enterprise architecture work exposes areas where business value can be realized.

**Performance Goal: Achieve excellence in IT management practices.**

| Measure | FY | Target | Results |
|---|---|---|---|
| | 2008 | 100% | |
| 3.1. Strengthen HHS enterprise-wide processes for collaborative | 2007 | 100% | |
| IT strategic planning, capital planning, and investment control. | 2006 | 100% | 100% |
| | 2005 | 100% | 100% |
| 3.1.1. Establish, implement, and maintain a 5- year HHS | 2004 | 100% | 100% |
| Enterprise IT Strategic Plan that supports "One- HHS". | 2003 | 100% | 100% |
| 3.1.2. Maintain Performance Plans and Goals, linked to the 5 | 2008 | 100% | |
| year HHS Enterprise IT Strategic Plan. | 2007 | 100% | |
| | 2006 | 100% | 100% |
| | 2005 | 100% | 100% |
| | 2004 | 100% | 100% |
| | 2003 | 100% | |
| | 2008 | 100% | |
| 3.2 Apply strong project management and performance measures | 2007 | 100% | |
| processes to critical IT projects to achieve project success. | 2006 | 100% | 100% |
| | 2005 | 100% | 100% |
| 3.2.1. Implement ITIRB practices for review and approval of IT | 2004 | 100% | 100% |
| investments. | 2003 | 100% | 100% |
| 3.3.Establish and maintain IT policies and SOPs to ensure | 2008 | | |
| compliance with evolving Federal legislation and OMB | 2007 | | |

| Performance Goal: Achieve excellence in IT management practices. | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| regulations. | 2006 | 100% | 100% |
| | 2005 | 99% | 99.8% |
| 3.3.1. Ensure HHS information collections meet the requirements of the PRA (e.g.,eliminate unapproved collections of information per the PRA) | 2004 | 99% | 100% |
| | 2003 | 100% | 100% |
| | 2008 | | |
| | 2007 | -5% from FY 2006 | -2.13% |
| 3.3.2. Reduce, minimize and control information burden on the public per the PRA, with a 5% reduction goal from the prior year. | 2006 | -5% from FY 2005 | +94.57 % |
| | 2005 | -5% from FY 2004 | |
| | 2004 | -5% from FY 2003 | +9.3% |
| | 2003 | -5% from FY 2002 | +1% |
| 3.3.3. Ensure compliance with GPEA requirements. | 2007 | N/A | N/A** |
| | 2006 | N/A | N/A** |
| ** Note: It is anticipated that OMB will no longer require GPEA compliance reports for 3.3.3 after implementation deadlines of October 2003. | 2005 | 95% | N/A** |
| | 2004 | 90% | N/A** |
| | 2003 | 83% | 83% |
| | 2002 | | |
| **Data Source:** HHS Enterprise Architecture, IT Capital Planning Programs, Annual Information Collection Report. | | | |
| **Data Verification and Validation:** | | | |
| **Cross Reference:** | | | |

Performance Goal 3. Achieve excellence in IT management practices.

*Performance Target:* Strengthen HHS enterprise-wide processes for collaborative IT strategic planning, capital planning, and investment control.

PG 3.1.1: Establish, implement, and maintain a 5-year HHS Enterprise IT Strategic Plan that supports “One HHS”. This performance goal/measure was identified in 1.7 in the FY 2004 performance plan.

PG 3.1.2: Maintain Performance Plans and Goals, linked to the 5-year HHS Enterprise IT Strategic Plan. This performance goal/measure is new and is associated with performance goal/measure 3.1.1 above.

*Performance Result:*

*In FY 2003:* Under the direction of the Secretary, IRM developed in May 2002 a Enterprise IT Strategic Plan to ensure the establishment of an enterprise architecture and to achieve an optimal integration and consolidation for IT infrastructure and common administrative systems across HHS. The 5-year HHS Enterprise IT Strategic Plan, covering FY 2003 to FY 2008, was delivered to the OMB in May 2003. In an effort to more effectively manage HHS business activities, we have endeavored to closely align the planning and performance components. We have highlighted herein major HHS objectives and rephrased or rewritten performance goals/measures to reflect the updates those objectives in our Enterprise Plan. We intend to monitor and update this Plan, as well as the associated performance plan, on an annual basis. To strengthen the Capital Planning and Investment Control (CPIC) process, HHS commissioned a

cross-functional CPIC Program Team with OPDIV participation as part of the IT Strategic Plan Initiatives new for FY 2003.

*In FY 2004:* The HHS Enterprise IT Strategic Plan for FY 2003 - FY 2008 was updated and delivered to OMB in December 2003. This plan reflects significant improvements in the HHS IT strategic planning program, including a structured planning process and improvements to the performance management activities that support the achievement of the HHS IT strategies. To further integrate strategic planning with CPIC and other IT management processes, HHS has identified the major integration points and continues to move toward the formal integration of these processes. These improvements to the HHS IT strategic planning program will result in a comprehensive program of performance-based IT planning and management and HHS. An initiative is underway that will link HHS planning processes from strategic planning through and including performance management along with the enterprise process continuum that includes enterprise architecture, capital planning, IT budgeting and project management. Once completed this will create an integrated set of processes that are mutually supportive and which are fully aligned with both strategic and tactical goals.

*In FY 2005:* The HHS Enterprise IT Strategic Plan has once again been reviewed and a corresponding update to the HHS IT Performance Plan has been completed. HHS has also reorganized the Office of the Chief Information Officer to place strategic planning, IT capital planning, enterprise architecture and performance management under the same oversight to ensure the integration of all of these programs into a composite set of processes that represent a complete enterprise planning and performance life cycle that are functioning in support of strategic and tactical goals and objectives.

*In FY 2006:* The HHS Enterprise IT Strategic Plan has been revised to reflect the annual perspectives needed to guide the HHS efforts. This year there will also be the development of tactical plans in both the infrastructure and mission areas in support of the HHS Enterprise IT Strategic Plan. This will provide a framework within which investments can be proposed and evaluated during the HHS Capital Planning and Investment Control process.

*In FY 2007:* The HHS Enterprise IT Strategic Plan is reviewed and revised each year to reflect the annual perspectives needed to support the HHS efforts. This year there will be a major revision to the HHS strategic business plan that will update the strategic direction for the Department. A corresponding revision of the HHS IT Strategic Plan will align the IT strategies in support of that revised strategic business direction.

*Performance Target:* Apply strong project management and performance measurement processes to critical IT projects to achieve project success.

PG 3.2.1: Implement ITIRB practices for review and approval of IT investments. This performance goal/measure was identified in 1.1 and 1.2 in the FY 2004 performance plan.

*Performance Result:*

*In FY 2003:* HHS developed a guide for IT Capital Planning and Investment Management wherein the requirements under CPIC will be emphasized, along with the requirement of OPDIV CIOs to annually provide and certify an inventory of all current and future IT-related initiatives. CIOs will also be required to submit a quarterly report on all initiatives reviewed by the OPDIV ITIRB and the outcome of each review. All major IT projects were reviewed by the HHS ITIRB

to ensure elimination of projects redundant with existing e-Gov efforts and project integration or interface with e-Gov efforts, as needed. In addition, HHS has installed the Information Technology Investment Portfolio System (I-TIPS) for portfolio management. To date, eleven HHS ITIRB reviews have been conducted.

*In FY 2004:* HHS drafted revised CPIC Policies for CPIC, Alternatives Analyses and drafted standardized templates for Business Cases and Work Breakdown Structures (WBS) that establish the responsibilities for performing IT CPIC throughout the Department. A second document, the HHS CPIC Procedures, provides the procedures and practices for conducting CPIC. The role of the ITIRB in the CPIC process has been clearly articulated in the CPIC Policy and CPIC Procedures. By first focusing on the CPIC governance structure and integration of CPIC critical partner functions, the Department is creating a standardized CPIC process to provide a Departmental framework for an integrated review of IT investments and portfolio selection and maintenance. As part of the CPIC reengineering effort, a pilot Control Review is being planned during FY 2004 for eighteen enterprise initiatives identified in the HHS IT Strategic Plan. The investments are conducted in a disciplined, well-managed, and consistent manner demonstrating sound project management principles. This year a portfolio management tool was implemented and used to collect information on proposed IT investments that were then used to inform budget deliberations for the FY 2006 HHS budget. This information illustrated the relative quality of the project planning effort completed prior to an investment being proposed.

*In FY 2005:* HHS for the second year developed a prioritized list of IT investments that will be used in developing the portfolio for consideration in the HHS IT budget. This list was developed based on a criteria representing alignment with strategic and tactical goals and objectives as well as a demonstration of sound project management potential.

This year HHS also began the control and evaluate reviews for IT projects currently underway, to ensure that the investment is performing and being managed to original expectations. The HHS ITIRB reviewed these ongoing projects on a quarterly basis with monthly earned value reports being made available for the first time in the process. HHS is approaching the collection of 100% of IT project earned value information and will reach that 100% goal as it further implements the earned value management (EVM) practices outlined in its EVM Roadmap.

*In FY 2006:* HHS each year develops a prioritized list of IT investments that will be used in developing the IT portfolio for recommended for consideration in the HHS IT budget deliberations. This list is always developed based on a criteria representing alignment with strategic and tactical goals and objectives as well as a demonstration of sound project management potential.

This year HHS implemented the rigor of earned value management withing the control and evaluate reviews for IT projects currently underway to ensure that the investment is performing and being managed to original expectations. The evaluation of this information that demonstrates that a project is being managed effectively based on cost, schedule and performance expectations was used to inform decisions of the IT Investment Review Board.

*In FY 2007:* HHS each year develops a prioritized list of IT investments that will be used in developing the IT portfolio for recommended for consideration in the HHS IT budget deliberations. This list is always developed based on a criteria representing alignment with strategic and tactical goals and objectives as well as a demonstration of sound project management potential.

This year HHS will implement additional reviews of investments by subject matter experts within the architectural business segment the investment is intended to support. This will ensure the efficacy of the IT investment approach taken in support of that segment of business activity at HHS. A project management stage review process will also be implemented this year to ensure that the rigors of effective project and investment management have been addressed for a preceding project stage before investments continue to the next stage of the project.

*Performance Target:* Establish and maintain IT policies and SOPs to ensure compliance with evolving Federal legislation and OMB regulations.

PG 3.3.1: Ensure HHS information collections meet the requirements of the Paperwork Reduction Act (PRA); e.g., eliminate unapproved collections of information per the PRA. This performance goal/measure was identified in 2.1 in the FY 2004 performance plan.

PG 3.3.2: Reduce, minimize and control information burden on the public per the PRA, with a 5% reduction goal from the prior year. This performance goal/measure was identified in 2.2 in the FY 2004 performance plan.

PG 3.3.3: Ensure compliance with GPEA requirements. This performance goal/measure is a modification to 2.3 in the FY 2004 performance plan.

*Performance Result:*

*In FY 2003:* With respect to information collections conducted pursuant to the PRA, HHS identified and remedied violations, which were reported in accordance with the Information Collection Budget process. Under the GPEA, the Department has included 340 transactions in the plan. Of these, 91 were designated as “not practicable” for compliance with GPEA. Of the remaining 249 transactions, HHS completed 207 (83%) by the deadline of October 2003. Only 40 (17%) were completed after the deadline. Due to new legislation that increased the information burden, particularly on CMS, the reduction goal of 5 was not met for PG 3.3.2.

*In FY 2004:* With respect to information collections conducted pursuant to the PRA, HHS will identify and remedy any violations, which will be reported in accordance with the upcoming Information Collection Budget process. To meet PG 3.3.1, eliminating unapproved collections of information per the PRA, a goal of 90% has been set for FY 2004 and 100% for FY 2005. It is not expected that specific reports regarding GPEA compliance, PG 3.3.3, will be required any longer by OMB since the implementation deadline of October 2003, set by OMB, has passed.

*In FY 2005:* HHS eliminated all but 2 of 924 violations with respect to approved collections for an approved percentage of 99.8%. In spite of the reduction of 36 million hours of reductions that were achieved with respect to major targeted collections, the HHS collection burden increased by over 283 million hours. Most of this increase (212 million hours) was related to the information collection requirements in the Medicare Prescription Drug Program.

*In FY 2006:* HHS eliminated all violations with respect to approved collections for an approved percentage of 100%. The reduction of more than 64 million burden hours was achieved by targeting major collections. The HHS collection burden decreased by 11.9% over last year. The majority of this decrease was related to an adjustment to the information collection requirements in the Medicare Prescription Drug Program.

*In FY 2007:* HHS will continue its zero tolerance approach to violations of the PRA with respect to approved collections. This effort should be facilitated by the interface of the HHS ICRAS system with the OMB ROCIS system which together will streamline the data collections review and approval process. HHS continues to pursue the 5% reduction each year in information collection burden.

<u>Office of Grants</u>

| **Long Term Goal: Improve the efficiency and accessibility of Federal assistance for the grant community.** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| HHS Competitive Grant Opportunities Announced Through Grants.gov. | 2008<br>2007<br>2006<br>2005<br>2004 | 100%<br>100%<br>100%<br>100%<br>80% | <br><br>100%<br>100%<br>80% |
| HHS Grant Programs for Which Grant Applications can be received Through the Grants.gov Fund and Apply Storefront | 2008<br>2007<br>2006<br>2005<br>2004 | 95%<br>90%<br>75%<br>50%<br>15% | <br><br>75%*<br>52%<br>15% |
| HHS Applications Received Through the Grants.gov Find and Apply Storefront | 2008<br>2007<br>2006<br>2005<br>2004 | 75,000<br>50,000<br>15,000<br>8,000<br>6,000 | <br><br>45,000+<br>2,357<br>Not Achieved |
| HHS Completion of Grant System Consolidation | 2007<br>2006<br>2005<br>2004 | <br>100%<br>40%<br>20% | <br>100%**<br>57%<br>17% |
| Provide oversight to all Departmental grant programs to improve overall consistency of administrative management of grants. | 2008<br>2007<br>2006<br>2005<br>2004 | 70% compliance<br>60% compliance<br>50% compliance<br>40% compliance<br>25% compliance | <br><br>50%<br>40%<br>25% |
| HHS Implementation of P.L. 106-107 Grants Streamlining Policy Initiatives | 2008<br>2007<br>2006<br>2005<br>2004 | 75%<br>60%<br>50%<br>40%<br>20% | <br><br>50%<br>40%<br>20% |
| **Data Source:** Spreadsheets from Grants.gov PMO and OG data call -*7 OPDIVs at 100% Apply Package Posting; 1 at 83%<br>**Does not include CMS mandatory grants | | | |
| **Data Validation:** | | | |
| **Cross Reference:** PMA | | | |

**Performance Narrative:**

<u>Performance Goals 1 – 3:</u> HHS serves as the Managing Partner for the government-wide initiative known as Grants.gov, which allows applicants for all Federal grants to search and apply for grants in a single location. Since the initiative's inception in 2002, HHS has worked with the 26 grant-making agencies, the Office of Management and Budget, and the grants community to address long-standing inefficiencies in Federal grants processes. Grants.gov's

Find and Apply accomplishes the mandates of the President's Management Agenda (PMA) to provide to the public a unified, citizen-centric web site that provides accurate and reliable information in a single location and simplifies the burden of the application process for the grant community. HHS's Office of Grants seeks to continue its coordinating role of this important project, with goals to increase the number of grant announcements in Grants.gov Find and Apply, as well as the number of programs for which grantees can apply and the number of applications received through the Grants.gov Find and Apply Storefront.

*Performance Results:* The Grants.gov Find and Apply began operations in October 2003. This has enabled HHS to establish baselines in FY 2004 and subsequent years, with respect to performance measures. HHS was an early adopter of Grants.gov Find and Apply and began posting its competitive grant opportunities in February 2003. Grants.gov's Find and Apply also supports achievement of key P.L. 106-107 Federal grants streamlining goals through the establishment of standard processes and data definitions for Federal agency/grants community interactions. This, in turn, reduces the administrative burden placed on the grants community.

As for Fiscal Year 2006 results, HHS has reached the 100% OMB milestone for posting of grant announcement synopses for discretionary grant opportunities on Grants.gov's Find and the 75% milestone of posting electronic application packages on Grants.gov's Apply, as enunciated below:

HHS has received approximately 45,000 grant applications via Grants.gov so far this fiscal year. This number is 300% of the target set forth at the beginning of the year and single-handedly fulfills the Grants.gov government-wide goal for submissions in FY2006. Receiving this amount of applications takes focused outreach and grantee support; HHS has actively and successfully promoted Grants.gov uptake among, which is at the heart of the OMB milestones.

The "HHS OpDiv Status" sheet shows that HHS has 1126 grant opportunity synopses, compared to 729 synopses with matching packages, or 65% Note that there were actually 759 "total packages," which includes situations where a single synopsis announces multiple competitions, with each competition having its own package. This "multiple competitions per synopsis" capability was built into Grants.gov to meet valid agency business process requirements, and the percentage milestone penalizes HHS for using that needed capability by lowering the result by 3.3 percentage points. HHS also has 339 continuation packages posted—packages that grantees can use to apply for continuation years of their grants. These continuation packages are actually quite fruitful for Grants.gov applicants, targeting a highly incentivized applicant population. The continuation packages do not require a synopsis, given that they are open only to existing grantees. Thus the special purpose and continuation packages, which contribute significantly to the Grants.gov uptake goal, do not count in the 75% goal as they did last fiscal year, yet the decision to exclude them was not made until March 2006, fully halfway into the fiscal year and too late for the agency to make accommodating adjustments. If we treated each package as having a synopsis, then we would calculate using 759 as the number of application packages and 338 (for continuations) would be included on each side of the equation:

$$(759+338)/(1126+338) = 74.9\ \%$$, which rounds to the whole number 75%

This rationale is credible, maintains the integrity of the 75% goal, and provides a way to score HHS's 45,000 applications received as supporting Grants.gov uptake. There should be no concern that the packages being counted are somehow less valuable than other packages, for Grants.gov has said that "The average number of submissions per posted package for HHS is

higher than the average of all agencies."

Performance Goal 4: HHS completion of Grant System Consolidation

*Performance Target:* As part of an overall effort to improve department-wide management of Federal assistance programs, HHS has determined that all grants are to be supported by a single unified HHS Enterprise Grants Management System (EGMS). The OG focus on grant management system consolidation within the Department includes the reduction of redundant, Operating Division-specific, electronic grant portals, in essence, consolidating eleven distinct systems into two unified systems. This determination requires that HHS Operating Divisions change their business processes to conform to the process supported by EGMS and is consistent with both the Office of Management and Budget direction and the HHS Secretary's call for "One Department," in addition to achieving greater efficiencies and consistencies with respect to grants management.

*Performance Result:* The HHS Operating Divisions have been directed to migrate away from OPDIV-specific grant management systems, moving to use either the ACF GATES or NIH eRA IMPAC II systems, saving the substantial cost of running redundant systems. All agencies have submitted migration plans, and have already initiated migration activities. Almost all agencies have issued new awards for 2006 using either ACF GATES or NIH eRA IMPAC II. HRSA, originally slated to migrate to NIH eRA IMPAC II, conducted further analysis and concluded that ACF GATES was the more appropriate system to meet its business needs. HRSA is on target to have ACF GATES as its system of record by September 2006. CMS Mandatory grants system managers have initiated discussions with ACF GATES. Migration completion is scheduled for September 2007. The key element of this strategy has been the communication established between NIH and ACF and the OG. This communication ensures that proposed changes to EGMS are fully coordinated enterprise-wide through a formal change management process and monitors the activities of the teams supporting the two EGMS component sub-systems.

Performance Goal 5: Provide oversight to all Departmental grant programs to improve overall consistency of administrative management of grants.

*Performance Target:* Streamlining, simplifying, improving and making more consistent the administrative management of grants, cooperative agreements and other forms of Federal assistance by conducting evaluations of OPDIV program announcements, and providing technical assistance. This will be accomplished in part by reviewing grant funding announcements and conducting oversight reviews to the more than 300 grant programs throughout the Department to ensure policy and procedure implementation consistency throughout OPDIV grants management offices.

Provide leadership in the areas of managing cost policy and have functional responsibility for cost principles and Department-wide cost policies and procedures affecting grants and contracts. Serve as the Departmental liaison and maintain working relationship with OMB and other Federal agencies in the development of government-wide cost principles; maintain similar relationship with association of States, universities, and other grantee contractor organizations.

*Performance Result:* OG continues to implement the Grant Review Process whereby all new, discretionary, non-biomedical, grant funding announcements and notifications are reviewed prior to dissemination/publication for accuracy, completeness, consistency and clarity, to ensure

compliance with all applicable Departmental regulations, policies and procedures. Since its inception in May 2002, a total of 1,700 announcements have been reviewed. The cost savings being realized are steadily increasing and are currently estimated to be $1M which should significantly increase within the next year as anticipated changes to HHS grants policy will no longer require announcements to be published in the Federal Register. In order to keep pace with new policy initiatives and changing requirements, the grant announcement review transformation process is currently underway to modernize this grants management business process (grant Announcement review) by adopting an electronic automation solution.

<u>Performance Goal 6:</u> HHS Implementation of P.L. 106-107 Grants Streamlining Policy Initiatives

*Performance Objective:* P.L. 106-107, Federal Financial Management Assistance Improvement Act, calls for grants streamlining across the 26 Federal grant making agencies. HHS is the lead agency for implementation of this law, co-managing the government-wide effort with OMB. OG has P.L. 106-107 responsibility for both government-wide leadership as well as its implementation with HHS. Four cross government P.L. 106-107 work groups (Pre-Award, Post-Award, Mandatory and Audit) have been established to develop government-wide streamlining policies in their respective areas. Grants.gov, one of the 24 government-wide e-gov initiatives, serves as the mechanism through which P.L. 106-107 policies are implemented in an electronic forum.

# ASSISTANT SECRETARY FOR ADMINISTRATION AND MANAGEMENT

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $15,644,000 | 15,854,000 | $16,418,000 | +$564,000 |
| FTE (including reimbursables) | 122 | 127 | 129 | +2 |

## Statement of the Budget Request

The FY 2008 request for the Assistant Secretary for Administration and Management (ASAM) is $16,418,000, an increase of $564,000 above the FY 2007 Continuing Resolution (CR) level.

## Program Description

The duties and responsibilities of ASAM include: advising the Secretary on all aspects of administration; providing leadership, policy guidance, supervision, and coordination of long and short-range planning for the Department; and ensuring that HHS meets its goals as set forth in the President's Management Agenda (PMA).

ASAM's responsibilities involve a number of functions which have been consolidated into the following major areas: Office of Acquisition Management and Policy, Office of Small and Disadvantaged Business Utilization, Office of Business Transformation, Office of Human Resources, Office of Facilities Management and Policy, Office of Diversity Management and Equal Employment Opportunity, and Office of the Secretary Executive Office. ASAM is also responsible for the Program Support Center, which is funded through other sources. Descriptions of each area follow:

**Office of Acquisition Management and Policy (OAMP)** – Provides performance leadership for HHS business practices through policy development and oversight and management of HHS contracts and logistics. OAMP's responsibilities include:

- Monitoring the performance of acquisition-related activities and programs of the Department; evaluating the performance of those programs on the basis of applicable performance measurements; and advising the Chief Acquisition Officer regarding appropriate business strategies to achieve the mission of the Department.

- Increasing the use of full and open competition by establishing policies, procedures, and practices that ensure receipt of sufficient numbers of competitive proposals from responsible sources.

- Increasing the appropriate use of performance-based contracts and performance specifications.

- Ensuring that acquisition decisions are consistent with all applicable laws, and establishing clear lines of authority, accountability, and responsibility for acquisition decision making.

- Managing the direction of acquisition and logistics policy (including travel policies) for the Department, including implementation of acquisition policies, regulations and standards unique to the Department.

- Developing and maintaining an acquisition career management program that ensures an adequate professional workforce.

- Facilitating the achievement of performance goals established for acquisition management, and reporting progress made in improving acquisition management capability.

- Leading the consolidation of administrative management functions in the areas of procurement and logistics.

- Providing leadership on department-wide workgroups tasked with reducing administrative expenses and eliminating redundancies in these business systems.

- Establish overall departmental travel policy, manage the travel card and e-travel systems, and provide direct travel support to the IOS and the OS STAFFDIVs.

Performance Analysis

The Service Acquisition Reform Act of 2004 requires agencies to improve contract operations and measure improvement efforts. OAMP continues to meet the standards set forth by the Act as outlined in our Program Activities and measured by our performance goals.

**Office of Small and Disadvantaged Business Utilization (OSDBU)** – Advises the Secretary and the Deputy Secretary on services and practices to best foster the use of small and disadvantaged businesses as Federal contractors pursuant to Public Law 95-507; provides leadership, guidance and policy recommendations as well as coordinating short and long range strategic planning to aid small business; manages the development and implementation of appropriate outreach programs with small businesses aimed at heightening the awareness of the small business community to contracting opportunities available within HHS.

OSDBU's responsibilities include:

- Monitoring the performance of acquisition activities by Department OPDIVs as they relate to Department's small business goals.

- Increase the use of small businesses as HHS contractors by best practices and policy that ensure that sufficient numbers of small businesses are considered during the procurement process.

- Ensure that acquisition decisions are consistent with applicable laws and fairly take into consideration the need and use of small businesses as HHS contractors.

OSDBU will continue to monitor the performance of acquisition activities by Department OPDIVs as they relate to the Department's small business goals; increase the use of small businesses; and ensure that acquisition decisions are consistent with applicable laws and fairly take into consideration the needs and use of small businesses as HHS contractors.

**Office of Business Transformation (OBT)** – Provides results-oriented strategic and analytical support for key management initiatives and coordinates with others the business mechanisms necessary to account for the performance of these initiatives and other objectives as deemed appropriate. OBT also oversees the implementation of strategic initiatives and competitive sourcing activities Department-wide to generate savings and improve efficiencies.

OBT's responsibilities include:

- Integrating the work performed by ASAM in the areas of business process reengineering, core business mission activities, responsibility, and investment matters as determined by ASAM.

- Providing coordination and management support, performing management and administrative analysis and developing policy and guidelines to ASAM as appropriate for proposed or ongoing management initiatives to improve management effectiveness and gain management efficiencies on a department-wide basis.

- Leading HHS development of results- and savings-oriented High Performing Organizations (HPOs), an alternative to public-private competition, by participating in a OMB-led working group developing government-wide policy guidance and collaborating with OPDIVs to create additional HPO proposals.

- Collaborating with STAFFDIVs, especially the Office of the Assistant Secretary for Planning and Evaluation and the Office of the Assistant Secretary for Resources and Technology, to formulate the process for developing the annual Department-wide Objectives.

- Providing Department-wide leadership, centralized oversight, policy and guidelines, and coordination support relating to competitive sourcing activities, and representing the Department in dealings with OMB, GAO and other Federal agencies in this area.

The OBT will continue to meet the specific requirements outlined in the PMA. As directed by Congress, the Department has developed a Green Competition Plan (GCP) based on "considerable research, sound analysis of past activities and consistency with the Department's mission." The GCP seeks to maximize the advantages of competitive sourcing without unnecessary disruptions. OMB approved the GCP through 2013 in May 2004. To date the Department has achieved the following estimated savings: FY 2003 – $105 million; FY 2004 – $196 million; FY 2005 – $155 million. In FY 2005, HPO-related savings were $34M with an additional $134M in savings is expected through FY2009.

**Office of Human Resources (OHR)** – Provides leadership in the development and assessment of the Department's human resources program and policies. Designs human resources programs and strategies that support and advance the HHS mission and objectives of the PMA. Serves as Department liaison to central management agencies exercising jurisdiction over personnel matters.

OHR's responsibilities include:

- Serving as the Departmental contact for Strategic Management of Human Capital, one of the five management objectives measured on the President's Management Agenda

scorecard and providing leadership to the development and assessment of the Department's human resources program and policies.

- Designing human resource programs that support and enhance the HHS mission, and overseeing enterprise-wide recruitment, retention, and succession programs, including: leadership development and succession programs (i.e. Emerging Leaders Program); SES candidate development; and college relations programs.

- Providing technical assistance through consolidated Human Resource Centers to the Department's operating divisions in building the capacity to evaluate the effectiveness of their human resource programs and policies.

- Evaluating and refining workforce planning processes to ensure they are integrated with the development of agency budget proposals, performance contracts and plans, workforce restructuring plans, hiring plans and plans for learning and development.

- Supporting workforce and career development through the formulation of policies, strategies, and programs that assist employees in attaining competencies required to meet current and future agency goals; directly providing classroom training, career planning and online learning options through the HHS University.

Key Performance Goals:

- Support HSPD-12 through establishment of policies, programs, and procedures to implement required changes in HR administration, to include determination of position sensitivity levels, revised intake procedures, coordination with other Federal agencies, etc.

- Implement a Human Capital Accountability Plan to facilitate continuous improvement of Human Resources Management.

- Achieve full deployment of Enterprise Workflow Information System (eWITS), to include tracking and reporting of personnel actions, and improve data integrity and accuracy by interfacing with other key automated HR systems.

- Maintain and support departmental intern programs to provide learning and developmental opportunities and work experiences for students in high school, vocational and technical schools, and undergraduate and graduate college programs.

- Establish a Department-wide mid-level development program to promote effective succession planning and to strengthen the skills of individuals who have shown the potential to become outstanding leaders within the Department. This new program will target current on board employees at the GS-12-14 levels who have demonstrated high potential for assuming greater leadership roles and responsibilities. The program will include rigorous training, developmental assignments, mentoring, group projects and exposure to the senior leadership throughout the Department.

OHR continues to meet performance goals, providing strategic leadership for managing human capital: assessing and refining strategies for recruitment, retention and redeployment, and thus ensuring that HHS has the employees with the knowledge and skills necessary for the future.

Specifically, OHR has:

- Refined and further developed data-based systems and metrics for documenting progress in implementing the human capital management provisions of the PMA.

- Implemented human resource reporting systems to provide decision-makers at the Department and OPDIVs with information they can use for strategic human resource planning and management.

- Implemented a 4-tier, one department Performance Management Appraisal Program (PMAP), where all employees performance plans align with and support the Departments mission, objectives and goals. These plan also adhere to merit system principles.

- Incorporated audit strategies, including the Performance Appraisal Assessment Tool (PAAT), at an HHS beta site to ensure that the Performance Management Appraisal Program (PMAP) is performing efficiently and effectively. The tool resulted in the development of strategies to improve our PMAP system's performance.

- Updated the Human Capital Plan, which establishes goals that support the HHS Strategic Plan objective to improve the management of human capital. For example, continuity of leadership and knowledge is ensured through succession planning and professional development. Performance appraisals for senior executives and managers link to agency mission and cascade appropriately throughout the organization.

- Developed the Accountability and Implementation Plan that sets forth HC goals, strategies and measures. This begins the process for agency self-auditing and provides for an annual report. Additionally, the plan meets OPM's standard for agency self accountability systems.

- HHS continues to reduce the number of days it takes to hire new employees.

**Office of Diversity Management and Equal Employment Opportunity (ODME)** – Consists of three directorates: EEO Compliance, Diversity, and Programs Evaluation and Policy, which provide oversight of the Department's efforts in the areas of diversity management and equal employment opportunity. ODME leads HHS in creating and sustaining a diverse workforce and promoting a workplace free of discrimination by establishing Departmental policy, conducting program evaluations, ensuring EEO compliance, and strengthening diversity through outreach, recruitment, and special employment initiatives.

ODME's responsibilities include:

- Establishing policy and conducting program evaluation to ensure Diversity and EEO efforts throughout the Department are integrated, standardized and compliant with regard to legislative and regulatory requirements.

- Providing oversight with regard to Departmental compliance with the Equal Employment Opportunity Commission Management Directive 715 which establishes guidelines for achieving a model EEO program.

- Providing technical assistance and coordination with the Office of Human Resources on management and recruitment initiatives, assessment reviews and OPDIVS review processes related to improving Diversity and EEO programs.

- Serving as the Departmental contact in the provision of assistive technology, devices and services to HHS employees with disabilities via the HHS partnership with the DoD Computer/Electronic Assistance Program (CAP).

- Reviewing, analyzing and adjudicating complaints of discrimination for purposes of issuing Final Agency Decisions on behalf of the Secretary, Health and Human Services.

Key Performance Goals:

- Increase hire of under-represented groups to levels matching the civilian labor force. Concentrate efforts specifically in the hiring of Hispanics and Persons with Disabilities, which are our most impacted groups with regard to representation in the workforce.

- Eliminate the "barriers" identified in Management Directive 715 (MD-715) with regards to establishing a model EEO program within the Department.

- Institute Standard Operating Procedures throughout the Department with regards to EEO practices, complaints processing, training and diversity efforts.

- Establish a Staff Assistance Program to conduct OPDIVS assessments and improve the quality of Diversity and EEO programs.

Performance Analysis

- Continued implementation of the HHS Plan for Employment of Persons with Disabilities, which consists of an HHS strategy, framework, guidelines, required actions and timetables to recruit, hire, develop, retain persons with disabilities and to provide reasonable accommodations and accessibility.

- Timely submission of annual statistical reports to OPM and EEOC such as MD-715 report, NoFEAR reports and Annual Federal EEO Statistical Report of Discrimination Complaints (462 Report).

- Final Agency Decisions completed and issued within the regulatory time-lines.

- Work in concert with the Office of Human Resources to implement key performance indicators to provide managers at the Department and OPDIV level with information they can use for strategic human resource planning and management, with diversity and EEO in mind.

**Office of Facilities Management and Policy (OFMP)** – OFMP is dedicated to providing mission-enabling facilities and a safe, secure and healthy work environment for all HHS employees. OFMP is also charged with fostering an environment of responsible stewardship and fiscal responsibility in managing the Department's real property assets.

OFMP responsibilities include:

- Developing policy for and monitoring HHS Occupational Safety, Health and Environmental Programs. Providing technical assistance for OPDIVs compliance with applicable Executive Orders (EO's) and Federal, State and local laws and regulations as demonstrated by development of a Departmental framework for Environmental Management Systems (EMS) per EO 13148.

- Developing and interpreting HHS real property policies and providing oversight and guidance to the OPDIVs to ensure effective management of HHS real property assets and the facilities capital budget planning and delivery process per EO 13327.

- Continuing development of a comprehensive program that ensures HHS compliance with the National Energy Conservation Act, EO 13123, Greening the Federal Government Through Efficient Energy Management, and the Energy Policy Act of 2005.

- Continuing development of a comprehensive Historic Preservation Program to protect and preserve prehistoric and historic properties controlled or affected by HHS Programs in accordance with the National Historic Preservation Act of 1996, as amended.

- Providing facility operations services at the Hubert H. Humphrey (HHH) Building and implementing HHH Building improvement projects designed to improve working conditions for HHS employees. Managing a performance-based contract for facility maintenance and operations at the HHH Building. Providing HHS interface to the General Services Administration, the Federal Protective Service, building owners and managers, and other entities for continued safe, secure and effective operation of HHS-occupied facilities in the Southwest Complex in Washington, D.C.

- Complying with guidance issued by the Federal Real Property Council (FRPC) for Real Property Asset Management to include reporting Mission Dependency, Utilization, Facility Condition, and Operating costs for properties occupied, operated or/and owned by HHS.

Performance Analysis

*Responsible Real Property Stewardship:* To ensure that all real property is acquired and disposed of in a responsible manner, OFMP reviews all such activities to insure that all transactions are executed in accordance with regulations and good fiscal practice. The program of review and goal of 100% compliance is based on Federal Real Property Regulations and HHS policy.

From FY 2002 through FY 2005, the Operating Divisions were required to submit all purchase and excess activities for review by OFMP. To date, 100% compliance has been achieved in accordance with regulations and policy.

All landholding Operating Divisions are required to sustain the condition of HHS-owned facilities and to gradually improve substandard properties to acceptable condition standards. OFMP reviews condition indexes (CI) and operating costs reported for each property in the new HQ Automated Real Property Information system (ARIS) to insure improvements and sustainment are in progress in accordance with approved strategies/policy. OFMP also reviews the budget requests for each Landholding Operating Division to confirm that adequate funds are being requested to a) sustain the condition of properties, b) improve the condition of properties with CI below 90, and c) reduce operating costs across the inventory. CI and operating costs for

all HHS owned properties are being reported in accordance with regulations and policy and budgets are being reviewed.

*Real Property Inventory Status:* Measure of OPDIVs' real property inventories for currency so that HHS reporting requirements to the GSA real property database will be met in December. It is required that OPDIVs' facility inventories be 100% current by October of each FY for upload to ARIS, which is the source for reports to OMB and GSA. Up-to-date inventory information improves opportunities for collaboration and cost avoidance by providing solid decision data.

*Signed Facility Project Approval Agreements:* This goal requires 100% of HHS Facility Project Approval Agreements to be signed prior to initiation of project execution. The FPAA fixes the budget, scope, and schedule for project execution. It is intended to reduce project risks by assigning accountability and is intended to provide traceable project documentation.

*Reduce Energy Use at All HHS Facilities:* In accordance with the Energy Policy Act of 2005 (EPAct) and E.O. 12902, OFMP is working with all HHS OPDIVs to develop an electric metering strategy to install meters on all buildings required by the Act. Metering is a first step toward managing energy use and reducing that component of operating cost, as facilities can for the first time be benchmarked against similar ones, and high energy users can be identified. Then, the reasons for the high use can be explored and possibly mitigated.

*Provide a Safe Work Environment:* The President signed the Safety, Health and Return-to-Employment (SHARE) initiative on January 9, 2004, replacing the Federal Worker 2000 initiative, and assigned the Department of Labor (DOL) as proponent. SHARE establishes the Administration's goal for reducing the cost of accidents in the Federal workplace and outlines the President's desire for agencies to work with DOL to set annual targets for 2004, 2005, and 2006. While Federal goals have not been established beyond 2006, HHS will continue to contribute to a safer, healthier work environment by keeping our case rate below the national average.

**Office of the Secretary Executive Office (OSEO)** – Provides critical assistance to the Office of the Secretary on resource management in the areas of budget and financial services, human resources, administration and management, information management, equal employment opportunity, and project management to 17 Staff Divisions, which include over 1700 employees and budgets totaling over $2.7 billion. The OSEO's exceptional combination of skills provides centralized, cost-effective service delivery that enables STAFFDIVs to execute key functions for the Secretary, which include providing economic policy analysis to develop appropriate health, disability, aging, and human services policies, legal advice, and directing the HHS preparedness and response activities related to bio-terrorism and other public health threats and emergencies.

OSEO's responsibilities include:

- Facilitating and enabling OS-wide administrative consolidations to provide an integrated and strategic assessment of functions, procedures and systems that result in higher economies of scale and administrative efficiencies.
- Developing and standardizing operating procedures for budget, human resources, administrative, and operational services. This will continue to result in customer satisfaction through innovative solutions and a strong focus on outcome measurement and cost savings.

- Streamlining management support processes to assure timely performance management that tie to Secretarial priorities, as well as placing a strong emphasis on developing timely assurances for meeting ethical reviews and training.

- Developing customer outreach initiatives, such as: expanding the OSEO intranet site, developing enhanced information packages to include brochures and handouts, continuing quarterly customer advisory meetings and assuring one-on-one customer sessions provide on-going communications.

The OSEO will continue to provide efficient resource management and advisory services in the areas of budget, financial services, human resources, administrative services, and information management to its customers in the Office of the Secretary.

The OSEO is committed to creating result-oriented performance contracts for all OSEO employees; establishing long-term outcome goals and annual targets; and developing specific measures that provide quantitative and evaluative information for Service Level Agreements.

Rationale for the Budget Request

The FY 2008 request for ASAM is $16,418,000, a net increase of $564,000 over the FY 2007 CR level. This amount will cover increased personnel costs, such as the annualization of the January 2007 pay raise and the anticipated January 2008 pay raise. Also included is a total of $213,000 for four former Taps, which will now be funded from GDM direct budget authority instead of from reimbursable authority contributions by other OPDIVs. Funding for two additional FTE will be absorbed by a decrease in Other Services.

# ASSISTANT SECRETARY FOR ADMINISTRATION AND MANAGEMENT
Detailed Performance Analysis

## Office of Facilities Management and Policy (OFMP)

### *I. Hubert H. Humphrey Building Operations and Maintenance*

**Long Term Goal:** To assure responsiveness, ensure that requests for building services in the HHH Building are acknowledged on the day received and corrective action taken within the GSA goal of 72 hours.

| Measure | FY | Target | Result |
|---|---|---|---|
| Number of complaints addressed within 72 hours as a percentage of the total number of requests received. *(outcome)* | *2008* | 100% | |
| | *2007* | 100% | |
| | *2006* | 100% | 100% |
| | *2005* | 100% | 100% |
| | *2004* | 100% | 100% |
| | *2003* | 100% | 100% |

**Data Source:** Service call desk records

**Data Validation:** Independent analysis of computer generated data from the OFMP Division of Operations and Maintenance service call system is performed. In order to ensure the accuracy of this data, a manual, random, periodic review of an individual work orders issued as a result of a request for service is pulled and performance verified. This has consistently supported the automated reports.

**Cross Reference:** The performance target is based on universally accepted GSA guidelines that building services complaints be addressed within 72 hours of receipt. HHS Management Goal #12, Real Property Asset Management.

*Significance of Goal:* Rapid response is an indicator of the overall quality of the program. It assures timely response to over 1500 customers in the HHH Building. OFMP is committed to a high level of performance in the management of the HHH Building. Effective response time is an indicator of the quality of service, which in turn affects employee morale and productivity.

*Improvements from Past Years:* Condition of the HHH Building is improving. GSA assessment in 2002 rated stewardship of the facility as marginal. A return GSA assessment in May 2005 indicated that building operations are much improved and systems are well maintained. Monthly service calls have dropped by approximately 50% on average.

### *II. Real Property Asset Management*

***Long Term Goal:*** Promote the efficient and economical use of HHS real property resources by identifying and properly accounting for the Department's real property holdings.

| Measure | FY | Target | Result |
|---|---|---|---|
| Measure 1: OPDIV inventories ready and 98% current by October of each FY to upload to HQ data service system so that HHS inventory is available per Federal Real Property Council and OMB requirements. (Old inventory measure, to hold FIRM user group meetings, dropped in FY 2003.)*(outcome)* | 2008 | *98%* | |
| | 2007 | 98% | |
| | 2006* | Development | 95% |
| | 2005 | | |
| | 2004 | | |
| | 2003 | | |

| Measure | FY | Target | Result |
|---|---|---|---|
| Measure 2: Percentage of acquisitions and disposals executed in accordance with regulations.*(outcome)* | *2008* | 100% | |
| | *2007* | 100% | |
| | *2006* | 100% | 100% |
| | *2005* | 100% | 100% |
| | *2004* | 100% | 100% |
| | *2003* | 100% | 100% |
| Measure 3: Percentage of HHS-approved facilities projects with signed Facility Project Approval Agreements.*(outcome)* | *2008* | 100% | |
| | *2007* | 100% | |
| | *2006* | 100% | 100% |
| | *2005* | transition | N/A |
| **Data Source:** New Automated Real Property Information System (ARIS) to be operational 1Q06 | | | |
| **Data Validation:** Inventories will be spot-checked by HQs oversight office. Acquisitions, disposals, and Facility Project Approval Agreements are reviewed in HQs oversight office. *Based on OMB 1Q data call due dates, both FY 2006-07 are considered developmental years. | | | |
| **Cross Reference:** B&F program, HHS Real Property Asset Management OMB Scorecard. HHS Management Goal #12, Real Property Asset Management. | | | |

*Significance of Goal:* This goal is consistent with the requirements of EO 13327, Real Property Asset Management, which mandates a much more business-like approach to Real Property management activities, and with HHS facilities goals, which are based on three guiding principles: efficient portfolio management, fostering mission success through occupant productivity and efficiency, and appropriate stewardship. In order to assure that real property is acquired and disposed of in a responsible manner, OFMP reviews all such activities to insure that all transactions are executed in accordance with regulations and good fiscal practice.

Real Property Inventory Status: Measure the currency of OPDIV real property inventories such that HHS reporting requirements to the GSA real property database will be met in December. It requires OPDIV facility inventories to be 98 percent current by October of each FY for upload to the new HQ Automated Real Property Information System (ARIS), the source for reports to OMB and GSA. Up-to-date inventory improves opportunities for collaboration and cost avoidance by providing solid decision data.

Signed Facility Project Approval Agreements: To assure that facility construction, repair and improvement projects receive HQ approval prior to project execution. This goal requires 100 percent of HHS Facility Project Approval Agreements to be signed. The FPAA fixes the budget, scope, and schedule and accountability for the project. It is intended to reduce project risks by assuring accountability and to provide traceable project documentation with a process to be able to follow changes.

*Improvements from Past Years*: To date 100 percent compliance on acquisition and disposals has been achieved in accordance with regulations and policy.

## III. *Energy Management*

| **Long Term Goal:** Reduce Energy consumption at HHS facilities as mandated by the energy Policy Act of 2005 (EP Act, EO 12902, and EO 13123 | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Measure: Number of buildings audited for energy usage as a percentage of the total number of buildings in the HHS inventory. (does not include new construction) | *2007* | 100% | |
| | *2006* | 100% | Dropped |
| | *2005* | 100% | 100% |

| Measure | FY | Target | Result |
|---|---|---|---|
| | 2004 | 90% | 90% |
| | 2003 | 80% | 80% |
| | 2002 | 70% | 70% |
| Measure: Percentage of identified buildings on which standard electric meters installed as required by 2005 EP Act. *(outcome)* | *2008* | *20%* | |
| | *2007* | 10% | |
| | *2006* | Development | |
| | *2005* | | |
| | *2004* | | |
| | *2003* | | |
| **Data Source:** In accordance with the Energy Policy Act of 2005 (EPAct), OFMP's Division of Real Property developed a Department-wide metering program based on a compliance review of all HHS OPDIVs. The performance targets are based on the Department's mandates provided to the OPDIVs. | | | |
| **Data Validation:** HQ OFMP oversight and review of status against plan. | | | |
| **Cross Reference:** EO 13327, Real Property Asset Management, and Real Property Asset Management Scorecard. HHS Management Goal #12, Real Property Asset Management. | | | |

*Significance of Goal:* To reduce energy consumption per national goals to reduce dependence on foreign oil, emissions, and greenhouse gasses. This is part of a long-term, national effort in accordance with the Energy Policy Act of 2005 (EPAct). The purpose of metering is to provide detailed information to identify and prioritize energy conservation projects, such as lighting retrofits, chiller upgrades, water conservation projects, as well as entering into energy savings performance contracts.

*Goal Changes:* Dropped EO 12902 energy audit goal (achieved) and added 2005 Energy Policy Act electrical metering goal.

*Improvements from Past Years*: Updated goal for 2005 EPAct requirements. The HHS Energy Program has saved some $180M since being initiated and has been recognized with a Presidential Energy Award for Leadership in Federal Energy Management in 2004.

## IV: *Employee Health and Safety*

| **Long Term Goal:** Provide a safe and healthful work environment for HHS employees and visitors. | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Measure 1: Percentage of HHS organizations having a total workers compensation case rate below the Federal government. *(outcome)* | *2.008e+23* | *100%*<br>*100%*<br>*100%*<br>*100%*<br>50%<br>50% | <br><br>100%<br>100%<br>50%<br>50% |
| Data Source: Worker's compensation claims | | | |
| **Data Validation:** Review of the posted Department of Labor (DOL) accident data and compared HHS to the Federal average. All HHS components reported a lower than national average. HHS's goal is to remain below the Federal average. | | | |
| **Cross Reference** | | | |

*Significance of Goal:* The President signed the Safety, Health and Return-to-Employment (SHARE) initiative on January 9, 2004, replacing the Federal Worker 2000 initiative, and assigned the Department of Labor (DOL) as proponent. SHARE establishes the Administration's goal for reducing the cost of accidents in the Federal workplace and outlines the President's desire for agencies to work with DOL to set annual targets for FYs 2004-2006 for reductions in four areas: total case rate, lost time case rate, timeliness in filing claims and lost production rate. DOL will measure agencies' progress using FY 2003 data as a baseline. The Department's target rate for improvement is consistent with the Administration's goals. Their

successful accomplishment continues to provide HHS employees with a safer, healthier work environment while controlling compensation costs and improving productivity.

*Goal Changes:* Measure #2 discontinued after FY 2005 when the responsibility for HHS-wide physical security policy and oversight was transferred to the Office of Public Health Emergency Preparedness.

*Improvements from Past Years*: HHS continues to have rates less than the Federal average, and now has new goals to work toward. HHS will work to reduce its total injury case rate and lost time case rate by 3 percent per year for the next three years; increase timely filing of Office of Workers' Compensation Program (OWCP) claims by 5 percent per year; and reduce the rate of lost production days due to injury by 1 percent per year.

## Office of Acquisition Management and Policy (OAMP)

| **Long Term Goal:** Improve Contract Operations, Implement Critical Maturity Steps for Acquisition Balanced Scorecard, and Maintain Good Survey Performance Results | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Improve contract operations throughout the Department. | 2008 | Develop HHS-wide Acquisition Benchmarks | TBD |
| | *2007* | Conduct Pilot-Test of Acquisition Maturity Model; and Implement Dashboard. | TBD |
| | *2006* | Develop Acquisition Dashboard, Process Metrics, and Maturity Model; and Explore Scorecard expansion to include additional business functions. | Successfully met target. |
| | *2005* | Develop Scorecard knowledge repository; and Negotiate Improvement Action Plans. | Successfully met target. |
| | *2004* | Implement Scorecard Systems Upgrade | Successfully met target. |
| | *2003* | Conduct Scorecard Study and HHS Acquisition Benchmarking Symposium | Successfully met target. |
| **Data Source:** Balanced Scorecard performance results | | | |
| **Data Validation:** Independent validation on the part of LMI | | | |
| **Cross Reference:** Performance measurement and improvement efforts are in accordance with HHS' Balanced Scorecard Desk Reference under KnowNet. | | | |

Goal: Improve Contract Operations [The FY 2006 and 2007 goal has been expanded to include the development of OAMP's innovative Acquisition Maturity Model and Acquisition Dashboard - both of which are intended to strengthen performance management efforts.]

*Performance Goal:* The goal of OAMP is to improve contract operations throughout the Department.

*Performance Report:* Progress in achieving this goal is measured by: (a) maintaining good

Scorecard performance results; and (b) implementing critical maturity steps to support HHS's Acquisition Balanced Scorecard. Moreover, gauging progress in this area has taken on renewed importance due to the Department's recent organizational and acquisition integration and modernization initiatives. These initiatives are expected to have a major impact on the acquisition environment. OAMP's Scorecard can serve as a useful tool to monitor the effectiveness and efficiency of any resulting strategic or organizational realignments.

Over the last decade, OAMP has successfully used a results-driven Acquisition Balanced Scorecard to measure and improve acquisition performance throughout the Department. The Scorecard is designed to achieve balance among various perspectives and objectives, such as efficient business processes, innovative leadership, empowered employees, satisfied customers, and dedicated vendors. Performance gaps are identified and cross-functional teams are used to target opportunities for organizational improvement. Each fiscal year, OAMP holds the Operating Divisions accountable for completing the appropriate phase of the Scorecard – conducting surveys, developing improvement action plans, or implementing improvements.

OAMP is proud of achieving good performance results, and will continue to strive for the best acquisition performance possible. Further, OAMP has concluded that, for this relatively mature stage of the Scorecard, maintaining a good performance record is a reasonable commitment – both now and in the long run. In fact, results tend to stabilize once any performance management system reaches a level of maturity. While it will take hard work to maintain performance at such a level, OAMP is up to the task. To put its results in the proper context, OAMP has developed the following survey measurement scale to characterize the performance of its Scorecard and similar government programs: 0-40% poor, 40-49% marginal; 50-59% fair; 60-69% average; 70-79% good; 80-89% very good; and 90-100% excellent. OAMP is pleased to report that its latest survey results continue to fall within the "good" range.

In addition to meeting the above quantitative target, OAMP plans to implement new critical qualitative maturity steps to further strengthen acquisition performance measurement and improvement. The blueprint for these steps is set forth in the chart above. Specifically, in FY 2003 OAMP provided a roadmap for its future systems upgrade by conducting a study entitled "Proposed Integrated and Improvement of Balanced Scorecard" – addressing such key areas as agency guidance, survey issues, agency reporting, improvement efforts, organizational responsibilities and facilitation, and small business and logistics functions. Moreover, OAMP held a productive Acquisition Benchmarking Symposium, which promoted the sharing and adoption of successful practices across the Department.

In FY 2004, OAMP launched the implementation of its roadmap for the systems upgrade and built upon its successful benchmarking efforts by (a) completing and disseminating OAMP's "Manual for Performance Measurement and Improvement" – covering such key topics as survey efforts, vulnerability indices, operating efficiency, improvement efforts, and action plans; and (b) preparing and distributing OAMP's "Integrated Performance Measurement and Improvement System" brochure – providing useful information to the broad HHS acquisition community on project background, system methodology, major areas of performance assessment, system goals, accomplishments, and future performance management objectives.

In FY 2005 and 2006, OAMP designed, developed and implemented a comprehensive, web-based knowledge repository for the Department's Acquisition Balanced Scorecard program. OAMP also designed and developed key Balanced Scorecard metrics for incorporation in the HHS Acquisition Dashboard – which captures performance standards, indicators and assessment

criteria for the Acquisition Balanced Scorecard, Acquisition Integration and Modernization initiative, Strategic Sourcing program, and Small Business program, and which is aligned fully with ASAM's 20 Department-wide Objectives and the Department's SES Performance Contracts. Finally, OAMP designed and developed a set of process-oriented measures that may be used as a proxy for results-oriented Balanced Scorecard measures between rounds of surveys.

In FY 2007 (funds permitting), OAMP plans to: pilot-test HHS' Acquisition Maturity Model and explore its potential as a performance management and benchmarking tool at other Federal agencies; and (b) officially launch the Department's Acquisition Dashboard. The goal for FY 2008 (funds permitting) is to identify HHS-wide organizational benchmarks based on Acquisition Balanced Scorecard results.

# OFFICE OF INTERGOVERNMENTAL AFFAIRS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $5,931,000 | $6,064,000 | $6,270,000 | +$206,000 |
| FTE | 36 | 36 | 36 | -- |

Statement of the Budget Request

The FY 2008 request for the Office of Intergovernmental Affairs (IGA) is $6,270,000, an increase of $206,000 above the comparable FY 2007 Continuing Resolution (CR) level.

Program Description

IGA is composed of a headquarters office and the ten offices of the Regional Directors. In addition to helping implement HHS initiatives and programs, IGA undertakes a variety of assignments for the White House, the Secretary, and the Deputy Secretary related to the Department's intergovernmental partners. IGA also works closely with individual States, local and tribal officials, and the local and national organizations that represent them, ensuring that important lines of communication are maintained among all levels of government.

IGA coordinates a range of outreach activities and facilitates 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. IGA also 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 activities include:

- Providing advice to State and local entities about the potential impact of proposed Departmental legislative, regulatory, and administrative decisions. This includes working with the HHS Operating Divisions as well as with State local and tribal officials in the development and implementation of Federal legislation and regulations on subjects ranging from welfare, to Medicare to bioterrorism. It also includes working with HHS representatives and State, local and tribal officials during the review process for comprehensive demonstration waivers, State plans for implementation of the State Children's Health Insurance Program (SCHIP), and other important departmental activities.

- Providing Departmental leadership in the field in several areas, including all top Secretarial priorities and initiatives. This includes coordinating all aspects relating to the public announcement of grants to States, tribal government, and non-profit grantees.

- Representing 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.

- Promoting general public understanding of programs, policies, and objectives of the Department through meetings, conferences, informational sessions, and through the dissemination of Departmental materials.

- Coordinating the Department's tribal consultation responsibilities, pursuant to the Indian Self-Determination and Education Assistance Act ( PL 93-638) and presidential Executive Orders on tribal consultation; to provide a single point of contact for nearly 700 American Indian/Alaska Native (AI/AN) tribes to access HHS program information and assistance.

- At the regional level, soliciting 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.

Performance Analysis

IGA takes the lead in coordinating crosscutting HHS initiatives in regions by building coalitions on major HHS initiatives and maintaining communications with stakeholders. IGA through its Office of the Regional Director serves as the Secretary's primary representative in the region for all HHS programs and services, as well as key Departmental and Administration initiatives. IGA also provides general management and supervision of the Secretary's Intradepartmental Council on Native American Affairs and reviews policy and actions to ensure program objectives are achieved. The Regional Director supervises the day-to-day implementation of the comprehensive public health and contingency plans, and with the Regional Emergency Coordinators (REC), assists tribal, State and local public health medical officials in the development of these plans.

Rationale for the Budget Request

The FY 2008 request for IGA is $6,270,000, an increase of $206,000. This will cover personnel costs, such as the annualization of the January 2007 pay raise and the anticipated January 2008 pay raise.

# OFFICE OF THE GENERAL COUNSEL

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $36,729,000 | $37,715,000 | $38,779,000 | +$1,064,000 |
| FTE (including reimbursables) | 345 | 343 | 347 | +4 |
| *HCFAC account*[1] | *[$4,778,000]* | *[$4,778,000]* | *[$4,778,000]* | *[ – ]* |
| *HCFAC FTE* | *34* | *34* | *34* | – |

## Statement of the Budget Request

The FY 2008 request for the Office of the General Counsel (OGC) is $38,779,000, an increase of $1,064,000 above the FY 2007 Continuing Resolution (CR) level.

## Program Description

OGC oversees the provision of legal advice and representation to all components of the Department (except the Office of Inspector General), on all aspects of agency operations. It is responsible for meeting all of the legal needs of Departmental components in carrying out their respective duties and responsibilities.

OGC currently manages more than 9,000 litigation matters annually, both in court and before administrative tribunals; by FY 2007, this number will reach 12,000. In addition, attorneys in OGC play key roles in policy formulation by advising senior officials about the Department's more than 300 programs.

OGC's administrative and court litigation work supports all of the program areas within the Department's portfolio and all of the Secretary's priorities for the Department, including:

- food safety protections;
- patient safety;
- welfare and health care reform;
- reducing the cost of prescription drugs for seniors;
- disease prevention;
- privacy protection;
- regulatory reform;
- Departmental reorganization;
- enhancing rural care;
- reducing the number of uninsured;
- child support enforcement;
- Native American tribal self-determination;
- Head Start;

[1] Funding for the Health Care Fraud and Abuse Control (HCFAC) program is appropriated separately and is a non-add to GDM. The FY 2007 and FY2008 HCFAC amount are estimates; final amount may differ, pending agreement between the Secretary of HHS and the Attorney General.

- improving the Medicare+Choice program; and
- support for mental health initiatives.

In addition, OGC works on Departmental and Presidential initiatives, such as Prevention Medical Errors/Health Care Quality (including Nursing Homes), Temporary Assistance to Needy Families (TANF) Reauthorization, Medicare Reform/Centers for Medicare & Medicaid Services (CMS) management reform, Long-Term Care, Medicaid/ State Children's Health Insurance Program (SCHIP) Reform, support for the Privacy Rule, Medical Malpractice Reform and Mental Health.

OGC accomplishes its mission through a structure of specialized headquarters divisions and ten regional offices. The headquarters divisions (e.g., General Law, Ethics)[1] are structured to have principal responsibility for providing policy guidance, direction and advice to the Department's major programs, while the regional offices are responsible for providing the full range of legal services to the Department's field operations.

Following is a discussion of several key OGC focus areas supporting the HHS Strategic Goals.

*Pandemic Flu Planning* – Supporting the Department to prepare the Nation for a potential H5NI flu pandemic, OGC had an instrumental role in amending the Executive Order of the President specifying the communicable diseases for which individuals may be subject to Federal quarantine to include pandemic influenza caused by novel or re-emergent influenza viruses. OGC also reviews the numerous pandemic influenza planning documents and supplementary guidance materials, including those generated by the White House and other departments. OGC participates in interdepartmental and internal meetings to discuss implementation of HHS authorities that may be necessary to respond to an influenza pandemic. OGC is providing legal services to implement the Public Readiness and Emergency Preparedness Act (Part B, title III of the Public Health Service Act) to protect pandemic products from liability and to compensate individuals injured by such products.

*Expanding Global and Domestic HIV/AIDS and Emerging Infections Programs* – OGC advises both CDC's Coordinating Office for Global Health and HRSA (HIV/AIDS Bureau) 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, consistent with the Secretary's 500-Day Plan to implement on schedule the goals of the President's Emergency Plan for AIDS Relief. OGC drafts and advises on HHS implementation policy on Prostitution and Related Activities, as statutorily required under the U.S. Leadership Against HIV/AIDS, TB and Malaria Act of 2003. OGC is also working with key personnel on the reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. OGC works with the Department of State and advises HHS and CDC on development of bilateral agreements with host countries where HHS/CDC work oversees to achieve privileges and immunities comparable to those enjoyed by U.S. embassies in order to improve efficiencies and accomplishments of such overseas programs.

[1] Attorneys in OGC's Civil Rights Division and Food and Drug Division report to, and are under the exclusive managerial authority of, the General Counsel for legal matters. However, their funding is provided by the Office for Civil Rights (OCR) and the Food and Drug Administration (FDA), respectively. Accordingly, any increase in legal work resulting from increases in OCR or FDA program activity are funded by OCR or FDA.

*Pharmaceutical Stockpile* – OGC assists the Centers for Disease Control and Prevention with its efforts to expand and maintain the Strategic National Stockpile, providing legal assistance and advice to the CDC regarding a number of significant issues involving the purchase, stockpiling, and deployment of various vital vaccines, drugs, and other medical supplies, including negotiation of deployment agreements with states, questions concerning deployment abroad, liability questions, the management and implementation of current contracts, and the negotiation and modification of new contracts.

*Oversight of Biomedical and Behavioral Research and Research Misconduct* – OGC assists 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. OHRP facilitates the ethical conduct of research by providing guidance and quality improvement consultations to research institutions, promoting innovative approaches to enhancing human subject protections, and monitoring compliance with the HHS protection of human subjects regulations. ORI promotes integrity in biomedical and behavioral research by monitoring institutional investigations of research misconduct, and facilitates the responsible conduct of research through educational activities and regulatory actions.

*Health Information Technology (HIT)* – OGC provides legal research and guidance and program perspectives to the Office of the National Coordinator of Health Information Technology (ONC) through the work of a recently created OGC practice group on Health Information Technology. Also, related to health IT matters, OGC provides legal advice to IHS and CMS regarding their electronic health record initiatives, and to IHS, CMS, and OCR on health information privacy protections under the HIPAA Privacy Rule and other privacy protection rules.

*Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Initiative* – As anticipated, OGC's workload has increased dramatically since the Medicare Modernization Act (MMA) was signed into law on December 8, 2003. OGC's work is expected to increase as CMS and the Department move from developing policies and regulations that govern the 2006 implementation of the new Medicare Part D benefit, and new Regional Medicare Advantage (MA) plans, to the actual implementation of these programs. The new Part D program adds a new outpatient prescription drug benefit that would be implemented both through Part C Medicare Advantage plans, for beneficiaries enrolled in such plans, and new "Prescription Drug Plan Sponsors," private insurance plans that would offer the new Part D drug coverage under contracts with CMS in exchange for a fixed payment. The new Regional MA plan program establishes new regional MA plans covering regions covering up to seven states. In addition, beginning for 2006, there is a new method for determining benefits and payments under Part C generally.

*Child Support Enforcement Penalties* – Over $230 million in penalties will be invoked against states this year, and there is a likelihood that this level of penalties will continue through Fiscal year 2008. These penalties are assessed against states which failed to implement statutory requirements for automated data processing systems and/or state disbursement units, or as a result of data reliability and performance-based audits which are oriented towards increasing the child support collection rate and rewarding results not programs. The latter penalties are invoked against states which have either bad data or which have poor performance in key program areas. OGC has primary responsibility for defense of these actions and anticipates continued administrative and court litigation through FY 2007 and beyond. Federal District Court challenges are pending, involving 11 States. Eight States are currently receiving penalties totally over $9 million and 10 additional penalty cases are pending before the Departmental

Appeals Board relating to second and third-round penalty impositions. Six other States have received warning letters noting they are at risk for penalties which may be imposed in FY 2007. These penalties, at these levels, or higher, and continued litigation challenging their imposition will continue through FY 2008.

*TANF Extension / Reauthorization (Work, Marriage, Child Support Enforcement)* – The TANF program has recently been reauthorized, modified and expanded, posing many legal issues. Interim Final Rules implementing new tougher work requirements for welfare recipients, and creating new penalties for States that fail to implement work participation plans effectively, are bound to generate legal issues and likely litigation. OGC has assisted in reviewing and clearing these rules and will assist ACF through FY2008 in responding to comments, issuing final regulations, and implementing these changes.

## Performance Analysis

OGC's eight divisions and ten regional components support the HHS Strategic Goals. With this performance plan, OGC's two developmental measures address its ability to measure its performance: how it supports the HHS goals; how timely it provides advice and counsel; and the confidence level of its clients. OGC is confident that the baseline measures it develops, in partnership with its stakeholders, will derive achievable performance plan elements.

## Rationale for the Budget Request

The FY 2008 request for OGC is $38,779,000, an increase of $1,064,000 above the FY 2007 CR level. This increase will cover increased personnel costs, such as the annualization of the January 2007 pay raise and the anticipated January 2008 pay raise, plus 4 additional FTE.

# OFFICE OF THE GENERAL COUNSEL
## Detail of Performance Analysis

| Long Term Goal: Effectively manage legal challenges to HHS. | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Implementation of the Enterprise Management System (EMS) operations system: Matter and Time Tracking Module **(Practice Manager)**. [efficiency] | 2008 | Implement Workflow and Document Control Modules: March 2008 | |
| | 2007 | Interface EHRP with Practice Manager: January 2007; Management Reports: March 2007; Interface Practice Manager with UFMS: September 2007 | |
| | 2006 | Matter and Time Tracking Module Refinement with Reports: March 2006 | Refinement/training completed. Report requirements under review. |
| | 2005 | System Deployment December 2004 | Implemented December 2004 |
| | 2004 | System Deployment November 2004 | New Measure |
| **Revised Measure:** Make the Attorney Practice Directory (APD) a useful tool to determine experts in legal practice areas. Fifty percent useful. [output]<br><br>**Original Measure:** Deployment of the Attorney Practice Directory (APD). [output] | 2008 | Attorneys use APD to find experts in relevant legal areas | |
| | 2007 | Data updates continue. Measure revised, September 2006 | |
| | 2006 | Deployment of APD: August 2006 | Functionality available. (See detailed performance summary) |
| | 2005 | Same as FY 2004 | Practice Manager unable to provide functionality |
| | 2004 | Deployment of APD - January 2005 | New Measure |
| Provide timely advice and counsel to the Secretary and the Department's Operating and Staff Divisions. (Developmental) [efficiency/output] | 2008 | | |
| | 2007 | Same as FY 2006 | |
| | 2006 | Establish baseline measures targeted for August 2006. | Changed to 2007 |
| | 2005 | Establish baseline measures targeted for January 2005. | Changed to 2006 |
| Increase OpDiv and StaffDiv confidence in OGC. (Developmental) [outcome] | 2008 | | |
| | 2007 | Same as FY 2006 | |

| Long Term Goal: Effectively manage legal challenges to HHS. | | | |
|---|---|---|---|
| | 2006 | Establish baseline measures targeted for August 2006. | Changed to 2007 |
| | 2005 | Establish baseline measures targeted for January 2005. | Changed to 2006 |
| **Data Source:** All measures have been contingent upon implementation of OGC's EMS operations system: Practice Manager. Practice Manager became operational December 10, 2005. OGC is now in the process of reviewing its original design criteria, and plans to make changes. The changes will align the system to OGC's business process. | | | |
| **Data Validation:** OGC has a Practice Manager Managers' Small Group that is the committee making recommendations and providing guidance to OGC leadership. OGC is working with the contractor through NIH to implement changes identified by the Small Group and approved by the leadership. | | | |
| **Cross Reference:** OGC's Practice Manager supports the Department's requirements to a have a full service law operation which meets the needs of the Department's legal advice and counsel. This supports the PMA initiatives, the Secretary's 500 day plan, and the Department's strategic goals and Top 20. | | | |

Performance Summary

OGC's overall goal is to provide effective and efficient legal support to the Department.

Goal 1. Effectively manage legal challenges to HHS

Measure - 1. *Performance Objective:* Implementation of the Enterprise Management System (EMS) Matter and Time Tracking Module (Practice Manager).

*Establishing Performance Targets:* In FY 2005 OGC deployed its first module of the OGC-wide EMS: Matter[1] and Time Tracking. In order to meet the deployment and implementation of the tracking system the following steps were completed: (1) Computer hardware installed December 2003, (2) system prototype identified in January 2004, (3) training completed in November 2004, and (4) system deployment December 10, 2004.

Soon after deployment of Practice Manager, OGC managers reviewed its original design criteria, and made changes in July 2006. The changes align the system to the law department's areas of law in which it practices and to OGC's business process. OGC revised the data elements in FY 2006 so that Practice Manager provided greater reporting capabilities. OGC instituted internal control procedures and testing of Practice Manager in September 2006.

OGC will in FY 2007 begin interfacing data from the Department's Employee Human Resource Personnel and Pay System (EHRP) into Practice Manager (it is now testing the capabilities of the two systems). Practice Manager will not only provide OGC leadership matter and time tracking functionality, but also will track FTE via staffing reports and ultimately become OGC's billing system, as well.

OGC will in FY 2008, if the FY 2007 interfaces work, begin interface with the Department's

[1] Matters includes both (1) cases which have actually been filed, or which either HHS or the Department of Justice is preparing to file; and (2) items which are discrete requests for legal services, including formal legal opinions as well as internally generated items of work, conferences, meetings, and informal advice.

Unified Financial Management System (UFMS), and use UFMS to process OGC's reimbursable Economy Act Order billings through UFMS's Project Accounting Module. Until OGC tests the interfaces and has assurance from the UFMS manager, OGC will process Economy Act Orders by a standard cost method, and after implementation of Practice Manager and UFMS interface OGC will bill by cost accumulation.

Measure - 2. *Performance Objective:* (revised) Make the Attorney Practice Directory (APD) a useful tool to determine experts in legal practice areas. Fifty percent useful. (original) Deployment of the Attorney Practice Directory (APD).

*Establishing Performance Targets:* The deployment of the APD is to create a legal knowledge map of staff within OGC that will: (1) facilitate the efficient transfer and use of legal knowledge, (2) grow communities of practice; (3) encourage learning and use of the OGC Intranet as the portal to the OGC knowledge Bank. Target changed to August 2006.

OGC's tests in FY 2006 found that the data in Practice Manager is not sufficient to implement fully the APD as envisioned in the previous paragraph. OGC believes that at least four years of data are required in Practice Manager to make the system relevant to the needs of the attorney community. Since practice Manager now has the functionality (after revising Practice Manager to follow the law department's practices), and to attain the purpose of the APD, OGC has changed measure 2 to Make the Attorney Practice Directory (APD) a useful tool to determine experts in legal practice area. Fifty percent useful.

Measure - 3. *Performance Objective:* Provide timely advice and counsel to the Secretary and the Department's Operating (OPDIV) and Staff Divisions (STAFFDIV).

*Establishing Performance Targets:* This is a developmental measure requiring different determinant vehicles, and subjective measures. Establish baseline measures targeted for August 2007.

Measure - 4. Increase OPDIV and STAFFDIV confidence in OGC.

*Establishing Performance Targets:* This is a developmental measure requiring different determinant vehicles, and subjective measures. Establish baseline measures targeted for August 2006.

*Performance Report*: OGC's Office of Legal Resources (OLR)-- established in 2003 "to anticipate the strategic legal resource requirements of OGC and facilitate organizational change resulting in improved operational performance"-- has moved OGC forward through the use of performance based budgeting and knowledge management concepts (1) improving its understanding of what it does and how it does it; (2) providing incentives for OGC offices to allocate resources and execute its budget with a focus on effectiveness (performance not process); (3) aligning authority and resources with accountability for particular results; and (4) improving results achieved by the Department and make that transparent to the citizens.

With its enterprise-wide management information system strategic plan, OGC can determine its OGC-wide workload, at-a-glance. It continues to learn how the business process and the EMS align so that it may determine its essential legal areas of practices, who the experts are, and to interface with other departmental management systems to inform its clients. OGC's use of emerging technologies to implement decision management tools to more effectively track

workload, time, and the general distribution of resources across OGC provides OGC leadership with the tool needed to manage its work. This system is now enabling OGC to bring legal research tools through electronic legal information management, the EMS Matter and Time Tracking Module, and the Attorney Practice Directory, to its employees via its intranet, permitting OGC to measure its workload, and reviewing emerging workloads and deploying the work to practice groups, allowing OGC the flexibility of determining workload vulnerabilities across OGC.

# DEPARTMENTAL APPEALS BOARD

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $8,691,000 | $9,714,000 | $11,967,000 | +$2,253,000 |
| FTE | 63 | 65 | 75 | +10 |

## Statement of the Budget Request

The FY 2008 request for the Departmental Appeals Board (DAB) is $11,967,000, an increase of $2,253,000 from the FY 2007 comparable full-year Continuing Resolution (CR) level.

## Program Description

The DAB provides impartial, independent hearings and appellate review, and issues Federal agency decisions under more than 60 statutory provisions governing HHS programs. DAB is a STAFFDIV in the Office of the Secretary; however, unlike most other STAFFDIVs, DAB performs functions that are mandated by statutes and regulations. Cases are initiated by outside parties who disagree with a determination made by an HHS agency or its contractor. Outside parties include States, universities, Head Start grantees, nursing homes, clinical laboratories, doctors, and Medicare beneficiaries. Disputes heard by the DAB may involve over $1 billion in Federal funds in a single year. DAB decisions have nation-wide impact. In addition, DAB decisions on certain cost allocation issues in grant programs have government-wide impact, since HHS is the “cognizant agency” whose decisions bind other Federal agencies.

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;
- Resolving disputes administratively, thereby avoiding costly court proceedings.

In its own operation, DAB has made 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, where feasible, and targets mediation services to reduce pending workloads.

DAB is organized into four Divisions:

- **Appellate Division** supports the Board Members, who preside in various types of cases;
- **Civil Remedies Division** supports DAB Administrative Law Judges (ALJs), who conduct evidentiary hearings;
- **Medicare Operations Division** supports DAB Administrative Appeals Judges (AAJs), who review decisions by HHS ALJs from the Office of Medicare Hearings and Appeals (OMHA) or, in a few older cases, by Social Security Administration (SSA) ALJs; and
- **Alternate Dispute Resolution Division**, which provides mediation services in DAB

cases and promotes the use of dispute resolution methods throughout HHS to reduce administrative and management costs.

Performance analyses for each Division are based on FY 2006 data to date. Workload assumptions are explained in the charts under Rationale for the Budget Request.

Board Members – Appellate Division

DAB Board Members are appointed by the Secretary; the Board Chair is also the STAFFDIV head for DAB. All Board Members are judges with considerable experience, who issue decisions acting in panels of three, with the support of Appellate Division staff. In some cases (such as Head Start terminations and Medicaid disallowances), Board Members conduct *de novo* review 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 brought by the Inspector General (IG) or CMS to improve program integrity.
- *De novo* review of Medicaid disallowances appealed by States pursuant to statute.

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

The Secretary will likely appoint a new Board Chair by March 2007, to replace the former Chair, who retired on April 1, 2006. During most of FY 2006, another Board Member position was also vacant. The Board Chair (or the Deputy Chair, when acting for the Chair) spends considerable time on management, administrative and training activities, or responding to Congressional requests for information and coordinating with program agencies on regulation development and related activities.

Performance Analysis: Despite part-year vacancies in two of the five Board Member positions, the Board/Appellate Division issued decisions in 77 cases and closed an additional 50 cases in FY 2006, while also meeting the *quality* standard for Board decisions (Performance Goal 2). That goal measures the number of Board decisions reversed or remanded in Federal court, as a percentage of all Board decisions. The Board maintained its extraordinary record of having no

more than 2% of its decisions overturned by the courts. The *timeliness* standard for the Division (Goal 1), as measured by the percentage of total Board decisions issued in cases with a net age of six months or less (35%), was also met. However, meeting this target during FY 2007 will be difficult, given the continuing vacancy in the Chair position, previous staff attorney reductions, and recent increases in case receipts which have created a backlog of cases ready for decision. The Board generally decides the oldest appeals first, which in turn increases the age of newer appeals ready for decision. In FY 2007, DAB will at most be able to fill only two of the Division's attorney vacancies. Therefore, given increased case receipts plus the need to train new staff in highly complicated issues and procedures, DAB is modifying the target for Goal 1 to 45% for FY 2007, and to 50% for FY 2008.

Administrative Law Judges – Civil Remedies Division (CRD)

DAB ALJs are supported by staff in CRD. These ALJs 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 brought by CMS or the Office of Inspector General (OIG) 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 now required by statute 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 requiring challenging testimony from independent medical/scientific experts, for example, in appeals regarding Medicare Local Coverage Determinations or issues of research misconduct.

DAB had no funds to replace staff lost from this Division over the last few years, including two ALJs who retired in FY 2006 (leaving six ALJs). In FY 2007, this Division will have fewer resources than in FY 2006. Yet some types of cases (such as HIPAA and OIG cases) are likely to increase by FY 2008, and some types of cases which DAB ALJs now hear (such as research misconduct and OIG false claims cases) are very resource-intensive. In addition, CRD nursing home case receipts are again increasing due to renewed enforcement efforts and enhanced oversight by CMS of the timeliness of survey actions. Appeals from clinical laboratories, appeals in provider/supplier enrollment cases, and appeals in OIG cases based on corporate integrity agreements are also generating more cases now than in FY 2005. DAB is addressing these increases by improved performance and new efficiencies. For example, DAB will implement a no cost e-filing initiative for CRD cases by mid-FY 2007, resulting in more efficient decision-drafting and other activities.

Performance Analysis: CRD closed 763 cases in FY 2006, 154 by decision. CRD met its two timeliness goals (Goals 3 and 4). The first 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 FY 2006 target (90%) was met. The second goal is to ensure 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. CRD exceeded the target of having no more than 100 cases from FY 2005 or earlier still pending at the end of FY 2006.

Medicare Appeals Council – Medicare Operations Division (MOD)

With support from MOD attorneys and staff, Administrative Appeals Judges 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 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.

MOD previously increased both the quality and rate of case dispositions, with fewer FTE. However, productivity gains did not substantially reduce the number of pending cases, since case receipts have increased about ten-fold in the last 10 years.

MOD receipts were up again in the first quarter of FY 2007; this trend is likely to continue in FY 2008, as the number of aged and disabled Medicare beneficiaries in the general population continues to increase. In addition, statutory changes for Medicare Part A and B appeals have resulted in lower amount-in-controversy requirements, 90-day timeframes, and a right to *de novo* review by the Council – all of which have increased both the number of cases and the amount of work required on each case. As OMHA's ALJs develop expertise in Medicare and become more productive, the demands on this Division will increase even more.

In FY 2006, the MOD also began receiving appeals for the Prescription Drug Plan (PDP) program. A Medicare beneficiary who enrolls in a PDP has the right to a coverage determination, including the right to request an exception to a PDP's tiered cost-sharing structure or formulary. An enrollee dissatisfied with any part of a coverage determination has the right to reconsideration and, if the determination is still adverse, the right to an ALJ hearing and to Medicare Appeals Council review of the ALJ decision. DAB is expending resources to review each PDP case, as well as to screen cases to ensure that enrollees whose health might be jeopardized from any delay get a quick decision.

Finally, implementation of mandated income-related reductions in Medicare Part B premium subsidies will generate additional new cases, beginning in late FY 2007.

Performance Analysis: In FY 2006, MOD was unable to fill some vacant positions, including two critical positions that were unexpectedly vacated (Administrative Appeals Judge and Team Leader). MOD staff also spent considerable time implementing statutory changes and coordinating with OMHA on issues of mutual concern related to the ALJ transfer from SSA. MOD gave priority to PDP and managed care cases involving pre-service denials, where delays could jeopardize beneficiary health. As a result, MOD did not meet the stretch goal (Goal 7) of constraining the growth in case age by reducing to 90 days (as measured from the date MOD

received the case folder) the average time to complete action on Medicare Part B cases. The average time for Part B cases (the majority of the workload) was 101 days in FY 2006. This is still a substantial reduction from the FY 2001 baseline of 19 months for Goal 7. MOD had previously exceeded its targets for increasing the number of case dispositions (Goal 8). For targets in FY 2005 and future years, DAB adjusted its method of case counting, but set targets for increased dispositions based on comparable data. Because of the factors mentioned above, MOD did not meet the adjusted target of 1,200 dispositions for FY 2006, but did dispose of 1,140 cases. In FY 2007, workload increases for all claim types (Parts A, B, C, D and entitlement), combined with the inability under a full-year Continuing Resolution to timely fill all vacant positions or hire new staff, will drive up processing times for all appeals. Therefore, DAB is modifying its FY 2007 target for Goal 7 to 125 days, and its FY 2007 target for Goal 8 to 1,150 dispositions. In FY 2008, with the requested new staff and increased output from staff hired in FY 2007, MOD will meet modified targets: 100 days for Goal 7, and 1500 dispositions for Goal 8. (Until a fully electronic record is implemented for Medicare cases, the time taken to obtain case folders will be a barrier to meeting the 90-day statutory deadline, which begins with receipt of the request for review.)

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.

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 cases filed with DAB, provide or arrange for mediation services in other HHS cases, and provide training and information on ADR techniques (including negotiated rulemaking).

DAB has only a small ADR staff, but leverages its reach through innovative activities. For example, DAB's Sharing Neutrals Program won an OPM award for its innovative use of collateral duty mediators to resolve workplace disputes. Also, DAB partners with the Department of Transportation's ADR office to provide a variety of quality conflict management seminars to HHS and DOT staff. DAB staff encourages parties to mediate DAB cases, and many staff members are trained mediators who serve in that capacity when their other duties permit.

Performance Analysis: In FY 2006, the ADR Division met its goal (Goal 6) of encouraging the use of ADR throughout HHS, to promote effective management practices and decrease administrative costs. The ADR Division used the Sharing Neutrals program to mediate 36 HHS workplace disputes in FY 2006 and, with DOT, provided 12 ADR training sessions for HHS employees. The ADR Division also met its goal of increasing the use of ADR in DAB cases (Goal 5). This goal is measured by the number of DAB cases in which ADR was provided in FY 2006, compared to FY 2005. To reduce the number of performance goals and to focus on outcomes, DAB will merge goals 5 and 6 for those years. The new core ADR objective will be to enhance ADR capacity, such that ADR is used whenever appropriate in disputes involving HHS. The new goal measures capacity as a function of training opportunities (which assure sufficient ADR information and skills in the HHS population) and ADR interventions in DAB cases (which measures actual use in a significant subset of HHS conflicts). The targets for the

number of trainings and interventions will go down in FY 2007 and FY 2008. ADR Division staff has been cut back (due to budget constraints), the ADR Division Chief, who is also the Chief Administrative Officer, has had new administrative and management duties (due to recent changes in various HHS administrative protocols and the lack of a Board Chair). Also, DAB helped established ADR programs in various HHS OPDIVs, and those programs now handle workplace disputes that formerly would have been referred to the DAB.

Key Performance Goals

| Performance Goal | Result | Context |
|---|---|---|
| Constrain growth in number of aged Civil Remedies Division cases. | DAB has met its target for this performance goal each year since it was adopted in FY 2003, reducing the number of aged CRD cases from 334 at the start of FY 2003 to 100 at the end of FY 2005, and maintaining that level in FY 2006 despite loss of staff. | This performance goal seeks to reduce case age at disposition as measured by the number of cases pending at the end of each fiscal year that were opened in previous fiscal years, rather than in the current year. |
| Constrain growth in average time to complete action on Medicare Appeals Council cases. | DAB previously exceeded its targets for this goal, reducing the average time from 19 months in FY 2001 to less than 90 days in FY 2005. In FY 2006 the time increased to 101 days, due to workload increases and unexpected loss of staff. | This performance goal refers to the average time to complete action on Medicare Part B requests for review, as measured from receipt of the case folder. |

Rationale for the Budget Request

At the requested funding level, DAB will be able to fund additional staff needed to quickly process Medicare Prescription Drug Plan and other cases that involve serious jeopardy to an enrollee's life or health, without compromising DAB's ability to meet statutory deadlines that apply to other cases. DAB needs more staff to address the growth in workload, largely from new jurisdiction, in order to fulfill its mission to provide timely, fair, and well-reasoned decisions and other dispute resolution services. Even with the requested staff, receipts will exceed case closings (as shown on the following charts), offsetting gains DAB has made in reducing the overall age of pending cases.

The funding request for DAB is fully justified by the increasing Medicare and other workloads, workload statistics for each Division (see below), increased personnel and other costs (such as IT costs and rent), DAB e-Government needs, and the potential fiscal and legal consequences of not meeting statutory and regulatory deadlines for hearings and appeals. Reducing DAB staff would create backlogs and increase case age at disposition for all workloads. Further, given the new Medicare appeals and the need to expedite some appeals where a beneficiary's health could be in jeopardy, new funds are needed before MOD can meet the 90-day statutory deadline for Medicare Part A and B appeals. DAB will shift some resources to MOD from CRD in FY 2007, but cannot shift other resources to MOD without delaying resolution of other important cases, such as those imposing Medicaid disallowances or enforcement penalties. This would undercut efforts to better manage programs such as Medicaid and would delay collection of disallowed funds and penalty amounts. DAB has had to adjust its performance targets for timeliness of

decisions because it has been unable to replace departing staff (including retirees from an aging workforce). DAB needs the staff to keep up with growing workload demands.

Board Members – Appellate Division

Chart A shows total caseload data for this Division, with FY 2007 projections based on actual numbers to date. Assumptions on which the data for FY 2007 and FY 2008 are based include:

- Nationwide Federal pay raise of 2.2% in January 2007 and of 3.0% in January 2008;
- Secretarial appointment of a new Board Chair by March 2007;
- Increases in Medicaid disallowance appeals due to stepped-up enforcement;
- Relatively high levels of appeals in non-CMS public assistance programs from disallowances or penalties resulting from program reviews after corrective action periods;
- Some measurable efficiencies from DAB's no cost e-filing project for these cases beginning in FY 2007; and
- FY 2007 funds sufficient to hire two attorneys to fill vacant positions by March 2007 (although they will not be fully trained and productive before FY 2008).

**Chart A**
**APPELLATE DIVISION CASES**

| | FY 2006 | FY 2007 | FY 2008 |
|---|---|---|---|
| Open/start of FY | 122 | 126 | 156 |
| Received | 131 | 160 | 160 |
| Decisions | 77 | 84 | 95 |
| Total Closed | 127 | 130 | 140 |
| Open/end of FY | 126 | 156 | 176 |

Administrative Law Judges – Civil Remedies Division

Caseload data for CRD is shown in Chart B. The caseload data and projections for FY 2007 were modified from prior budget charts to reflect more recent data as well as updated information from HHS agencies. Assumptions include the following:

- Nationwide Federal pay raise of 2.2% in January 2007 and of 3.0% in January 2008;
- No new resources for this division during FY 2007 or FY 2008;
- A continued upward trend in nursing home enforcement cases;
- Receipt of 20 provider/supplier enrollment cases in FY 2007 and FY 2008;
- Receipt of about 10 LCD cases per year;
- Receipt of 2 research misconduct cases from ORI in FY 2007 and FY 2008; and
- Some measurable efficiencies from DAB's e-filing initiative, beginning in FY 2007.

**Chart B**
**CIVIL REMEDIES DIVISION CASES**

| | FY 2006 | FY 2007 | FY 2008 |
|---|---|---|---|
| Open/start of FY | 435 | 378 | 398 |
| Received | 706 | 740 | 750 |
| Decisions | 140 | 120 | 120 |
| Total Closed | 763 | 720 | 720 |
| Open/end of FY | 378 | 398 | 428 |

Medicare Appeals Council – Medicare Operations Division

By strategic management of human capital and improved management generally, MOD has dramatically improved staff productivity and achieved greater control over a caseload that had increased dramatically. For example, redesign of the MOD intake and processing procedures had contributed to substantial increases in the number of case closings per year, peaking at 1,619 in FY 2005. As predicted, however, simultaneously adjudicating cases under old procedures, while implementing new procedures for current cases, as well as other factors, reduced case closings in FY 2006 to 1,140. While this is about 10 times higher than closings in the mid-1990's with more staff, the efficiencies the MOD has achieved are still insufficient to meet the statutory deadline of 90 days to completion (measured from receipt of the request for review). If these deadlines are not met, this caseload is likely to receive Congressional and court attention. Reasons why cases are taking more time now include the following: the Medicare Appeals Council must now perform *de novo* review (rather than a less resource-intensive substantial evidence review); the 90-day deadline hampers MOD's ability to group related cases for more efficient processing; and, in general, more cases are raising complex issues than in the past. In addition, one of four Administrative Appeals Judge positions was vacant from June 1, 2006 to January 21, 2007, and MOD has been unable to fill some other vacancies.

The President's Budget for FY 2007 included new funding for four attorneys and one clerical for this Division, justified by the 90-day deadline on Medicare Part A and Part B appeals. This did not include funds to expedite any PDP appeals or any funds for premium subsidy reduction appeals. Given the effects on case age of the new workloads, and of operating under a full-year Continuing Resolution in FY 2007, DAB's need for the FY 2008 funds requested for this Division is even more critical.

Chart C contains projected FY 2007 data for this Division, based on actual numbers to date, and trends in receipts data. DAB is now reporting data by counting just those cases requiring individual determinations; related claims are not separately counted, even though each case may represent hundreds of Medicare claims and more that one Medicare contractor denial. (For example, the 1,432 cases docketed in FY 2005 represent over 18,247 claims.) Assumptions on

which the data are based include:

- Nationwide Federal pay raise of 2.2% in January 2007 and 3.0% in January 2008;
- Increased receipts of appealed and referred cases in FY 2007 and FY 2008, as OMHA's disposition rate increases;
- No substantial increase in PDP appeals in FY 2008, but other increases from the increasing number of Medicare beneficiaries (particularly for Medicare Part B cases) and from premium subsidy reduction cases;
- FY 2007 funds sufficient to fill some of the vacant positions by hiring a Team Leader, two attorneys, and two legal technicians in March 2007, who will be trained and fully productive by some time in FY 2008; and
- FY 2008 funds, per the request, to hire 2 AAJs, 2 staff attorneys, 1 legal technician, and 1 clerical, who will be trained and fully productive by some time in FY 2009.

**Chart C**
**MEDICARE OPERATIONS DIVISION CASES**

| | FY 2006 | FY 2007 | FY 2008 |
|---|---|---|---|
| Open/start of FY | 752 | 850 | 1,800 |
| Received | 1,238 | 2,100 | 2,500 |
| Total Closed | 1,140 | 1,150 | 1,500 |
| Open/end of FY | 850 | 1,800 | 2,800 |

Alternative Dispute Resolution Division

DAB's Sharing Neutrals Program is an example of DAB's strategic management of human capital. This program won an OPM award for its innovative use of collateral duty mediators to resolve a variety of disputes. In FY 2007 and FY 2008, ADR will strive to meet the following goals:

- Continue ADR leadership role by promoting ADR services and training, including convening a forum for HHS ADR programs to discuss trends, needs, resources, and how best to serve the HHS Community;
- Continue to work with staff in other HHS offices and the Federal ADR community to advance joint ADR goals, including high-quality, low-cost training and mediation services; and
- Continue using ADR in HHS cases so as to increase efficiency and decrease contentiousness in case resolution.

ADR's ability to meet these goals will be affected if DAB needs to transfer resources from this Division to meet other management and workload demands.

# DEPARTMENTAL APPEALS BOARD
## Detailed Performance Analysis

**Long Term Goal 1: Strengthen program management by maintaining the efficiency of Appellate Division case processing. (outcome and efficiency measure)**

| Measure | FY | Target | Result |
|---|---|---|---|
| Percentage of Board decisions with net case age of six months or less. | 2008 | 55% | |
| | 2007 | 45% | |
| | 2006 | 35% | 36% |
| | 2005 | 70% | 35% |
| | 2004 | 70% | 60% |
| | 2003 | 70% | 82% |

**Data Source:** Case data are entered into a controlled-access, Oracle database, with case-specific identification.

**Data Validation:** Data used in this performance measure are validated by generating periodic reports from the database. At the end of the fiscal year, the interim report totals are cross-checked with the annual totals.

**Cross Reference:** G 1,3,4,5,6,8

**Long Term Goal 2: Maintain reversal and remand rate of Board decisions appealed to Federal courts as a measure of quality of decisions. (outcome measure)**

| Measure | FY | Target | Result |
|---|---|---|---|
| Number of decisions reversed or remanded on appeals to Federal court as a percentage of all Board decisions issued. | 2008 | 2% | |
| | 2007 | 2% | |
| | 2006 | 2% | 2% |
| | 2005 | 2% | 2% |
| | 2004 | 2% | 2% |
| | 2003 | 2% | 2% |

**Data Source:** Current case data are entered into a controlled-access, Oracle database, with case-specific identification, and used to update baseline data.

**Data Validation:** Data used in this performance measure are validated by generating periodic reports from the database. At the end of the fiscal year, the interim report totals are cross-checked with the annual totals.

**Cross Reference:** G 1,3,4,5,6,8

**Long Term Goal 3: Assure maximum compliance with regulatory time frames for deciding enforcement, fraud and exclusion cases by increasing Civil Remedies Division processing rates for Inspector General cases. (outcome and efficiency measure)**

| Measure | FY | Target | Result |
|---|---|---|---|
| Percentage of decisions issued within 60 days of the close of the record. | 2008 | 90% | |
| | 2007 | 90% | |
| | 2006 | 90% | 90% |
| | 2005 | 85% | 95% |
| | 2004 | 80% | 100% |
| | 2003 | 80% | 88% |

**Data Source:** Case data are entered into a controlled-access, Oracle database, with case-specific identification.

**Data Validation:** Data used in this performance measure are validated by generating periodic reports from the database. At the end of the fiscal year, the interim report totals are cross-checked with the annual totals.

**Cross Reference:** G 5,8

| **Long Term Goal 4: (beginning FY 2004) Constrain growth in number of aged Civil Remedies Division cases. (outcome and efficiency measure)** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Number of case open at end of Fiscal Year that were opened in previous Fiscal Years. | 2008 | ≥100 | |
| | 2007 | ≥100 | |
| | 2006 | ≥FY 2005 | 100 |
| | 2005 | ≥FY 2004 | 100 |
| | 2004 | ≥FY 2003 | 157 |
| | 2003 | ≥334 cases | 207 cases |
| **Data Source:** Case data are entered in a controlled-access, Oracle database, with case-specific identification. | | | |
| **Data Validation:** Data used in this performance measure are validated by generating periodic reports from the database. At the end of the fiscal year, the interim report totals are cross-checked with the annual totals. | | | |
| **Cross Reference:** G 5, 8 | | | |

| **Long Term Goal 5 (see below): Increase use of ADR (e.g., mediation) in DAB appealed cases to save resources and decrease contentiousness in case resolution. (outcome and output measure)** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Number of cases in which ADR is used in FY compared to target. | 2008 | Maintain 05 | |
| | 2007 | Maintain 05 | |
| | 2006 | Maintain 05 | 42 |
| | 2005 | 5% increase over FY 2004 | 41 (5%) |
| | 2004 | 5% increase over FY 2003 | 40 (5.3% increase) |
| | 2003 | 10% increase over FY 2002 | 38 (5% increase) |
| **Data Source:** Case data are entered in a controlled-access, Oracle database, with case-specific identification. | | | |
| **Data Validation:** Data used in this performance measure are validated by generating periodic reports from the database. At the end of the fiscal year, the interim report totals are cross-checked with the annual totals. | | | |
| **Cross Reference:** G 8 | | | |

| **Long Term Goal 6 (see below): Encourage use of ADR throughout HHS to promote effective management practices and decrease administrative costs. (outcome and output measure)** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Number of conflict resolution training sessions conducted. | 2008 | 8 sessions | |
| | 2007 | 8 sessions | |
| | 2006 | 8 sessions | 8 |
| | 2005 | 6 sessions | 10 |
| | 2004 | 12 sessions | 12 |
| | 2003 | 12 sessions | 18 |
| Number of HHS cases mediated through Sharing Neutrals. | 2008 | 36 | |
| | 2007 | 36 | |
| | 2006 | 36 | 36 |
| | 2005 | 38 | 40 |
| | 2004 | 38 | 38 |
| | 2003 | 36 | 33 |
| **Data Source:** Number of training sessions are recorded and tracked. Sharing neutral cases are tracked through an ACCESS database (migrating to Oracle). | | | |
| **Data Validation:** Participant sign-in sheets, course evaluations, and reports of training sessions. Periodic reports of Sharing Neutral cases are generated and cross-checked against earlier reports. | | | |
| **Cross Reference:** G 8 | | | |

| **Long Term Goal 5 (revision and merging of Goals 5 and 6): Enhance ADR capacity at HHS so as to decrease contentiousness and associated costs in dispute resolution and promote efficiency in management practices. (outcome)** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Number of conflict resolution seminars conducted. | 2008 | 8 sessions | |
| | 2007 | 8 sessions | |
| Number of DAB cases (those logged into ADR Division database) requesting facilitative ADR interventions prior to more directive adjudicative processes. | 2008 | 36 | |
| | 2007 | 36 | |
| **Data Source:** Number of training sessions are recorded and tracked. Case data are entered in a controlled-access, Oracle database, with case-specific identification. | | | |
| **Data Validation:** Participant sign-in sheets, course evaluations, and reports of training sessions. Caseload data are validated by generating periodic reports from the database. At the end of the fiscal year, the interim report totals are cross-checked with the annual totals. | | | |
| **Cross Reference:** G 8 | | | |

| **Long Term Goal 6: Constrain growth in average time to complete action on Medicare Appeals cases. (outcome and efficiency measure)** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| 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 determined after excluding outlier cases in which delays related to court proceedings beyond DAB's control. | 2008 | 95 days | |
| | 2007 | 100 days | |
| | 2006 | 90 days | 101 days |
| | 2005 | 90 days | 80 days |
| | 2004 | 16 months | 12 months |
| | 2003 | 18 months | 15 months |
| **Data Source:** Case data are entered in a controlled-access, Oracle database, with case-specific identification. | | | |
| **Data Validation:** Data used in this performance measure are validated by generating periodic reports from the database. At the end of the fiscal year, the interim report totals are cross-checked with the annual totals. | | | |
| **Cross Reference:** G 3, 8 | | | |

| **Long Term Goal 7: Increase number of Medicare Appeals dispositions to resolve and respond to Medicare claims brought by program providers and beneficiaries. (output and efficiency measure)** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Number of dispositions. Counting method changed in FY 2005 (see narrative below); FY 2004 comparable results are 2183 cases. | 2008 | 1,800 | |
| | 2007 | 1,250 | |
| | 2006 | 1,200 | 1,140 |
| | 2005 | 1,800 | 1,619 |
| | 2004 | 11,200 | 16,000 |
| | 2003 | 10,800 | 12,021 |
| **Data Source:** Case data are entered in a controlled-access, Oracle database, with case-specific identification. The method for counting MOD dispositions has been revised to avoid potential overstatement of actual workload because of lower level appeals docketing practices. The MOD database system distinguishes cases in which there is one docket number (singles) and cases in which there are numerous docket numbers assigned, but one lead case. A lead case is defined in the database as a "parent" and related cases are identified as "children". Beginning in FY 2005, this measure counts singles, parents, and only those children requiring individual fact determinations. | | | |
| **Data Validation:** Data used in this performance measure are validated by generating periodic reports from the database. At the end of the fiscal year, the interim report totals are cross-checked with the annual totals. | | | |
| **Cross Reference:** G 3, 8 | | | |

Changes and Improvements over Previous Year

DAB has generally been praised for having meaningful performance goals and objectives, and reliable measures of DAB performance in meeting those goals.

For FY 2006, DAB adopted a target for average time to complete action in Medicare claims appeals cases (Goal 7) to reflect the 90-day statutory deadline for Part B cases. The measure for this goal is the average time to complete action in Part B requests for review, measured from receipt of the case folder. Until electronic filing is in place for these cases, this measure will differ from the statutory 90-day deadline. Using receipt of the case folder as the starting point links the measure to DAB performance. The time to receive the case folder is largely outside of DAB's control, and DAB cannot work on the case without the folder. For FY 2007 and FY 2008, however, the targets were adjusted to be more realistic (125 and 100 days, respectively), given the need to expedite most PDP cases, overall increased case receipts, the staff level for this workload, and the continuing transition to new OMHA ALJs and new procedures. The target for Goal 7 for FY 2008 will, however, reflect an increase in total number of dispositions in Medicare claims appeals to reflect adding new staff in FY 2007 and FY 2008 for this caseload. The FY 2007 target for Goal 1, to reduce case age in the Board/Appellate Division's caseload, is being modified from 55% to the more realistic target of 45%, but increases to 50% for FY 2008. Both targets are higher than the FY 2006 target of 35%. The vacancies in Board Member positions and other staff losses have created a backlog of Board cases ready for decision, so increasing the percentage of closed cases that are less than six months old will be difficult, even with added staff, until that backlog is eliminated.

In keeping with the FY 2008 guidance, the ADR Division has merged goals 5 and 6. The new goal measures ADR capacity at HHS as a function of training opportunities (which assure sufficient ADR information and skills in the HHS population) and ADR interventions in HHS cases logged into the DAB database (which measures actual use in a significant subset of HHS conflicts). The overall number of trainings and interventions has remained constant until recently. However, the number of interventions has now begun to decline, as reflected in the FY 2007 and FY 2008 targets. DAB believes this decline is due in part to reductions in ADR Division staff from budget constraints, and reassignments to new administrative and management duties (due to recent changes in various HHS administrative protocols and the vacancy of the Chair position). The decline in interventions is also attributed to the fact that programs which DAB helped establish at various Operating Divisions are now sufficiently established that workplace cases at those agencies are now being referred to those programs, rather than to DAB.

Links to HHS Strategic Plan

DAB's Performance Budget supports the HHS Strategic Goals and Objectives and the Secretary's "500-Day Plan: 250-Day Update." DAB's Performance Budget primarily supports the following HHS Strategic Goals and Objectives (referred to by the Goal and Objective number, such as "HHS 3.2"):

- Increase the percentage of the nation's children and adults who have access to healthcare services and expand consumer choice through strengthening and improving Medicare (HHS 3.2);
- Improve the quality of healthcare services through reducing medical errors and improving consumer and patient protections (HHS 5.1 and 5.5); and

- Achieve excellence in management practices through creating a unified HHS committed to functioning as one Department, improving financial performance, and reducing the regulatory burden on providers and consumers of HHS services (HHS 8.1, 8.4 and 8.7).

DAB's Performance Budget also generally supports related visions and strategies outlined in the Secretary's "500-Day Plan: 250-Day Update."

Links between DAB's Performance Goals and HHS' Strategic Goals and Objectives include:

- DAB Performance Goals 1 and 2, for providing quality, timely Board decisions support the HHS Objectives of strengthening the programmatic and financial stability of Medicare (HHS 3.3), and of achieving excellence in management practices (HHS 8.1, 8.4, and 8.7). The quality and timeliness of Board decisions issued on behalf of the Secretary in grants cases (particularly Medicaid cases) are important for improving financial management in HHS programs by ensuring that funds are spent only for authorized purposes (HHS 8.4). Timely, quality Board decisions on cross-cutting grant requirements ensure consistent interpretations across HHS programs and contribute to the overall objective of having a unified HHS committed to functioning as one Department (HHS 8.1). Timely, quality Board decisions in Medicare cases such as provider enforcement and National Coverage Determination cases support the objectives of strengthening Medicare (HHS 3.3), of reducing the regulatory burden on providers and consumers of healthcare services (HHS 8.7), and of ensuring that funds are spent only for authorized purposes (HHS 8.4). By timely providing impartial review of disputes about how Medicare regulations apply to specific fact situations and by issuing decisions that provide a clear rationale that will hold up in court, the Board contributes to each of these objectives.

- DAB Performance Goals 1 and 2 of providing quality, timely decisions in disputes heard by the Board also assure that grant funds are not wasted on needless litigation and that grant recipients receive clear decisions and due process before funds are disallowed. Grant funds generally support the HHS Strategic Goals and Objectives of increasing the percentage of the nation's children and adults who have access to healthcare services, and expanding consumer choice, through strengthening the healthcare safety net (HHS 3.2), improving the economic and social well-being of individuals, families, and communities, especially those most in need (HHS 6.1 and 6.4); of reducing the major threats to the health and well-being of Americans (HHS 1); and of enhancing the capacity and productivity of the nation's health science research enterprise (HHS 4).

- DAB Performance Goals 3 and 4, for the timeliness of ALJ decisions in CRD cases, also link to HHS Objectives. Goal 3, for timely hearing decisions in cases brought by the IG, supports the Objective of improved financial management (HHS 8.4) by contributing to program integrity efforts and to more timely collection of civil money penalties (CMPs) in IG cases. Similarly, DAB Performance Goal 4, for timeliness in all CRD cases, supports improved financial management by promoting more timely collection of CMPs in nursing home and other provider enforcement cases (HHS 8.4).

- DAB Performance Goals 1, 2, 3, and 4 also link to HHS Strategic Goal of improving the quality of healthcare services (HHS 5). Enforcement of Medicare and Medicaid quality of care requirements leads to the provider and supplier and other cases that DAB ALJs hear and the Board reviews.

- DAB Performance Goals 6 and 7 are directed at increasing the timeliness and number of dispositions in Medicare claims cases, and thereby improve overall program management and eliminate improper payments. These DAB goals further the Objectives of strengthening the programmatic and financial stability of Medicare (HHS 3.3) and increasing the appropriate use of effective healthcare services by medical providers (HHS 5.2). Issuance of timely and correct decisions ensures that covered services are properly identified and that Medicare funds are properly spent, thus also furthering the HHS goals of improving financial management by eliminating improper payments (HHS 8.4) and reducing the regulatory burden on providers and consumers (HHS 8.7).

- DAB Performance Goal 5 promotes effective management practices and decrease administrative costs by encouraging ADR wherever appropriate to save costs and improve program management by reducing conflict and preserving relationships that support program goals. These Performance Goals further the HHS Objectives of improving strategic management of human capital, improving financial management, and reducing the regulatory burden on providers and consumers of HHS services (HHS 8.2, 8.4 and 8.7) and therefore further the Goal of achieving excellence in management practices. Performance Goal 6 also furthers the HHS Objective of improving the strategic management of human capital (HHS 8.4) since mediating HHS cases through DAB's Sharing Neutral's program (which won an OPM award for its innovative use of collateral duty mediators to resolve workplace disputes) saves HHS human capital resources and is cheaper than hiring outside mediators.

- In general, DAB's Performance Budget also supports the President's Management Agenda and HHS goals of strategically managing human capital, improving financial performance, and budget and performance integration. In FY 2006, DAB management implemented a new performance appraisal system for all staff by March 31, participated in efforts to complete the new annual assurance on internal controls over financial reporting as of June 30, and will execute its budget consistent with performance targets.

Partnerships and Coordination

DAB performs a unique function of providing hearings and issuing decisions on behalf of the Secretary in cases within DAB's jurisdiction. To the extent consistent with its role as providing independent review, the DAB coordinates with other HHS components on issues such as developing a case tracking system for Medicare claims appeals that will eliminate duplication of data entry and on developing more efficient appeals procedures. Also, DAB receives its administrative support from the OSEO.

Performance Measurement Linkages

DAB's budget is primarily personnel costs and associated costs such as rent, equipment, supplies and training. Additional funds are needed in order to provide hearings, such as the cost of travel to hearings and for hearing transcripts. When personnel and personnel-associated costs are higher that expected, DAB cannot transfer funds from mission-critical activities such as holding hearings in CRD cases, so it must leave positions vacant – and this affects DAB's ability to meet its goals. Better management of existing staff (including use of ADR methods when the parties agree) has resulted in some improvements in the number and timeliness of dispositions; however, increases in the number of cases received (a factor outside of DAB control) may offset efficiency gains. DAB has also used IT planning to improve the quality and timeliness of its

decisions, where possible, but most of its IT contracting has gone toward the database management needed to improve management reports and oversight. IT resources have not been sufficient for DAB to implement electronic filing in its cases (to make case tracking and decision-writing more efficient). Nevertheless, DAB has initiated projects to provide for e-filing at no cost to DAB (and with potential savings for OGC and the IG, as well as DAB) and to electronically record some oral proceedings (to reduce transcript costs). However, there are inherent limits to how much further DAB can improve performance with decreases in staff levels and high levels of case receipts.

# OFFICE ON DISABILITY

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $643,000 | $658,000 | $661,000 | +$3,000 |
| FTE | 4 | 4 | 4 | -- |

## Statement of the Budget

The FY 2008 budget for the Office on Disability (OD) is $661,000, an increase of $3,000 from the comparable FY 2007 Continuing Resolution (CR) level.

## Program/Activity Description

The role of OD is to help break down barriers to support the full integration of people with disabilities into all aspects of everyday life, including employment, education, housing, transportation, health care, and the use of adaptive technologies. OD's mission -- to promote the abilities of all persons with disabilities -- dovetails with the Secretary's broader vision and goals for the Department, emphasizing accountability, effectiveness and quality of service delivery, research, and policy on behalf of the 54 million Americans with disabilities.

The OD's mission is guided by five core strategic goals:

- Effective access;
- Efficient community integration;
- Individual self-determination (ownership);
- Integrated health and wellness services; and
- Organizational excellence.

These goals are, in turn, operationalized through a series of objectives/program initiatives:

- **Promote Integrated Health and Wellness Services:** Ensure service capacity and affordability; encourage health education initiatives to include persons with disabilities; promote prevention and wellness for persons with disabilities; ensure that research routinely includes persons with disabilities; promote healthcare provider knowledge of best practices to meet the full range of health needs of persons with disabilities of all ages.

- **Promote Effective Access:** Ensure that persons with disabilities across the lifespan have access to the full range of health, social support, education, employment, technology, transportation, housing and income services needed to live with dignity in the community; ensure that service providers (health care, education, employers) have the tools and knowledge needed to serve the whole person with a disability; and build on the ADA to promote accessibility of all services and facilities to serve persons with disabilities.

- **Individual Self-Determination:** Promote the value of "ownership" for persons with

disabilities, emphasizing self determination and self reliance; Foster Federal, State and local policies that promote and award self reliance and engagement in work, family and community over chronic entitlement and dependency; provide and promote the knowledge and skills that enable individuals with disabilities to coordinate and manage their lives in the community.

- **Efficient Community Integration:** Promote seamless integrated services to meet the individual, community-based needs of persons with disabilities across the lifespan; Promote development and use of evidence based/ best practices in service delivery and support in communities nationwide to promote independence for persons with disabilities which enhance collaborations across service orientations to correct current "stove pipe" services and funding.

- **Organizational Excellence:** Coordinate the HHS NFI initiative; Oversee, coordinate, develop and implement disability programs and initiatives within HHS that impact people with disabilities; Ensure that persons with disabilities across the lifespan have a voice within HHS; Heighten the interaction of programs within HHS and with Federal, State, community and private sector partners; Manage and educate about the provision of interagency disability-based budget reporting and analyses to enhance policy decision making and reduce funding duplications through comprehensive information on how HHS funds are expended and budgeted for all disability groups

# OFFICE ON DISABILITY
## Detailed Performance Analysis

| **Long Term Goal**: Promote the coordination, development and implementation of programs and special initiatives to help increase the service capacity and affordability for integrated health and wellness services for persons with disabilities. | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Increase the number of States (from a total of 6) that establish collaborative agreements across respective state agencies to provide integrated services across all six life domains (housing, employment, education, health, assistive technology, and transportation) on behalf of young adults (14 to 30 years) with disabilities as part of the OD Young Adult Program initiative. | 2008<br>2007<br>2006<br>2005 | 6 States<br>4 States<br>2 States | <br><br>2 States |
| Increase the number of States (from a total of 6) that establish supporting infrastructures to sustain cross-agency collaborations to provide integrated services across respective state agencies to provide integrated services across all six life domains (housing, employment, education, health, assistive technology, transportation) on behalf of young adults (14 to 30 years) with disabilities as part of the OD Young Adult Program initiative. | 2008<br>2007<br>2006<br>2005 | 6 States<br>4 States<br>2 States | <br><br>2 States |
| Increase the number of States (from a total of 6) that demonstrate utilization of evidence-based practices to sustain integrated services across all six life domains (housing, employment, education, health, assistive technology, and transportation) on behalf of young adults (14 to 30 years) with disabilities as part of the OD Young Adult Program initiative. | 2008<br>2007<br>2006<br>2005 | 6 States<br>4 States<br>2 States | <br><br>2 States |
| **Data Source**: Data resulting from the Office on Disability initiative's competitively selected 6 states participating in the technical contractor (National Governor's Association) Policy Academy planning process. | | | |
| **Data Validation:** Impact evaluation study resulting from the Office on Disability initiative's evaluation contractor. | | | |
| **Cross Reference**: Support HHS Strategic Goals, HP 2010 | | | |

Performance Narrative

The Office of Disability's (OD) long-term goal is to promote the abilities of all persons with disabilities, leading to the vision of an inclusive America. OD's goal is operationalized through a series of objectives/program initiatives, all of which support one or more of the HHS eight strategic goals. These objectives are being accomplished through a series of specific programs and activities identified under each of the following six categories.

At this time, one objective can demonstrate impact through use of performance measures - the OD's Young Adult Program initiative. The Young Adult planning and evaluation processes support the promotion of integrated health and wellness services, effective access, self-determination/reliance, efficient community integration, and organizational excellence on behalf of young adults (14 to 30 years) with disabilities. The following objectives' measures will be reviewed throughout the 2007 – 2008 time period as to implications in following fiscal years for the following OD programs:

Objectives and Supporting Programs

**Health and Wellness Promotion**

- Promote the *Surgeon General's Call to Action (CTA) to Improve the Health and Wellness of Persons with Disabilities* including monitoring of the National Action Plan to operationalize CTA recommendations and strategies.
- Collaborate in the education of persons with disabilities about their roles and responsibilities under the MMA Drug Benefit and community-based Medicaid-related programs.
- Promote physical fitness for youth with disabilities in conjunction with the President's Healthier US Initiative and the President's Council on Physical Fitness and Sports, through the OD's "I Can Do It, You Can Do It" program promoting physical fitness among children and youth with disabilities.
- Monitor and advance the action plan for the Serve Young Children with Hearing Loss and their families program.
- Advance the action plan in collaboration with the Office on Women's Health to address health screening and access barriers for women with disabilities.
- Partner with the Office of Minority Health to develop and implement programs to meet the special health challenges of persons with color with disabilities, populations who suffer the greatest disparities in health and wellness.
- Ensure disability attention to all Departmental initiatives including, eliminating health disparities, health promotion/disease prevention, Healthy People 2010 objectives, and Healthy People 2020 planning.
- Collaborate with other Federal departments to ensure that the resulting disability-based action steps from the December 2006 White House Conference on Aging are implemented.
- With Administration on Aging and other HHS partners, address the caregiver/workforce challenges for persons with disabilities, including promotion of interagency funding collaborations and effective use of resources.

**Housing: Deterring Homelessness**

- Provide roadmaps for affordable, available, and accessible housing through universal design opportunities for persons with disabilities in partnership with the Centers for Medicare &Medicaid Services (CMS), Fannie Mae, the Department of Housing and Urban Development (HUD), and other public and private experts on disability-based housing.

**Transportation**

- Continue collaboration with the Federal Transit Administration (FTA) to implement the President's Coordinated Transportation Executive Order, United We Ride, to work with States to provide best transportation options for persons with disabilities and ensure disability-related action steps are identified and acted on.

**Employment Opportunities**

- Collaborate with the Department of Labor, Department of Education, Social Security Administration, and others to identify best practices for employing persons with disabilities within private and public sections.
- Promote information on tax incentives and individual investment plans for employers and

tax credits for persons with disabilities.

**Community Integration**

- In partnership with the HHS Assistant Secretary for Preparedness and Response, the Federal Emergency Management Agency, and the Department of Homeland Security develop and help promote disability-based emergency preparedness templates, evidence-based and best practices, and toolkits to support the special needs of persons with disabilities, first responders and other emergency response providers at the Federal, State and local levels during all emergency situations.
- Implement and manage the interdepartmental demonstration initiative for the OD program, Needs of Youth with Co-Occurring Developmental Disabilities and Emotional/Substance Abuse Disorders.
- Continue OD interagency and interdepartmental supported Young Adult Program (addressing young adults between ages 14 to 30 years) to promote integrated support systems (spanning education, health, assistive technology, employment, transportation and housing) and provide outcomes of a three year process and impact evaluation.
- Conduct the Secretarial October 2008 Biennial International Congress in collaboration with the United States Agency for International Development, the United Nations Children's Fund, and delegate nations spanning each geographic region of the world to help local communities build cross-disciplinary systems of support that integrate health, education, and social needs with special attention to inclusive community-based programs, role of family members with professionals and politicians, and sustaining progress over time.
- Promote education and information on disability-based topics by facilitating HHS NFI interagency workgroup and supporting subcommittees.
- Convene quarterly cross-disability input meetings with constituent leadership representing the 54 million persons with disabilities to obtain recommendations on enhancing the NFI and prevent unnecessary institutional, including attention to the MMA to ensure constituent understanding of the law's prescription card process and other key disability-based parameters.
- Convene regularly scheduled NFI-based interagency meetings to share, inform and educate agencies on all aspects of disability and related matters especially regarding integration of children and youth Medical Home Systems initiatives with the Health Resources Services Administration, American Academy of Pediatrics, and other HHS agency programs.

**Assistive Technology**

- Manage and ensure Department-wide adherence to Section 508 of the Rehabilitation Act through on-going training of 508 officials and managers responsible for procurement across all HHS Operating Divisions.
- Manage and enhance the OD website, a focal point and clearinghouse on HHS-related and other government disability information.
- Develop best practices in Federal/ State partnerships to promote one-stop electronic service network for persons with disabilities by enhancing the Office on Disability website.

# OFFICE OF GLOBAL HEALTH AFFAIRS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $9,690,000 | $9,803,000 | $11,339,000 | +$1,536,000 |
| FTE (including reimbursables) | 52 | 52 | 54 | +2 |

## Statement of the Budget

The FY 2008 request for the Office of Global Health Affairs (OGHA) is $11,339,000, an increase of $1,536,000 over the comparable FY 2007 Continuing Resolution (CR) level. This request will support three major initiatives: the US-Mexico Border Health Commission (USMBHC); the Secretary's Afghanistan health initiative; and the Latin American Health Initiative.

At the request level, OGHA will be able to continue its mission to promote the health of the world's population by advancing the Department's global strategies and partnerships, thus serving the health of Americans. The increased funding will also allow OGHA to further advance one of the Secretary's priorities: Improving the Human Condition around the World.

## Program/Activity Description

OGHA provides policy and staffing support to the Secretary, Deputy Secretary and other HHS leaders in the area of global health and family issues, and policy advice, leadership and coordination of international health and social matters across HHS, including leadership on major cross-cutting global health and family initiatives and the Department's relationships with other Federal agencies and with multilateral organizations.

OGHA also provides expert advice on international health, family and social policy on behalf of the Department, as part of U.S. Government inter-agency processes related to Presidential and Secretarial initiatives, multilateral organizations and HHS bilateral cooperation with specific countries and, topically, to infectious diseases, health security, post-conflict health assistance, negotiation of free trade agreements, and health and sustainable development. More specifically, OGHA:

- Represents the Federal government and HHS on international health and family policy issues to other governments, international organizations and U.S. non-governmental constituencies.
- Plans and staffs all international travel by the Secretary and Deputy Secretary and provides support to international travel by Assistant Secretaries and Heads of Operating and Staff Divisions.
- *Presidential initiatives:* Leads and coordinates HHS participation in the design and implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

- *Emergency Plan:* OGHA provides staff and policy support to the Secretary, to HHS agencies, and 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 heavily involved in all aspects of U.S. involvement with the Global Fund to Fight AIDS, Tuberculosis and Malaria (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 half of the annual U.S. contribution. OGHA staff serve on various international working groups to provide input into the operations of the Fund and U.S. Government inter-agency core groups to determine U.S. policy towards the fund.

- *Multilateral cooperation:* Participates in policy development and reform efforts, including priority-setting, related to multilateral health organizations, notably the World Health Organization (WHO), Pan American Health Organization, United Nations Children's Fund (UNICEF), Organization for Economic Cooperation and Development (OECD), and United Nations Educational, Scientific and Cultural Organization (UNESCO), and provides expert advice through the inter-agency process related to the Group of Eight (G8), Asia Pacific Economic Cooperation, Summit of the Americas, and others.

- *Bilateral cooperation:* Promotes key bilateral (country-to-country) relationships in the health sector with countries in all geographic regions of the world, including but not limited to Canada, Mexico, Spain, Italy, Ireland, India, China, Vietnam, Afghanistan, Iraq, Egypt, Russia, and South Africa. Illustrative, but not exhaustive, examples include the following:

  - *Afghanistan:* Leads and coordinates HHS efforts in a cooperative program with the Afghanistan Ministry of Public Health that focuses on reducing maternal mortality by developing a sustainable program to train specialists in obstetrics/gynecology – through maternal and child health teaching clinics, beginning at Rabia Balkhi Hospital in Kabul. OGHA is working with Afghan counterparts, and has assisted various HHS agencies in creating a Department-wide plan to assist in the reconstruction of Afghanistan's health sector; OGHA also leads HHS' contribution to an Inter-agency Afghanistan Health Working Group.

  - *Iraq:* Coordinates HHS contributions to policy and program development in post-conflict Iraq, including the assignment of personnel to the new U.S. Embassy in Baghdad, within the context of overall Federal efforts.

  - *Mexico:* Strengthens cooperation with Mexico through the Health Working Group of 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), including policy development, logistical arrangements, meeting agendas, meeting minutes, and working with contractors.

  - *Russia and other Eurasian nations:* Manages the HHS Biotechnology Engagement Program funded by the Department of State, including management of more than 20 high-priority public health projects and engagement of several hundred former Soviet scientists (including former bio-weapons scientists) in peaceful health research activities.

- *Infectious diseases and health security:* Together with the Assistant Secretary for Preparedness and Response and other HHS technical agencies, promotes cooperation on policy 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, including: Global Health Security Action Group; U.S.-Japan common agenda; U.S.-European Union Transatlantic Alliance; Indo-US Vaccine Action Program; Asia Pacific Economic Cooperation Health Task Force; and bilateral relationships with China, Egypt, Mexico, Russia, South Africa, and the European Union. This includes participation in the Regional Emerging Disease Intervention Center, a newly-created organization based in Singapore to support regional cooperation in health security, infectious disease surveillance, and research.

- *Refugee and humanitarian affairs:* Provides effective policy guidance, coordination and advocacy related to refugee health, particularly concerning refugees in the United States, and to other humanitarian issues such as trafficking in persons.

- *Inter-agency partnerships:* Partners on international health, family and social policy matters with other Federal agencies, including the U.S. Agency for International Development, the Environmental Protection Agency, and the Departments of State, Commerce, Defense, Education, and Energy; represents HHS on relevant inter-agency policy coordination committees convened by the National Security Council and Domestic Policy Council; and represents HHS on inter-agency trade policy committees convened by the U.S. Trade Representative.

- *Health attachés:* Supports HHS International Health Attaché positions in the U.S. Mission to the European Office of the United Nations and other International Organizations in Geneva (Switzerland), Brussels (Belgium), New Delhi (India), Hanoi (Vietnam), Pretoria (South Africa), Beijing (China) and Paris (France). The attaché in Pretoria is the South Africa regional position for the Southern African Development Council (SADC), which includes 15 African countries.

Performance Analysis

In CY 2005, OGHA's Afghanistan Health Initiative and the USMBHC were assessed through the PART process, the only two direct programs of OGHA at that time. Beginning in FY 2008 OGHA will have an additional direct program to administer, the Latin American Health Initiative. The balance of OGHA's funding comes from reimbursable agreements with other Federal agencies.

**Afghanistan Health Initiative**

Authorization for this activity is given under the Afghanistan Freedom Support Act of 2002. Under this Act, the U.S. Government is authorized to develop programs to improve maternal and child health and reduce maternal and child mortality. HHS has determined it might best use its expertise and resources by establishing training programs focused primarily on physicians, nurses, midwives and hospital administrators at selected tertiary health care facilities in Afghanistan. To date, HHS has been the only member of the donor community to offer to develop training programs specifically for Afghan hospitals, despite the acknowledged need within the health care system.

HHS is working with the Department of Defense (DoD) on matters related to both the physical infrastructure of the first major site, the Rabia Balkhi Women's Hospital (RBH) in Kabul, and logistics/security for HHS technical advisors. HHS is building on DoD efforts by supporting training activities within RBH. Additionally, HHS has initiated programs with the Ministry of Public Health to develop quality assurance programs and improve hospital management capability at this and other maternity and children's hospitals within and outside Kabul. An expected outcome of the HHS plan is to train physicians and other health care workers, after their training, will practice medicine in the rural areas where the need is greatest.

In addressing these problems, HHS has been fortunate to partner with DoD, which has supported critical infrastructure improvements, including upgrades of the electrical, plumbing and sewer systems at the hospital, as well as other needed improvements. Additionally, DoD has provided some funds to support maintenance programs at RBH.

For FY 2008, funding is included to continue to support much-needed efforts to rebuild maternal health care and physician and para-professional training in Afghanistan, including support for hospital management through the Ministry of Public Health. Additionally, HHS will continue efforts to expand its training activities in maternal and child health to a total of four sites, thus fulfilling the Federal government's commitment.

| | | |
|---|---|---|
| To establish a Training Program for Physicians and other staff at Rabia Balkhi Women's Hospital (RBH) in Kabul, Afghanistan. | Nov 16, 2006 | Since HHS began involvement at RBH in mid-2003, there has been improvement in the maternal and neonatal mortality rates there. The hospital previously lost three to four mothers per day, and now loses only two to four mothers per month and some months went by without any maternal deaths at all. There have been similar results in neonatal mortality rates. |

**United States-Mexico Border Health Commission**

Funding is included in the FY 2008 request to continue the work of the USMBHC, which is in its seventh year of existence. The goals of the Commission include institutionalizing a domestic focus on border health which can transcend political changes, and creating an effective venue for binational discussion to address public health issues and problems which affect the US-Mexico border populations.

In the health arena, the U.S. Section of the USMBHC will collaborate with Border States and communities to prioritize immunization rates through increased education of parents and providers. It will also increase its engagement with Border and Binational Health Councils to reduce the incidence of HIV/AIDS at the border, through an improved awareness and education campaign using community health workers.

Together with the Centers for Disease Control and Prevention (CDC), the Commission will support and assist in the coordination of the Border Health and Behavior Risk Factor Survey in the US-Mexico border region. The establishment of a border-wide chronic disease behavior risk factor surveillance system for residents on both sides of the border will help identify behaviors than can be targeted with the most appropriate chronic disease prevention strategies.

The Commission will also improve upon established alliances with Ten against Tuberculosis and the Environmental Health Working Group of Border 2012. These alliances, along with new engagements in women's health, will reinforce the Border Health goals and improve collaborations at all levels. In addition, the Commission is a central partner with the Department in meeting the health security needs of the border. Improvements to Commission Information Technology will better serve border communities in areas related to public health preparedness and further cooperation with the HHS Command Center.

Based on a program of work called *Healthy Border 2010*, the USMBHC has begun a phased expansion to ensure that it will meet its 20 measurable objectives by the year 2010. In addition, the Commission is a central partner with the Department in meeting the health security needs of the border.

| | | |
|---|---|---|
| To identify and evaluate current and future health problems that affect the U.S. Mexico border area, and to encourage and facilitate actions to address these problems | | The Commission is recognized as the border agency that convenes, encourages, and facilitates actions to address border health problems. In this capacity, the Commission encourages partners as sister-cities, border health councils, border States, and other border organizations to adopt and achieve *Health Border 2010* goals/objectives. Already the Healthy Border 2010 Program has improved cross-border collaboration |

**Latin American Health Initiative**

This initiative channels U.S. Government and private-sector resources to touch people's lives by delivering direct patient care and training local health workers, and thereby improve the image of the United States in the Hemisphere. The initiative has three main purposes:

- Train Latin American health-care workers in the region.
- Train U.S. Government medical personnel through deployment to Central American countries as part of U.S. Military medical and humanitarian missions to provide oral health care for poor populations in the region.
- Establish a strategic approach to engage with U.S. Government-funded non-

governmental organizations (NGOs) that provide health care in Latin American and Caribbean countries to re-brand their assistance as provided by both the U.S. Government and the NGOs and coordinate it with direct U.S. Government efforts in health.

The creation of a multi-country training center in Central America will be the first step toward the development of a coordinated health approach in the region, with the intent of shifting the focus of Central American's health-care institutions toward preventive and public-health approaches. Rather than bringing students to the United States, health care professionals (community health workers, sub-physicians, sub nurses, technicians) in the region will receive training at the regional training center, to improve their skills and abilities to provide basic care to poor populations and be prepared for specific situations related to infectious disease, including respiratory conditions and potential emerging threats like pandemic influenza. The uniqueness of this training is that students will return to their homes to apply the skills learned, which will therefore contribute to the improvement of health care provided for their communities.

A unique aspect of the training of U.S. Government personnel is the provision of good quality oral health care, particularly preventive dental care. The *2003 World Oral Health Report* shows that the rate of dental caries among 12-year-olds is declining in developed countries, but increasing in developing countries. HHS's Indian Health Service is a pioneer in the development of a program on oral health care in which the application of sealants has proved highly cost-effective, and the U.S. Government will pioneer the implementation of such a model of care in Central America. The use of dental sealants in children has immediate and long-term medical and psychological benefits, provides significant improvement in quality of life, and can have unquestionable public-health impact.

Non-governmental organizations (NGOs) are essential partners that will significantly increase the success of U.S. Government health diplomacy in Central America. In addition to supporting the training component of this initiative through coordinated health campaigns, NGOs can help better identify the needs of rural populations in Central America. OGHA will develop a Request for Proposal to award a cooperative agreement for NGOs in 2008 to provide care, participate as faculty, develop dissemination strategies and create an evaluation plan for the initiative.

**Other**

OGHA will continue its efforts with the State Department to support the Biotechnology Engagement Program (BTEP). The State Department annually transfers BTEP funds to OGHA, to reduce the risk of bioterrorism by engaging former Soviet biological scientists in areas of research and development that address priority public health concerns in the former Soviet Union. The estimated transfer in FY 2008 is $8,000,000.

OGHA will also continue efforts with various components of the US Agency for International Development (USAID), largely through the provision of HHS technical experts to USAID programs of mutual interest. USAID transfers funds to OGHA to support these various programs.

Rationale for the Budget

The FY 2008 request for OGHA is $11,339,000, an increase of $1,536,000 above the FY 2007 CR level. As described on the preceding pages, this amount will primarily cover three major

initiatives: the Secretary's  Afghanistan health initiative; the US-Mexico Border Health Commission (USMBHC); and the Secretary's Latin American Health Initiative.   In doing so, these funds will be used for advancing the Secretary's priority of "Improving the Human Condition Around the World" through the use of health diplomacy as a means to improve binational relations.

Reimbursable FTE and funds are central to the effective operation of OGHA.  In FY 2008, an estimated $29,000,000 in reimbursable funds from other agencies will support OGHA functions in the following areas:

- OGHA's entire core humanitarian affairs and refugee health function;
- current International HHS Health Attaché positions at the US Mission in Geneva and Paris, and the US Embassies in New Delhi, Pretoria, Hanoi, and Beijing and future positions at the US Missions in New York and Brussels;
- core bilateral program positions in OGHA, including those associated with cooperation with China, Singapore, Vietnam, India, Egypt, Israel, Spain, Italy, Ireland, the European Union, Mexico, Russia, and South Africa, among others;
- core functions associated with HHS involvement in multilateral health organizations;
- policy and related program cooperation with USAID and several of its missions; and
- key public health positions with USAID's Office of Foreign Disaster Assistance.

# OFFICE OF GLOBAL HEALTH AFFAIRS

## FUNDING SOURCES

| Activity | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| ***GDM Appropriation:*** | | | |
| US-Mexico Border Health Commission | $3,381,000 | $3,459,000 | $3,465,000 |
| Afghanistan Health Initiative | 5,889,000 | 5,916,000 | 5,941,000 |
| Other GDM | 420,000 | 428,000 | 433,000 |
| Latin American Heath Initiative | 0 | 0 | 1,500,000 |
| ***Subtotal, OGHA Budget Authority*** | ***$9,690,000*** | ***$9,803,000*** | ***$11,339,000*** |
| Biotechnology Engagement Program (funds transferred from State Dept) | 8,000,000 | 8,000,000 | 8,000,000 |
| Reimbursables (estimated) | 25,000,000 | 28,000,000 | 29,000,000 |
| ***Subtotal, OGHA Other*** | ***$33,000,000*** | ***$36,000,000*** | ***$37,000,000*** |
| **TOTAL, OGHA Program Level** | **$42,690,000** | **$45,803,000** | **$48,339,000** |

# OFFICE OF GLOBAL HEALTH AFFAIRS
## Detailed Performance Analysis

## Afghanistan Health Initiative

| **Long Term Goal: By 2007, reduce by 20% the number of maternal and neonatal deaths in Afghanistan. The overall purpose of the program is to achieve the long term goal by improving the skills and training of the hospital staff.** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| The maternal mortality rate at RBH in Kabul, Afghanistan. | 2008<br>2007<br>2006<br>2005<br>2004 | <br>170<br>170<br>170<br>Baseline | <br>November 2007<br>177.6<br>156<br>180.5 |
| The percent of trainees enrolled in courses. | 2008<br>2007<br>2006<br>2005 | <br>80%<br>75%<br>Baseline | <br>November 2007<br>70%<br>50% |
| The time to hire and deploy essential staff trainers. | 2008<br>2007<br>2006<br>2005 | <br>3 months<br>2.5 months<br>Baseline | <br>November 2007<br>4.2 months<br>3 months |
| The staff trainer retention rate. | 2008<br>2007<br>2006<br>2005 | <br>89%<br>89%<br>Baseline | <br>November 2007<br>85%<br>80% |
| The intrapartum mortality rate among neonates with a birth specific rate of 2500 grams at RBH in Kabul, Afghanistan. | 2008<br>2007<br>2006<br>2005<br>2004 | <br>8<br>6.3<br>6.3<br>Baseline | <br>November 2007<br>8.2<br>7.2<br>7.0 |
| The predischarge neonatal mortality rate among neonates with a birth specific weight of 2500 grams at RBH in Kabul, Afghanistan. | 2008<br>2007<br>2006<br>2005<br>2004 | <br>4.0<br>2.2<br>2.5<br>Baseline | <br>November 2007<br>5.7<br>6.6<br>2.8 |
| The percent of nurse midwiferies who meet competency measures on the 37 Afghanistan Standards of Practice. | 2008<br>2007<br>2006<br>2005 | <br>85%<br>50%<br>Baseline | <br>November 2007<br>75%<br>40% |
| The post-operative infection rate among maternity patients at RBH in Kabul, Afghanistan. | 2008<br>2007<br>2006<br>2005<br>2004 | <br>4.0<br>3.0<br>3.4<br>Baseline | <br>November 2007<br>5.3<br>2.5<br>3.7 |
| **Data Source:** Utilize a new record-keeping system that includes tabulation of the numbers of maternal and neonatal deaths that occur at Rabia Balkhi Hospital. | | | |

| **Data Validation:** The staff at Rabia Balkhi Hospital will be able to monitor the system on a daily basis to insure that the data is correct. This will also allow the staff to monitor their own performance. |
|---|
| **Cross Reference:** Program Assessment Rating Tool (PART) goal |

*Performance Summary:* The long-term goal of the program is to improve maternal and child health by reducing the maternal and child mortality rates in Afghanistan. To achieve this goal the Afghanistan Health Initiative has established a training program for Physicians and other staff at Rabia Balkhi Women's Hospital (RBH) in Kabul, Afghanistan. To track progress the program has developed annual measures such as: recruit/hire and retain essential staff trainers and to increase the number of trainees enrolled in courses. The expected outcome of this program is to train physicians and other health care workers which, after their training, will practice medicine in the rural areas where the need is greatest.

Since HHS began involvement at RBH in mid-2003, there has been improvement in the maternal and neonatal mortality rates there. The hospital previously lost three or four mothers per day, and now loses only two to four mothers per month; some months there are now no maternal deaths at all.

US-Mexico Border Health Commission

| **Long Term Goal: To improve access to primary health care via the Healthy Border 2010 program** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Results** |
| Reduce the percent of indirect spending on border health activities. | 2008<br>2007<br>2006<br>2005<br>2004 | 9%<br>10%<br>11%<br>12%<br>Baseline | <br><br>4%<br>24.6%<br>16% |
| The number of health cards distributed to health care providers. | 2008<br>2007<br>2006<br>2005<br>2004 | <br><br><br>36,678<br>Baseline | <br>Not determined<br>due to closure<br>of the program<br>29,343 |
| The incidence of tuberculosis cases per 100,000 inhabitants on the U.S. side of border. | 2010<br>2000 | 5<br>Baseline | <br>10 |
| The incidence of HIV cases per 100,000 inhabitants on the U.S. side of the border. | 2010<br>2000 | 4.2<br>Baseline | <br>8.4 |
| The diabetes death rate on the United States side of the border (number of deaths per 100,000 inhabitants). | 2010<br>2000 | 24.2<br>Baseline | <br>26.9 |
| The number of health screenings provided to U.S.-Mexico border health residents during the Border Binational Health Week to improve detection of chronic diseases. | 2008<br>2007<br>2006<br>2005<br>2004 | <br><br><br>24,457<br>Baseline | <br><br>March 2007*<br>15,836<br>19,566 |

| | | | |
|---|---|---|---|
| Increase the number of patients at the US-Mexico border using the TB Card. | 2008<br>2007<br>2006<br>2005<br>2004 | <br>600<br>600<br>540<br>Baseline | <br><br>March 2007*<br>1281<br>470 |
| **Data Source:** Data compiled by the National Center for Health Statistics and US-Mexico border communities collect health data on immunization rates, morbidity and mortality which contributes to the Healthy Border 2010 agenda | | | |
| **Data Validation:** Commission and National Center for Health Statistics analyze Healthy Border 2010 related data for impact on the health of border populations. | | | |
| **Cross Reference:** Program Assessment Rating Tool (PART) goal | | | |

* midterm evaluation will determine if the program is on track to meet the 2010 target.

*Performance Summary:* The Commission is recognized as the border agency that convenes, encourages, and facilitates actions to address border health problems. In this capacity, the Commission encourages partners as sister-cities, border health councils, border States, and other border organizations to adopt and achieve Healthy Border 2010 goals/objectives. Already the Healthy Border 2010 program has improved cross-border collaboration.

The long-term goals are to increase and improve the quality of life and years of healthy life and to reduce health disparities among residence of the US Mexico Border. The Healthy Border 2010 objectives have ten-year targets that expect positive outcomes for the health of border populations. For example, by 2010 the Commission expects that, through active surveillance including the testing of at-risk populations, providing curative therapy to tuberculosis patients and ensuring that therapy is completed, the incidence of tuberculosis on the US side of the border should be reduced by 50%.

Latin American Health Initiative

This initiative will focus on improving the quality of health care in the Central America region. Performance measures for this initiative are currently under development.

# OFFICE OF PUBLIC HEALTH AND SCIENCE
## Summary Table

| | FY 2006 Actual | | FY 2007 CR | | FY 2008 Budget | |
|---|---|---|---|---|---|---|
| | FTE | Amount | FTE | Amount | FTE | Amount |
| GDM Direct: | | | | | | |
| Immediate Office | 37 | $8,131,000 | 37 | $8,205,000 | 38 | $9,336,000 |
| Office of HIV/AIDS Policy | 4 | 932,000 | 4 | 941,000 | 4 | 959,000 |
| Adolescent Family Life | 14 | 30,203,000 | 14 | 30,307,000 | 15 | 30,307,000 |
| Office of Disease Prevention and Health Promotion | 19 | 7,330,000 | 19 | 7,402,000 | 20 | 7,499,000 |
| President's Council on Physical Fitness and Sports | 8 | 1,228,000 | 8 | 1,240,000 | 8 | 1,270,000 |
| Office of Minority Health | 66 | 56,388,000 | 66 | 53,993,000 | 67 | 43,775,000 |
| Office on Women's Health | 47 | 28,205,000 | 47 | 28,283,000 | 48 | 27,369,000 |
| Office for Human Research Protections | 33 | 6,921,000 | 33 | 6,989,000 | 34 | 7,357,000 |
| Commissioned Corps Initiatives | 6 | 4,128,000 | 6 | 4,157,000 | 124 | 38,439,000 |
| National Vaccine Program Office | 7 | 7,004,000 | 7 | 7,073,000 | 7 | 7,287,000 |
| Public Health Reports | 2 | 456,000 | 2 | 461,000 | 2 | 466,000 |
| PHS Historian | 3 | 480,000 | 3 | 480,000 | 3 | 480,000 |
| Subtotal, Direct | 246 | $151,406,000 | 246 | $149,531,000 | 370 | $174,544,000 |
| GDM Reimbursables: | | | | | | |
| Office of Research Integrity[1] | 23 | [8,172,000] | 23 | [8,172,000] | 25 | [8,723,000] |
| Other | 34 | – | 34 | – | 36 | – |
| Subtotal, Reimbursables | 57 | | 57 | | 61 | |
| *Subtotal, Direct + Reimbursables* | *303* | | *303* | | *431* | |
| Service and Supply Fund | 64 | – | 71 | – | 71 | – |
| Total, GDM | 367 | $151,406,000 | 374 | $149,531,000 | 502 | $174,544,000 |
| PHSSEF: | | | | | | |
| Medical Reserve Corps | 6 | $9,748,000 | 5 | $9,748,000 | 5 | $15,113,000 |
| TOTAL, OPHS | 373 | $161,154,000 | 379 | $159,279,000 | 507 | $189,657,000 |
| *[PHS Evaluation Set-Aside; non-add]* | | *[$4,552,000]* | | *[$4,552,000]* | | *[$4,552,000]* |

[1] ORI is funded by NIH dollars, which are reflected as non-add.

# OPHS IMMEDIATE OFFICE

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $8,131,000 | $8,205,000 | $9,336,000 | +$1,131,000 |
| FTE | 37 | 37 | 38 | +1 |

## Statement of the Budget Request

The FY 2008 request for the OPHS Immediate Office is $9,336,000, an increase of $1,131,000 above the FY 2007 CR level. The request provides funding to support the Immediate Office of the Assistant Secretary for Health (ASH) and the Office of the Surgeon General.

## Program Description

OPHS is under the direction of the 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 budget for the Office of the Surgeon General (OSG) is located within the Immediate Office. The role of the Surgeon General is to protect and advance the health of the nation. The SG, who reports to the ASH, provides a highly recognized symbol of national commitment to protecting and improving the public's health, communicates with the American people on issues related to health and advises on health related behaviors and interventions.

The Immediate Office and OSG directly support several of the Secretary's priorities identified in the 500 Day Plan, such as Obesity Prevention, Pandemic Preparedness, and Emergency Response and Commissioned Corps Renewal. In its leadership role, the Immediate Office ensures a public health perspective on all other Secretarial and Presidential priorities. The Immediate Office provides leadership to and oversight of the OPHS policy/program offices as they implement their programs and other HHS and Presidential priorities.

The Immediate Office operates essentially through the support of salaries and costs that support staff, including rent, travel, supplies and equipment, overhead (personnel costs, fiscal charges, and IT support) and general support contracts.

## Rationale for the Budget Request

The FY 2008 Budget for the OPHS Immediate Office is $9,336,000, an increase of $1,131,000 above the FY 2007 CR level. This level will allow the Immediate Office to maintain its cadre of senior public health staff brought on-board during FY 2007. Funds support salaries and benefits, rent, and other overhead costs.

## Performance Analysis

The OPHS performance plan includes three strategic goals (Strengthening Prevention; Closing the Health Gap, and Strengthening the Public Health and Research Infrastructure) and five crosscutting function areas (Shaping Policy at Local, State, National and International Levels; Communicating Strategically; Promoting Effective Partnerships; Building a Stronger Base; and Leading and Coordinating Key Initiatives within or on Behalf of the Department). The Immediate Office, through its leadership role, ensures that OPHS policy offices strive toward meeting these goals.

| Performance Goal | Results | Context |
|---|---|---|
| Increase by at least 10% 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 has met target. | OPHS establishes and strengthens 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. |
| On an annual basis, OPHS will lead and coordinate 20% more key initiatives within and on behalf of the Department. | For the last several years, actual performance has increased by almost 50% annually. | OPHS coordinates numerous Prevention Initiatives. For example, the Secretary recently announced that OPHS/ODPHP will take the lead on the Obesity Prevention Initiative. In addition, OPHS coordinates the President's prevention initiative, *HealthierUS*, and the Secretary's prevention initiative, *Steps to a HealthierUS*. |

# OFFICE OF HIV/AIDS POLICY

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $932,000 | $941,000 | $959,000 | +$18,000 |
| FTE | 4 | 4 | 4 | -- |

Statement of the Budget Request

The FY 2008 Budget for the Office of HIV/AIDS Policy (OHAP) is $959,000, an increase of $18,000 above the FY 2008 CR level.

Program Description

The Secretary has delegated to the ASH responsibility for coordinating, integrating, and directing the Department's policies, programs, and activities related to HIV/AIDS. OHAP works with the ASH to meet the Department's needs by supporting its mission and goals in the following areas:

- OHAP provides strong, responsive, and accountable administrative structure to HIV/AIDS related issues for OPHS and OS that ensures the success of the Department's HIV/AIDS programs, policies, and activities, while maintaining fiscal accountability and engaging in outcome evaluation.

- OHAP serves as the senior advisory agency on HIV/AIDS issues to the Secretary, the Deputy Secretary and the ASH. The Office also provides policy information and analysis to the Department's OPDIVs and STAFFDIVs. 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.

- OHAP serves as the Department's central coordinating office for the following agencies and activities:

  - OHAP is leading a two year National HIV/AIDS Community Mobilization Campaign to promote the President's domestic agenda, to address the issue of HIV related stigma and to encourage HIV testing and the use of rapid HIV testing technology application in non traditional venues to reach hard to serve populations and individuals.

  - OHAP is the lead for all Minority AIDS Initiative program and budget activities, including monitor, reporting and evaluation.

- OHAP provides a leadership role as the Co-Chair of the Department's HIV/AIDS Management Coordination Team (HMCT), which is comprised of principals from all of the HHS agencies with key HIV/AIDS portfolios. With the HMCT, OHAP and Assistant Secretary for Planning and Evaluation are developing and implementing strategies and policies to address priority areas that HMCT has identified.

- OHAP coordinates both inter-agency and intra-agency HIV/AIDS activities.

- 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 to promote HHS policies, resources and programs.

- OHAP provides staff development opportunities to senior HHS officials and to OPDIV and other HHS staff. 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 both inside and outside the Department.

- OHAP improving HHS' usage of the Internet, Federal web sites, and e-mail to support the Department's programs, goals, and objectives.

OHAP continues to monitor the implementation of the Department's strategic plan for the prevention and treatment of HIV/AIDS.

Rationale for the Budget Request

The FY 2008 Budget for OHAP is $959,000, an increase of $18,000 above the FY 2007 CR level. This level will allow OHAP to maintain its staffing and operations at the FY 2007 level.

Performance Analysis

| Performance Goals | Results | Context |
|---|---|---|
| To promote and facilitate the creation of 6 to 9 significant new collaborations and/or partnerships among agencies and offices performing HIV/AIDS over the next 12 months | Forging partnerships and collaborations is a tool of OHAP to reduce redundancy /duplication, and to achieve greater accountability. Over arching goal is to be position to conduct comprehensive assessments and evaluation of programs and activities. | OHAP is coordinating 6 Work Groups or Roundtables to establish conduct assessments and to design evaluation tools and strategies. Report from this work will inform future programmatic and research activities necessary to maximize the Federal investment in HIV/AIDS prevention, care, treatment and research expenditures. |
| To design and implement a National HIV/AIDS Community Mobilization Campaign to promote "Know Your HIV Status" through eliminating barriers to HIV testing, addressing HIV related stigma, and to encouraging the use of rapid HIV testing technology. | Through partnerships and collaborations with faith and community-based organizations promote standardized messages designed to reach and educate 50 million Americans about the continued threat of HIV disease. | OHAP and its partners and collaborators intend to initiate or align with more than 1000 events and activities across the US to address elimination of barriers and to promote HIV/AIDS messages regarding prevention, care, treatments. |

Performance Narrative

The Office of HIV/AIDS Policy's 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 50 percent.

OHAP achieves results by looking at HIV/AIDS in the following contexts:

- OHAP has assumed administration of the HIV/AIDS Regional Resource Network (HRRN) project that was under the management of the Office of Minority Health. The HRRN went under a year long assessment and evaluation, and it was determined that the project should continue. The HRRN project significantly increases contributions to the national response to the HIV/AIDS epidemic.

- OHAP actively promotes the Center for Disease Control and Prevention's (CDC) Advancing HIV Prevention initiative, which encourages increasing use of HIV testing and focuses on preventing the spread of HIV/AIDS by working with HIV positive individuals to minimize risk.

- OHAP furthers the Department's priorities in this area by working with the SAS Institute to develop an effective HIV/AIDS data tracking and retrieval system. OHAP has also been a leader in expanding and promoting e-government and the use of the www.grants.gov website.

- OHAP looks at HIV/AIDS in context with other health disparities, and analyzes the

impact of the HIV/AIDS epidemic in terms of its effect on those Americans who face the greatest need for health care and the largest challenges in accessing that care.

- OHAP supports the White House's and the Department's objectives of bringing more faith-based denominations and community-based organizations into HHS funding and decision-making processes. OHAP promotes the funding of faith-based HIV/AIDS prevention, care, and treatment programs, and the inclusion of faith leaders in the development of Federal HIV/AIDS policy.

- OHAP is involved in the development of a Federal initiative to build public health care infrastructure that is able to meet health care needs in times of crisis. Through this initiative, OHAP will be working with senior Department officials and other government leaders to ensure that people living with HIV/AIDS have access to health care services and medications in the event of a national crisis.

- OHAP's role as coordinator of HHS's HIV/AIDS programs, policies, and activities meet the Secretary's goal of strengthening management and providing more accountability for results. OHAP has also contributed to stronger management by using resources effectively and by encouraging competitive sourcing for its HIV/AIDS programs.

# ADOLESCENT FAMILY LIFE

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $30,203,000 | $30,307,000 | $30,307,000 | -- |
| FTE | 14 | 14 | 15 | +1 |

## Statement of the Budget Request

The FY 2008 budget for the Adolescent Family Life Program is $30,307,000, the same as the FY 2007 CR level.

## Program Description

The Adolescent Family Life (AFL) program, authorized in 1981 under Title XX of the Public Health Service Act, is administered and directed by the Office of Adolescent Pregnancy Programs (OAPP) in the Office of Population Affair (OPA). AFL funds care demonstration projects that provide and evaluate innovative and integrated approaches to the delivery of comprehensive services to pregnant and parenting adolescents, and prevention demonstration projects which provide services promoting abstinence from sexual activity for adolescents. The Title XX statute also requires an independent evaluation of all funded demonstration projects and authorizes research grants in the area of adolescent family life. Community-based, community supported, faith-based, and school-based applicants are encouraged to apply for Title XX grants.

To provide and evaluate comprehensive care and prevention services, the AFL program supports two types of demonstration programs:

- *Prevention* demonstration programs to develop and test curricula, educational materials, youth development or developmental assets approaches designed to encourage adolescents to postpone sexual activity until marriage; and

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

Although these demonstration grants work with distinctly different populations, both Prevention and Care projects are focused on ways to build and strengthen families and measure outcomes of such efforts. In FY 2006, OAPP focused intensive efforts on strengthening the evaluations of AFL projects by increasing the percentage set aside for independent evaluation (increased from 5% to 25%) and providing technical assistance. In addition, the AFL program is also authorized, by statute, to provide support for basic and applied research into the causes and consequences of adolescent premarital sexual relations, adolescent pregnancy and parenting.

The AFL demonstration projects support the goals and objectives of the HHS Strategic Plan.

The care demonstration projects particularly support increasing access to health care services, not only for adolescents and their infants, but also for their parents and other family members, as well as young fathers. The care programs assist in preventing disease, particularly STDs and HIV/AIDS; promoting early childhood and youth development; reducing child abuse and neglect; and reducing health disparities by ensuring that pregnant and parenting adolescents have access to adequate prenatal and postnatal care as well as pediatric care. The AFL program also supports the Secretary's "500 Day Plan." Specifically, AFL grants increase the commitment to faith and community-based grants by encouraging these organizations to apply. The AFL program has also been instrumental in expanding opportunities for faith-based community organizations to participate in the delivery of services. The AFL program also supports the First Lady's initiatives on Helping America's Youth by teaching adolescents about good health habits and preventing diseases, promoting healthy life styles, and reducing disparities in health services for young people.

The AFL program supports the Department's *One HHS's* Program Objectives which include: the enhancement of the research and evaluation capacity; improving efforts to involve parents in adolescent health services and decision-making; promoting risk avoidance strategies for adolescents; and strengthening the capacity of programs in preparing and supporting efforts to encourage healthy marriages and parenting relationships. The AFL program has incorporated developmental assets and youth developmental approaches in both prevention and care projects in an effort to encourage and motivate adolescent clients and their families to adopt risk avoidance strategies. AFL is expanding new and innovative parental involvement and communication efforts in all projects to encourage the prevention of initial adolescent pregnancies, repeat pregnancies, child abuse and neglect, as well as school drop outs. The AFL program continues to increase its efforts to strengthen program evaluation designs to determine the effectiveness and efficiency of both prevention and care projects.

## Rationale for the Budget

The FY 2008 Budget for the Adolescent Family Life Program is $30,307,000, the same as the FY 2007 CR level. At this level of funding, AFL will maintain the same level of operations as in FY 2007.

## Performance Analysis

| **1. Long Term Goal for Adolescent Family Life Abstinence projects: Encourage adolescents to postpone sexual activity by developing and testing abstinence interventions.** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| **Performance Measure 1.1**<br>Increase the involvement of parents in the lives of their adolescent children. | *2011* | TBD* | Mar-12 |
| | *2010* | | Mar-11 |
| | *2009* | | Mar-10 |
| | *2008* | | Mar-09 |
| | *2007* | | Mar-08 |
| | *2006* | Baseline | Mar-07 |

| Measure | FY | Target | Result |
|---|---|---|---|
| **Performance Measure 1.2**<br>Increase adolescents' understanding of the positive health and emotional benefits of abstaining from premarital sexual activity. | *2011* | TBD* | Mar-12 |
| | *2010* | | Mar-11 |
| | *2009* | | Mar-10 |
| | *2008* | | Mar-09 |
| | *2007* | | Mar-08 |
| | *2006* | Baseline | Mar-07 |

**2. Long Term Goal for Adolescent Family Life Care projects: Ameliorate the effects of too-early-childbearing by developing and testing interventions with pregnant and parenting teens.**

| Measure | FY | Target | Result |
|---|---|---|---|
| **Performance Measure 2.1**<br>Reduce the incidence of repeat pregnancies among clients in AFL Care demonstration projects. | *2011* | TBD* | Mar-12 |
| | *2010* | | Mar-11 |
| | *2009* | | Mar-10 |
| | *2008* | | Mar-09 |
| | *2007* | Baseline | Mar-08 |
| | *2006* | | Mar-07 |
| **Performance Measure 2.2**<br>Increase AFL Care demonstration project client conformance with recommended infant immunization schedules. | *2011* | TBD* | Mar-12 |
| | *2010* | | Mar-11 |
| | *2009* | | Mar-10 |
| | *2008* | | Mar-09 |
| | *2007* | Baseline | Mar-08 |
| | *2006* | | Mar-07 |
| **Performance Measure 2.3**<br>Increase the educational attainment of AFL Care demonstration project clients. | *2011* | TBD* | Mar-12 |
| | *2010* | | Mar-11 |
| | *2009* | | Mar-10 |
| | *2008* | | Mar-09 |
| | *2007* | Baseline | Mar-08 |
| | *2006* | | Mar-07 |

| 3. Long Term Goal for Adolescent Family Life Care and Prevention projects: Identify interventions that have demonstrated their effectiveness to: 1) promote premarital abstinence for adolescents and 2) ameliorate the consequences of adolescent pregnancy and childbearing. | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| **Performance Measure 3.1**<br>Improve the quality of the independent evaluations, required by statute, of Title XX prevention and care demonstration projects. | *2011* | TBD* | Mar-12 |
| | *2010* | | Mar-11 |
| | *2009* | | Mar-10 |
| | *2008* | | Mar-09 |
| | *2007* | | Mar-08 |
| | *2006* | Baseline | Mar-07 |
| **Data Source:** Grantee Annual End of the Year reports will provide aggregate data to track performance measures 1.1, 1.2, 2.1, 2.2 and 2.3. Reviews of Annual End of the Year Evaluation Reports will provide information to track performance measure 3.1. | | | |
| **Data Validation:** The AFL will incorporate cross checks to ensure data is valid. | | | |
| **Cross Reference:** Healthy People 2010 goals: 7-1, 9-1, 9-2, 9-3, 9-7, 9-8, 9-9, 9-11; HHS Strategic Goal: Reducing the major threats to the health and well-being to Americans; OPHS GPRA FY 2007 Goals: Enhance Prevention Strategies, Communicate Strategically, and Strengthen the Prevention Base. | | | |
| **Notes:** *The Core Data Instruments were distributed to grantees in October, 2005 to uniformly gather FY 2006 baseline and follow-up aggregate data. An OMB approved End of the Year report template will gather aggregate data from the Core Instruments being implemented. Baseline data for Measures 1.1, 1.2, and 3.1 will be gathered by Spring 2007 after end of the year reports are assessed for FY 2006 and targets will be set at that time. Baseline data for Measures 2.1, 2.2, and 2.3 will be gathered by Spring 2008 after end of the year reports are assessed for FY 2007 and targets will be set at that time.<br>1.1 Measured by the change in the proportion of AFL Prevention demonstration project clients who communicate with their parents about puberty, pregnancy, abstinence, alcohol, and/or drugs.<br>1.2 Measured by the change in the proportion of AFL Prevention demonstration project clients who indicate that it is important to them to remain abstinent until marriage.<br>2.1 Measured by the proportion of project clients with a repeat pregnancy at annual follow-up.<br>2.2 Measured by the proportion of project clients whose infant has received all recommended immunizations at annual follow-up.<br>2.3 Measured by the proportion who have enrolled in or completed a high school or GED program at annual follow-up.<br>3.1 Measured annually by an independent review of grantee end of year evaluation reports. | | | |

## Performance Narrative

In Spring 2004, the AFL program was reviewed through the Performance Assessment Rating Tool (PART) process and was rated as “Results Not Demonstrated (RND).” AFL was praised for its efforts in creating core data instruments; however, there were no performance measures or measurement data at that time, and the PART score reflected this fact. The AFL program subsequently developed and submitted an action plan utilizing major milestones, and formulated long-term and short-term performance measures. The plan included specific actions (the adoption and implementation of the core data instrument and performance measures) to move the program forward in preparation for a reassessment of its RND rating. Additional information on the AFL PART and AFL program accomplishments related to the PART can be found on ExpectMore.gov.

In order to standardize data collection from 76 grantees, core data instruments were developed and sent through the OMB review and approval process. In September 2005, these core data instruments were approved by OMB for use in AFL demonstrations projects. All AFL grantees funded after FY 2004 are required to use the core data instruments and report aggregate data to OAPP. Technical assistance is provided to AFL grantees on the proper use of the core data instruments to ensure consistency.

The PART process also encouraged AFL to develop and solidify performance measures based on these instruments and subsequently prompted the program to develop an End of the Year report template to gather information pertinent to these measures. In May 2006, AFL received OMB approval of end of the year reporting templates for grantees that incorporate reporting of AFL performance measures. These templates include data and statistical reporting tools that provide uniformity across grantees. Standardization of reporting will allow OAPP to assess and improve the quality of evaluations across all AFL programming. Baseline data will be gathered in the Spring 2007 for measures 1.1, 1.2, and 3.1. Because measures 2.1, 2.2, and 2.3 specifically reference annual follow-up data, baseline data will be gathered on these measures in Spring 2008. With this data, the AFL program is preparing for an RND reassessment.

The approved performance measures are directly related to the two types of Title XX Demonstration projects funded: Care and Prevention. Each measure was developed to function as an accurate standard to measure the impact of the Title XX Demonstration projects. While all Title XX projects differ on many levels, they each have a base from which they begin. That base is tied to the goals of the Title XX performance measures and ultimately the Title XX legislation. Since September 2005, AFL implemented the core data instruments, solidified performance and efficiency measures and is now gathering measurement data in order to set targets. The AFL core data collection instruments collect, compile and disseminate program performance information on an annual and uniform basis. Because of the PART process, the AFL program will now be able to ascertain performance on a cross-site basis. A contract has been awarded to an independent agency in order to develop methods of quantifying and interpreting data. This information will be used to inform the budget decision making process.

# ADOLESCENT FAMILY LIFE
## Program Data

| Activity | FY 2006 Actual | | FY 2007 CR | | FY 2008 Budget | |
|---|---|---|---|---|---|---|
| PROGRAM FUNDING | No, | Amount | No. | Amount | No. | Amount |
| Title XX Demonstration Grants: | | | | | | |
| Care | 32 | $12,870,000 | 31* | $12,870,000 | 31 | $12,870,000 |
| Prevention | 57 | $13,120,000 | 45* | $13,120,000 | 45 | $13,120,000 |
| Subtotal, Demonstration Grants | 89 | 25,990,000 | 76 | 25,990,000 | 76 | 25,990,000 |
| Research/Agreements/TA | 5 | 2,052,000 | 5 | 1,926,000 | 5 | 1,861,000 |
| Subtotal | 94 | 28,042,000 | 81 | 27,916,000 | 81 | 27,851,000 |
| Support Costs | | 2,161,000 | | 2,391,000 | | 2,456,000 |
| TOTAL | | $30,203,000 | | $30,307,000 | | $30,307,000 |
| CLIENTS SERVED | | | | | | |
| Title XX Care Demonstrations | 32 | 25,220 | 31 | 24,433 | 31 | 24,433 |
| Title XX Prevention Demonstrations | 57 | 86,000 | 45 | 68,000 | 45 | 68,000 |
| TOTAL | 89 | 111,220 | 76 | 92,433 | 76 | 92,433 |

* Because of funding evaluation intensive grants in FY 2007, the amount of each new grant will increase by $100,000. Thirty-seven grants are ending their five year cycle, funded at $225,000-$300,000 per year, and 25 new grants will be funded in their place, at an estimated $350,000-$400,000 per grant year. Eight care grants are phasing out and seven new Care grants will be funded in their place accounting for increases in grant amount. Therefore, the number of grants is reduced for FY 2007 and FY 2008. Because new prevention demonstration projects are funded at the end of FY 2007 and the new care demonstration projects were just funded, FY 2007 and FY 2008 the number of "clients served" are estimates. For programs that have been funded prior to FY 2007, "clients served" are estimated from program applications and site visit reports. AFL is currently implementing a new OMB approved core data collection instrument for care and prevention projects that will gather the information on the actual number of participants in these programs. Data from this form will be gathered in FY 2007 and reported in Spring of FY 2008.

# OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $7,330,000 | $7,402,000 | $7,499,000 | +$97,000 |
| FTE | 19 | 19 | 20 | +1 |

## Statement of the Budget Request

The FY 2008 budget for the Office of Disease Prevention and Health Promotion (ODPHP) is $7,499,000, an increase of $97,000 above the FY 2007 CR level.

## Program Description

ODPHP provides leadership, coordination and policy development for public health and prevention activities within OPHS. ODPHP's central mandates are to assist the Assistant Secretary for Health and the Office of the Secretary in:

- Coordinating health promotion and disease prevention activities, especially those related to the President's *HealthierUS* initiative, the *Steps to a HealthierUS* initiative (e.g., the National Prevention Summit and Prevention Partnerships), and *Healthy People 2010.*
- Developing, evaluating, and promoting innovative approaches to communicating health information and operating the National Health Information Center, as part of the emerging national health information infrastructure and network; and
- Addressing cross-cutting issues in public health, prevention, and science.

ODPHP plays an important coordinating role in support of the Department-wide objective, Emphasize Healthy Living and Prevention of Disease, Illness, and Disability. ODPHP coordinates *HealthierUS* and related prevention initiatives on behalf of the Department. Together, these initiatives focus on promoting health and preventing obesity and related chronic diseases by addressing major risk factors (physical inactivity, poor nutrition, tobacco use, and youth risk-taking behaviors) and reducing the burden of disease through appropriate health screenings and prevention of secondary conditions. The 3rd National Prevention Summit: Innovations in Community Prevention was held October 24-25, 2005, in Washington, DC. More than 600 health professionals from non-profit organizations, academia, businesses and government attended. The Secretary presented the Innovation in Prevention awards to 10 organizations that have implemented innovative and creative chronic disease prevention and health promotion programs.

ODPHP coordinates the implementation of *Healthy People 2010. Healthy People* supports the President's *HealthierUS* initiative by offering specific national goals across a range of health areas. Through evidence-based objectives with measurable targets, it provides a framework for programs necessary to achieve the vision of these initiatives. The objectives have been

reassessed through a Midcourse Review process during FY 2006. The results of that review will be published in FY 2007. In FY 2006, ODPHP began the final round of progress reviews to assess the status of objectives in the 28 focus areas of *Healthy People 2010.* These progress reviews will be completed in FY 2008. Planning for the next decade's 10-year health objectives began in FY 2006 and will continue in FY 2007 and FY 2008.

ODPHP lead the HHS oversight of scientific revisions to the *Dietary Guidelines for Americans*. The *Dietary Guidelines for Americans* form the cornerstone of Federal nutrition policy and are the basis of Federal food, nutrition, and health programs, including *HealthierUS*. Collectively, they describe a dietary pattern that promotes health and helps prevent chronic disease, including an emphasis on physical activity. Every five years HHS and the US Department of Agriculture convene an Advisory Committee to review the scientific underpinnings of the guidelines. In 2006, ODPHP implemented a communications plan to disseminate the *Dietary Guidelines for Americans* released in January 2005. A 340 page consumer book, *A Healthier You*, based on the Dietary Guidelines for Americans, was released in October 2005. *A Healthier You* provides guidance on how to start changing habits, underscores the importance of finding balance between calories in and calories out, and explains why eating too much fat, added sugars and salt can undermine efforts to achieve a healthier weight. The book has numerous recipes, charts, work sheets and lists to help readers put their new habits into action. Working with the Government Printing Office, ODPHP has made this book available for sale in Barnes and Noble bookstores and on commercial websites, such as Amazon.com. Efforts to assist Americans in using the dietary guidelines will continue in 2008.

ODPHP has developed opportunities for professional growth and development in both prevention policy and medical education through the Luther Terry Fellowship as well as education and training of Preventive Medicine Residents, medical students, emerging leaders, and public health interns as part of the Visiting Scholar Program.

ODPHP advances prevention science by undertaking select analytic projects, such as the dietary reference intakes studies and the application of systems thinking methodologies, including systems dynamics theory. A workshop, Systems Thinking and Modeling for Public Health, which brought together experts for a discussion of promising approaches, was held on May 8, 2006, at the National Institutes of Health. The workshop was informed by a White Paper Report. These projects will be useful in advancing the understanding of the interactions of various factors, analyzing downstream outcomes, informing investments, and directing the discovery of new knowledge.

ODPHP contributes to the Department-wide goal, Transform the Healthcare System. A key component of ODPHP's mission is to provide leadership and innovative research in online consumer health information. ODPHP manages the National Health Information Center which, in addition to traditional information and referral services, supports Web sites for *HealthierUS, Healthy People 2010*, and healthfinder®, the Federal government's award-winning health information portal. In FY 2006, ODPHP pursued innovative research and targeted pilot projects to strengthen eHealth tools for prevention and consumer self-health management for wellness and chronic disease.

Rationale for the Budget Request

The FY 2008 Budget for the Office of Disease Prevention and Health Promotion is $7,499,000, an increase of $97,000 above the FY 2007 CR level. The increase provides funds to partially

support mandatory pay increases. This level will allow ODPHP to continue support for it key activities described above -- *Healthy People 2010* and *HealthierUS* ; the National Health Information Center and associated communications efforts; and the preventive medicine resident rotations and prevention science activities.

Performance Analysis

| **Long Term Goal:** Communicate strategically by increasing the reach of ODPHP disease prevention and health promotion information and communications | | | |
|---|---|---|---|
| **Annual Measure** | **FY** | **Target** | **Result** |
| Visits to ODPHP-supported websites *(output)* | *2008* | 13,648,909 | Dec-08 |
| | *2007* | 12,755,990 | Dec-07 |
| | *2006* | 11,921,486 | 16,173,733 |
| | *2005* | 11,141,579 | 14,156,238 |
| Consumer Satisfaction with healthfinder.gov (*output*), measured every three years at a minimum | *2010* | 80% | Dec-10 |
| | *2006* | 75% | 75% |
| | *2003* | baseline | 72% |
| Awareness of Dietary Guidelines for Americans (*outcome*) will be measured at least two times between 2005 and 2010 | *2008* | 41% | Dec-08 |
| | *2007* | 39% | Dec-07 |
| | *2006* | 37% | 48% |
| | *2005* | baseline | 42% |
| **Data Source:** National Health Information Center Service Level Reports; American Customer Satisfaction Index's Forsee Results Survey; Special DGA supplement to the FDA Health and Diet Survey | | | |
| **Data Validation:** Program office project officer oversight | | | |
| **Cross Reference:** Healthy People 2010; OPHS GPRA Plan - Strengthen Prevention/ Communicate Strategically; HHS 20 Department-wide Objectives (# 1- Transform the Healthcare System) | | | |

| **Long Term Goal**: Shape prevention policy at the local, State and national level by establishing and monitoring National disease prevention and health promotion objectives | | | |
|---|---|---|---|
| **Long Term Measure** | **FY** | **Target** | **Result** |
| Increase the percentage of Healthy People 2010 objectives that have met the target or are moving in the right direction (New measure, February 2007) | 2010<br>2005 | 60% | <br>42.2% |
| **Annual Measure** | **FY** | **Target** | **Result** |
| Percentage of States that use the national disease prevention and health promotion objectives in their health planning process (*outcome*) | *2008* | 100% | Dec-08 |
| | *2007* | 98% | Dec-07 |
| | *2006* | 94% | 96% |

| | | | |
|---|---|---|---|
| | *2005* | 92% | 96% |
| | *2004* | 90% | 65% |
| | *2003* | | not measured |
| 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*) | *2008* | 75% | Dec-08 |
| | *2007* | 50% | Dec-07 |
| | *2006* | 25% | 100% |
| | *2005* | baseline | 0 |
| **Data Source:** For long-term goal, data source is Healthy People Data 2010, National Center for Health Statistics, For the two annual goals: Assessment of the Uses of HealthierUS and Healthy People 2010 Survey; OPHS Administrative Records | | | |
| **Data Validation:** annual survey of State HP 2010 coordinators beginning in 2006 | | | |
| **Cross Reference:** Healthy People 2010; OPHS GPRA Plan - Strengthen Prevention, Shape policy at the local, State and national level; 20 Department-wide objectives (#19-Emphasize Healthy Living and Prevention of Disease, Illness, and Disability | | | |

Performance Narrative

In 2005, ODPHP was reviewed through the Performance Assessment Rating Tool (PART) and was rated as "Results Not Demonstrated." While ODPHP's overall management was found to be solid, the assessment identified a lack of long-term outcome measures. It was also determined that ODPHP's internal management plan and practices needed to be updated, to reflect new initiatives and activities. In FY 2006, ODPHP made significant progress on its improvement plan. A long term outcome measure relating to the number of healthy people objectives that have been met or are moving in the right direction was established. The objectives were established in 2000 and the Midcourse Review results (www.heathypeople.gov) served as the first measure of progress on all of the objectives. In addition, a strategic planning retreat was held on May 18, 2006 to begin the process of updating the ODPHP management plan and to transform it into more of a strategic planning document incorporating performance measures. Additional information on the ODPHP PART can be found on ExpectMore.gov.

One of ODPHP's core activities is the maintenance of a National Health Information Center. Healthfinder.gov and several other websites maintained by ODPHP are key to this activity. In FY 2006, ODPHP exceeded the target set for visits to ODPHP-supported websites. A survey to measure consumer satisfaction with healthfinder.gov was also fielded and results indicate 75 percent of those who use healthfinder.gov are satisfied with the health information they find on the site. An additional survey to measure awareness of the Dietary Guidelines for Americans was released in FY 2006 showing that 48 percent of Americans are aware of the DGAs, exceeding the target. The Department and USDA have mounted significant communication activities to achieve this level of awareness.

Another annual measure is States that use the national disease prevention and health promotion objectives in their health planning process by 2010. This activity was stimulated in FY 2006 by an annual meeting with the Healthy People 2010 State coordinators followed by regional calls. Tracking the 467 disease prevention and health promotion objectives for the Nation and monitoring progress toward meeting the established targets is ODPHP's second core activity.

Beginning in June 2006, ODPHP initiated a second round of monthly progress reviews on the 28 focus areas to review the most current data and to look for opportunities and challenges.

# OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION
## Program Data

| Activity | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| PREVENTION FRAMEWORK | | | |
| *Healthy People 2010*, *HealthierUS, Steps* outreach and coordination | $910,000 | $910,000 | $915,000 |
| Other (personnel, overhead, expenses) | 1,967,109 | 2,006,051 | 2,046,602 |
| *Subtotal* | *2,877,109* | *2,916,051* | *2,961,602* |
| PREVENTION COMMUNICATION | | | |
| National Health Information Center | 1,758,200 | 1,758,200 | 1,810,960 |
| Communication Support | 774,800 | 774,800 | 774,800 |
| Other (personnel, etc.) | 825,359 | 841,698 | 870,246 |
| *Subtotal* | *3,358,359* | *3,374,698* | *3,456,006* |
| PREVENTION SCHOLARSHIP AND SCIENCE | | | |
| Prevention Education | 250,000 | 250,000 | 250,000 |
| Communications plan for *Dietary Guidelines for Americans* | | | |
| Other (personnel, etc.) | 844,532 | 861,251 | 831,392 |
| *Subtotal* | *1,094,532* | *1,111,251* | *1,081,392* |
| TOTAL | $7,330,000 | $7,402,000 | $7,499,000 |

1/ *Dietary Guidelines* work will be completed using evaluation set-aside funds.

# PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $1,228,000 | $1,240,000 | $1,270,000 | +$30,000 |
| FTE | 8 | 8 | 8 | -- |

Statement of the Budget Request

The FY 2008 Budget for the President's Council on Physical Fitness and Sports (PCPFS) is $1,270,000, an increase of $30,000 above the FY 2007 CR level.

Program Description

Physical activity and fitness have made great strides in the last several decades. However, there is still evidence that, despite the increased awareness and knowledge of the benefits of a fit and active lifestyle, the US continues to be a basically sedentary population. With enhanced national and State-level partnerships and collaborations, PCPFS plans to develop and implement creative, grassroots/ community initiatives and collaborations to advance both the Departmental and administrative goals and policy recommendations for improving the health, physical activity/ fitness of all Americans, able and disabled.

Develop and implement grassroots partnerships and collaborations to enhance age-appropriate and culturally sensitive programs and materials. PCPFS develops and implements a wide range of physical activity/fitness and health programs and information/education materials to not only inform the public about the benefits of an active lifestyle but also to provide motivational, easy-to-use, tools and resources. With the growing diversity of the American public and its changing demographics, this increase would target those most vulnerable in their venues and language.

PCPFS plans to accomplishment the following objectives in FY 2008:

- Support/promote the Secretary's Prevention Priority and enhance collaboration with other OPHS and/or Departmental components to ensure effective and efficient incorporation of physical activity/fitness strategies.

- Collaborate and coordinate activities inter-Departmentally to develop and implement preventive measures to ensure progress on the First Lady's Helping America's Youth initiative targeting inner city male youth. A previous Surgeon General's Report documented that the introduction of physical activity early in life is important in helping children to develop better social skills with which to manage conflict and anger.

- PCPFS plans to implement the second term action plan by encouraging governors and corporations to incorporate the President's Challenge program, expand the President's Challenge awards program into more schools and educational venues, and work closely with OPM on creating a healthier, more active Federal work force (HealthierFeds).

- In order to avoid duplication of effort and additional confusion among the practitioners in the field, PCPFS plans to evaluate findings on regional hearings on the efficacy, reliability, and validity of its original physical fitness and health fitness awards battery. PCPFS has been approached to consider replacing the original batteries with another popular program and has had an opportunity to hear the developers' and organizational comments. Since the President's Challenge is so popular throughout the nation, PCPFS needs to hear comments and opinions on this issue from actual users.

One of PCPFS' greatest assets is the presidentially appointed Council, whose mandate is to meet at least once a year to generate creative ideas and initiatives to promote and enhance the development and maintenance of physical activity/fitness and sports programs. Council meetings are the best venue to generate ideas and initiatives by this highly knowledgeable and prestigious group of volunteers, leaders in physical activity, sports, medicine, education, business, and organizations. The Council is the main advocacy and educational tool of PCPFS, and enhanced teamwork among the members will increase productivity. A greater number of public speaking appearances by the Council members, the Executive Director and senior staff, as well as representation and participation at major physical activity conferences, which are important national information-exchange venues, will assist PCPFS to increase its effectiveness in promoting and advocating physical activity and raising awareness to diverse audiences on the administration's and Department's initiatives highlighted above.

PCPFS seeks to enhance its grassroots outreach through enhanced collaborations with public and private entities, to further the goals of the Administration and the Department in the areas of physical activity and fitness, and to ensure effective implementation of existing initiatives and programs.

Rationale for the Budget Request

The FY 2008 Budget for PCPFS is $1,270,000, an increase of $30,000 above the FY 2007 CR level. This increase provides increases for mandatory pay increases to allow the Council to maintain the same level of activity as in FY 2007. Funds for this activity only provide salaries and benefits, rent, travel and other overhead costs for the Council.

Performance Analysis

| Performance Goal | Results | Context |
|---|---|---|
| Synthesize practitioners' comments from FY 2006/2007 regional hearings on efficacy and applicability of President's Challenge Physical Fitness Test for purpose of improving, updating and modifying based on science. | Synthesis of regional hearing comments for the purpose of improving, updating, and modifying test based on science. | The President's Council Physical Fitness Test is regularly modified and updated based on scientific recommendations. Practitioners comments and experience will also be considered for next round of changes and modifications. Test standards are currently based on 1985 school population fitness survey and validated in 1998, by means of comparison with large nationwide sample collected in 1994. |

| | | |
|---|---|---|
| Build on presidential recognition award for adults. | Expand test/award based on science-based physical activity recommendations for adults/baby boomers to encourage healthy movement | The President's Challenge program currently offers presidential recognition for ages six and older. A new test for adults will be added to the programs currently offered to adults and seniors. Baby boomers who took the fitness test as children want to test themselves as adults. The test being devised in 2006/2007 will be evaluated and expanded as needed per counsel by the PCPFS science board. |

# OFFICE OF MINORITY HEALTH

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $56,388,000 | $53,993,000 | $43,775,000 | -$10,218,000 |
| FTE | 66 | 66 | 67 | +1 |

## Statement of the Budget Request

The FY 2008 Budget for the Office of Minority Health (OMH) is $43,775,000, a net decrease of $10,218,000 below the FY 2007 CR level. The FY 2007 level assumes a one-time health disparities earmark of $7,400,000.

## Program Description

OMH was 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 is the Federal focal point for addressing the health status and quality of life for racial and ethnic minority populations in the US It provides national leadership to improve minority health by developing and implementing new policies; partnering with States, tribes, and communities; developing and implementing data policy; and, disseminating information. OMH coordinates and monitors activities and existing policies across the Department that relate to disease prevention, health promotion, service delivery, and research with respect to racial and ethnic minority populations.

The focus of OMH's work is to reduce and ultimately eliminate disparities in health for African Americans, Hispanic Americans, Asian Americans, Native Hawaiians and other Pacific Islanders, and American Indians and Alaska Natives. The 2006 *National Healthcare Disparities Report* (NHDR) found that significant disparities between whites and racial and ethnic minorities continue, with some signs of improvements. For most core quality measures, Blacks (73 percent), Hispanics (77 percent), and poor people (71 percent) received worse quality care than their reference groups. For most measures for minorities, significant changes in disparities were not observed. Increasing disparities were especially prevalent in chronic disease management. Compared to their reference groups:

- Blacks had 90 percent more lower extremity amputations for diabetes.
- Asians were restrained in nursing homes 46 percent more often.
- American Indians and Alaska Natives were hospitalized from home healthcare 15 percent more often.
- Hispanics had 63 percent more pediatric asthma hospitalizations.
- Poor people were 37 percent less likely to receive recommended diabetes care.

For most core access measures in the report, Hispanics (83 percent) and poor people (100 percent) had worse access to care than their reference groups. Disparities were *increasing* for most measures for Hispanics (80 percent).

Many of these disparities are preventable and avoidable, and OMH is working to eliminate these and other health disparities by building local capacity for addressing health and human service issues, improving access to quality health and human services for all individuals, improving public awareness of health disparities, and promoting healthy behaviors. OMH's efforts are supported through partnerships; grants, cooperative agreements, and contracts with states, tribes and tribal organizations, community-based organizations, and national health organizations; and information/technical assistance from the OMH Resource Center (OMHRC).

Inequalities Eliminated

Eliminating health disparities and inequalities in health outcomes is a complex endeavor. Strategic actions must take into account that:

- Racial and ethnic minority populations are not homogeneous and there is no "one size fits all" solution to the problems impacting them.
- Racial and ethnic minority populations are effected disproportionately by multiple priority diseases/health conditions (i.e., heart disease and stroke, cancer, diabetes, HIV/AIDS, infant mortality, and vaccine preventable diseases).
- Not all causes and contributing factors to health disparities are well understood. Health status is influenced by the interaction of physiological, behavioral, psychological, cultural, and societal factors that are poorly understood for the general population and even less so for racial and ethnic minorities.

The response to addressing the complexities of health disparities is equally complex and requires multiple partners to achieve reductions in health care inequalities. In this regard, OMH supports demonstration projects that assist State and local governments, tribes/tribal organizations, faith- and community-based organizations, health care organizations, national minority serving institutions, among others to improve access to quality health services for racial and ethnic minorities, including individuals who are limited-English-proficient (LEP).

State, Tribal, and Community Partnerships

The *OMH State Partnership Program*, is designed to assist states strengthen their existing infrastructure, develop or adopt statewide collaborative plans for eliminating health disparities, ensure use of best practices in providing services for all populations, and implementing innovative programs that reduce disparities in health. In FY 2005, 32 states received the first year of funding under the *OMH State Partnership Program*. In FY 2006, nine additional states and two tribal entities received support for disparities elimination planning activities. It is anticipated that approximately 40 states and five tribal area health boards working in collaboration with tribal epidemiology centers will receive funding in FY 2007. This FY 2008 budget request includes funding to support continuation of the *OMH State Partnership* and the *American Indian and Alaska Native Health Disparities Programs*.

The FY 2008 funding request includes support for community projects under the *Bilingual/Bicultural Service Demonstration Program* to improve the ability of health care providers and other health care professionals to deliver linguistically and culturally competent health services to LEP minority populations and improve accessibility/utilization of health care services among LEP individuals. In addition, the FY 2008 request includes support for the

*Community Programs to Improve Minority Health Grant Program* to address health promotion and disease risk reduction in minority communities. Both programs will be shaped by outcomes of robust interventions carried out by prior OMH grantees.

In FY 2006, OMH announced funding for the Youth Empowerment Program (YEP) to address unhealthy behaviors in at-risk minority youth, and provide them opportunities to learn more positive lifestyles and enhance their capacity to make healthier life choices. Approximately 23 institutions of higher education received support and provide activities in the areas of academic enrichment, personal development and wellness, cultural enrichment, and career development intended to reduce high risk behaviors, strengthen protective/resiliency factors, and develop skills and behaviors that lead to healthier lifestyle choices. This FY 2008 budget request includes funding to continue support for this Program.

OMH has also undertaken an effort aimed at assisting tribes in improving coordination of health promotion programs that will impact upon disparities. An example of this effort is the new FY 2006 initiative aimed at reducing methamphetamine use among American Indian/Alaska Natives. With support from HHS, four tribes and two national American Indian/Alaska Native-serving organizations will develop a national information and outreach campaign and a culturally specific methamphetamine abuse education kit, document and evaluate promising practices in education on meth use, and create meth awareness multi-disciplinary education teams.

OMH also supports HIV/AIDS programs, some of which are funded by the Minority HIV/AIDS Initiative. These programs include the *Technical Assistance/Capacity Development (TA/CD) Demonstration Program for HIV/AIDS-Related Services in Highly Impacted Minority Communities.* The TA/CD Program assists minority-serving community-based organizations, in communities where there are needs or gaps in providing HIV/AIDS-related prevention and care services, develop financial and programmatic capacity to compete for funds and effectively manage needed services. The FY 2008 budget request includes funding for the Minority Community Health Partnership Program aimed at increasing awareness and access to HIV/AIDS counseling, testing, and care.

Minority Health Data

OMH continues to actively promote the collection of health data and the strengthening of data infrastructures in order to enable the identification and monitoring of health status among US racial and ethnic minorities. In FY 2006, OMH launched a new minority health data portal that was developed through Department-wide effort. The purpose of the HHS Minority Health Data Portal is to create a comprehensive web-based minority health research and data resource; to identify data gaps and opportunities for linkages; feature Federal, other governmental and private sector minority health research and data sources; and, promote sharing and wide dissemination of minority health research and data sources. The target audience for the minority health data portal are researchers, policy staff, communities, students, media and HHS staff

Health Disparities Leadership

Health disparities leadership is intended to develop and implement a systems approach to coordinating activities at the community, state, regional, and national levels.

In January 2006, OMH in concert with partner organizations sponsored the 2006 National

Leadership Summit on Eliminating Racial and Ethnic Disparities in Health. At the Summit, more than 2,000 leaders from across the country shared best practices, presented programs in diverse settings, and discussed ways to address health disparities. The Summit revealed the importance of empowering communities and key stakeholders within them to make change; coordinating regional activities; improving the effectiveness of health disparities messages; leveraging existing partnerships; and developing new, broad-based partnerships to expand the health disparities dialogue and support a wide range of actions.

In 2007, the Office of Minority Health, on behalf of the Department of Health and Human Services, will announce a new initiative, the five main objectives are:

- To increase awareness of health disparities
- To strengthen leadership at all levels for addressing health disparities
- To improve patient-provider interaction
- To improve cultural and linguistic competency
- To improve coordination and utilization of research and outcome evaluations

To mobilize support for the NAA, OMH will work closely with national leaders and public and private sector partners to convene a series of community, state, regional, and Tribal events nationwide.

Better Informed Consumers

A primary objective for OMH is to increase awareness and understanding of the major health problems of racial and ethnic minorities in the US through a wide range of informational and educational efforts aimed at individuals and their families, communities, health care decision-makers, and health professionals. OMH is accomplishing this through a number of campaigns, efforts of the Office of Minority Health Resource Center, OMH funded projects, and its partnerships with a number of national organizations.

Communications

The OMH website is an important vehicle for providing information to individuals and health care providers. To facilitate its use and provide improved consumer and professional resources, OMH launched a new website in January 2006. This new website features population-specific health information, links unique visitors to on the ground resources and up-to-date comprehensive data and statistics on health issues impacting racial and ethnic minorities. In FY 2005, OMH had 341,000 unique visitors to its website.

OMH continues to meet its objectives for increasing available information and knowledge about health disparities and effective interventions to address them. In FY 2005, OMH published two peer-reviewed documents and plans to publish two additional articles in FY 2006.

Community-Based Approaches

OMH continues to increase the reach and impact of its efforts to reduce disparities by developing partnerships with key organizations and building capacity at local levels. OMH also supports a number of community-based projects through its cooperative agreement programs including:

- *The Mid-Atlantic Asian American and Pacific Islander (AAPI) Hepatitis B Campaign and Vaccination Program (MAHP)*: Hepatitis B (HBV) can cause lifelong infection, inflamation of the liver, cirrhosis (scarring) of the liver, liver failure, liver cancers, and ultimately premature death. Although the number of new infections have declined, approximately 1.25 million have chronic HBV infection. The good news is that hepatitis B is preventable by three immunizations given over six months. Fully 80 percent of liver cancer among Asian Americans and Native Hawaiians and other Pacific Islanders is caused by HBV and these populations are up to 13 times more likely to die from liver cancer than Whites. In response to these disparities, OMH expanded its *Mid-Atlantic Asian American and Pacific Islander (AAPI) Hepatitis B Campaign and Vaccination Program* (MAHP) to ensure greater national reach. This program is an application of a "promising practices" model as it builds on the success of a similar program implemented in the Boston area..

- *Get With The Guidelines*: The treatment gap in cardiovascular disease is well documented. Nowhere is the gap more evident than in the treatment of African American and Hispanic men and women. Minority populations are at a greater risk for cardiovascular diseases and stroke than their white counterparts. In FY 2006, OMH initiated a pilot project to evaluate the impact of the American Heart Associations' *Get With The Guidelines* (GWTG) within hospitals that reach underserved populations. These hospitals often face challenges that might be barriers to utilization. GWTG will effectively close racial and ethnic group guideline treatment gaps that persist. The pilot program includes an assessment of a hospital's current acute treatment and discharge protocols. This assessment will provide a baseline against which a hospital can compare their future results and measure their success from using the GWTG. By using the GWTG tools, they can achieve continuous quality improvements in treatment and discharge procedures.

- *Disparities in Lupus:* An estimated 1.5 million people in the US have lupus, approximately 90 percent of them women. Lupus is a leading cause of kidney disease, stroke and cardiovascular disease among young women. Hispanics and African Americans have a higher incidence of lupus, tend to develop lupus at a younger age, experience more serious complications, and have higher mortality rates. In FY 2006, OMH initiated a project to support the replication of a successful grass-roots model in Brooklyn, New York. The neighborhood organizations involved in the project include health providers, social services agencies, and educational organizations which will be made aware of Lupus especially as it impacts on minority women ages 15-44 through community-based outreach, and facilitating access to testing and treatment services.

Research Results Benefit People

OMH continues to work toward completing a number of evaluation studies in order to disseminate findings. As part of its efforts to assess the impact of OMH-funded projects and activities, OMH developed a uniform information/data set (UDS). This project was selected as one of eight excellent evaluation projects that were highlighted in the HHS Report to Congress on evaluation. In addition, an article on the UDS project was published in the journal, *Evaluation and Program Planning*. The UDS was fully implemented in FY 2005 and OMH has trained all of its grantees on its use.

Workforce Pipeline Programs

OMH continues to focus efforts on strengthening the nation's capacity to prepare health professionals to serve minority populations and to address the elimination of racial/ethnic health disparities. In FY 2006, a cooperative agreement was awarded to the Morehouse School of Medicine to improve the health status of minorities and disadvantaged people and increase the diversity of the health-related workforce by: (1) increasing interest of minority youth in pursuing careers in the health arena; (2) increasing the number of individuals from minority populations recruited and trained for careers in health fields; (3) increasing the level of cultural competence of health care providers serving targeted minority populations; (4) and increasing access and utilization of health care services by targeted minority populations.

Center for Emergency Preparedness

Recent events demonstrate that planning for the mobilization of diverse communities including, racial and ethnic minorities, is a critical component of effective emergency preparedness efforts. To facilitate the participation of racial and ethnic communities in these efforts, OMH began working in FY 2006 to develop strategies that optimize the way minority populations are included in national emergency preparedness and response activities.

Through established relationships with national minority-serving organizations, State Departments of Health, Institutions of Higher Education in the Gulf Coast and community-based organizations, OMH was able to contribute to the HHS Katrina response and support activities that could more rapidly connect minority communities with available services. Since those events, organizations representing minority communities have continued to reach out to OMH to assist in filling emergency preparedness gaps for their communities.

The Center for Public Health and Emergency Preparedness in Disadvantaged Communities is a "center without walls" and serves as a resource to the Assistant Secretary for Health, the Assistant Secretary for Preparedness and Response, HHS Divisions, and other federal agencies with lead responsibilities for emergency response. The intent of creating the Center is to ensure access to critical information, facilitate rapid connections and communications between federal leaders and key leaders in minority communities, and develop strategies prior to and post a public health or emergency event. Key activities that were funded in FY 2006 include: (1) a Consensus Panel on Diversity and Preparedness; (2) a tool kit to improve responsiveness of emergency managers and relief agencies to Latino disaster victims; (3) cultural competence training tailored for emergency responders; and (4) a community and health care-based comprehensive medical home initiative in northwest Louisiana.

Center for Linguistic and Cultural Competence in Health Care

The mission of the Center for Linguistic and Cultural Competence in Health Care (CLCCHC) is to enhance the ability of the healthcare system to effectively deliver culturally and linguistically appropriate healthcare services to ethnically and racially diverse populations in collaboration with federal agencies and other public and private entities. The vision of the CLCCHC is to remove health care service barriers and increase access to health care to culturally and linguistically diverse populations. It is the intent of the CLCCHC to serve as a catalyst for promoting collaboration and partnerships at different tiers of the healthcare delivery system, i.e., policy makers; local and federal government; health care providers; public and private organizations; academia; and, the general community, to achieve this goal.

The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) Setting the Agenda for Research on Cultural Competence in Health Care, and the IOM *Unequal Treatment Report* recommendations instruct and guide much of the work of the CLCCHC. The achievement and support of the CLCCHC's mission and vision is provided through the following overarching goals. The CLCCHC will:

- Facilitate access and exchange of information on literature, research and programs for removing cultural and language barriers to healthcare services for racially and ethnically diverse populations through a variety of dissemination strategies;
- Develop demonstration projects on removing cultural and language barriers to providers of healthcare for racially and ethnically diverse populations;
- Conduct evaluations on the demonstration projects undertaken and determine their feasibility for replication and transferring of this knowledge to targeted audiences;
- Promote research and other initiatives through collaboration with federal agencies, public health agencies, institutions of higher education and community-based organizations on removing cultural and language barriers for providers of health care for racially and ethnically diverse populations; and
- Provide technical assistance to providers of health care on removing cultural and language barriers to healthcare services to racially and ethnically diverse populations.

Collaboration is Customary

Partnerships and collaborations are essential components of OMH's plan for improving the health status and outcomes of racial and ethnic minorities. As the HHS focal point for eliminating health disparities, OMH has initiated and/or led a number of efforts and collaborative activities.

In FY 2006 OMH hosted a series of Roundtable discussions with Departmental partners, experts in research, and minority-serving organizations. These Roundtables were intended to raise awareness of specific health disparity issues, build partnerships that are critical to reducing disparities, and generate thoughts on actions that the public and private sector can take to better address health disparities. An example is a roundtable that focused on increasing minority participation and activity in research and clinical trials. The inadequate representation of racial and ethnic minorities hinders researchers' ability to properly access new procedures and drug treatments across different segments of the population and may lead to the generalization of results from clinical trials. A Roundtable on advancing the field of Public Health Services Research is planned for FY 2007. The outcomes of OMH Roundtables are being used to strengthen disparities-related activities that are being carried out by states, tribes, and national and community-based organizations.

OMH has also been asked to lead the Tribal Health Research Advisory Group. This group was created in response to recommendations by tribal leaders for coordination of research effecting American Indian and Alaska Native people. Members include tribal leaders and representatives from the Office of the Assistant Secretary for Planning and Evaluation, Office of Intergovernmental Affairs, Agency for Healthcare Research and Quality, Indian Health Service, and National Institutes of Health. Meetings of this group were initiated in FY 2006.

## Rationale for the Budget Request

The FY 2008 Budget is $43,775,000, a net decrease of $10,218,000 below the FY 2007 CR level. Funds will support mandatory salary increases, and projects supported through grants and cooperative agreements programs will be reduced by total of $3,000,000. See program data chart for display of activities to be supported by OMH.

## Performance Analysis

| **Long Term Goal:** Increase the 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. | | | |
|---|---|---|---|
| **Outcomes** | **FY** | **Target** | **Result** |
| **Objective** - Increase action across the country to improve racial/ethnic minority health for health conditions in which progress is not being made<br><br>**Outcome** - Increase the 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. | *2010* | 68.6 % (629/917) | Dec 2010 |
| | *2005* | Baseline | 62.4% (572/917) |
| **Data Source:** National Center for Health Statistics | | | |
| **Data Validation:** *Healthy People 2010* Steering Committee and Focus Area Work Group oversight | | | |
| **Cross Reference:** *Healthy People 2010*; HHS Strategic Goals; OPHS GPRA Plan; Secretary's 500-Day Plan. | | | |

| **Annual Measure:** Increase awareness of racial/ethnic health status and health care disparities in the general population. | | | |
|---|---|---|---|
| **Outcomes** | **FY** | **Target** | **Result** |
| **Objective** - Increase organizational, institutional, and systems support for addressing racial/ethnic disparities in health care and health status<br><br>**Outcome** - Increase knowledge and understanding of the nature and extent of racial and ethnic health disparities in the general population | *2010* | 52.9% | Dec 2010 |
| | *2009* | 51.9% | Dec 2009 |
| | *2008* | 50.8% | Dec 2008 |
| | *2007* | 49.8% | Dec 2007 |
| | *1999* | Baseline | 47.5% |
| **Data Source:** Kaiser Family Foundation and Princeton Survey Research Associates | | | |
| **Data Validation:** | | | |
| **Cross Reference:** | | | |

| **Efficiency Measure:** Increase the average number of persons participating in OMH funded efforts per $1 million in OMH grant support. | | | |
|---|---|---|---|
| **Outcomes** | **FY** | **Target** | **Result** |

| Measure | FY | Target | Result |
|---|---|---|---|
| **Objective** - Increase the reach and influence of OMH grant-supported efforts through more efficient use of resource dollars<br>**Outcome** - Increase the average number of participants in OMH funded efforts per standard level ($1 million) of funding support | *2010* | 21339 | Dec 2010 |
| | *2009* | 20717 | Dec 2009 |
| | *2008* | 20114 | Dec 2008 |
| | *2007* | 19529 | Dec 2007 |
| | *2006* | Baseline | 18,960 |
| **Data Source:** OMH/OPHS Uniform Data Set | | | |
| **Data Validation:** | | | |
| **Cross Reference:** | | | |

Performance Narrative:

In 2005, OMH was reviewed through the Performance Assessment Rating Tool (PART) and was rated as "Results Not Demonstrated." In FY 2006, OMH developed long-term and annual performance measures with baselines, ambitious targets, and time frames that meaningfully reflect the program's purpose and demonstrate progress. OMH is currently incorporating long-term and annual performance measures into agreements with grantees, contractors, and other partners to ensure commitment and contributions to program outcome and efficiency goals. In addition to the PART re-assessment requirements, OMH has developed a plan for a systems approach to addressing minority health and health disparities that ensures coordination and non-duplication of similar efforts in the public and private sectors.

# OFFICE OF MINORITY HEALTH
## Program Data

| Activity | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Change |
|---|---|---|---|---|
| CONTRACTS: | | | | |
| OMH Resource Center | $2,770,000 | $3,000,000 | $3,000,000 | $0 |
| Logistical Support Contract | 900,000 | 1,100,000 | 1,000,000 | (100,000) |
| Center for Linguistic and Cultural Competency in Health Care | 1,900,000 | 1,600,000 | 1,500,000 | (100,000) |
| Center for Emergency Preparedness in Health Disparity Communities | 0 | 0 | 100,000 | 100,000 |
| Health Disparities Campaign | 1,200,000 | 0 | 0 | 0 |
| Stroke Belt Initiative | 0 | 250,000 | 0 | (250,000) |
| Other Contracts & IAAs | 1,280,000 | 3,029,000 | 3,029,000 | 0 |
| Subtotal, Contracts | 8,050,000 | 8,979,000 | 8,629,000 | (350,000) |
| COOPERATIVE AGREEMENTS: | | | | |
| Youth Empowerment Program | 7,400,000 | 5,971,000 | 5,946,000 | (25,000) |
| Meharry Medical Center | 500,000 | 0 | 0 | 0 |
| Charles R. Drew University | 0 | 0 | 0 | 0 |
| Morehouse School of Medicine | 0 | 0 | 0 | 0 |
| Morehouse Male Health Project | 1,000,000 | 500,000 | 0 | (500,000) |
| HIV/AIDS Coop Agreements | 2,800,000 | 2,300,000 | 2,000,000 | (300,000) |
| Other Cooperative Agreements | 1,500,000 | 2,300,000 | 1,975,000 | (325,000) |
| Subtotal, Coop Agreements | 13,200,000 | 11,071,000 | 9,921,000 | (1,150,000) |
| DEMONSTRATION PROJECTS: | | | | |
| Bilingual/Bicultural Demonstrations | 2,950,000 | 2,300,000 | 2,000,000 | (300,000) |
| Health Disparities Program: State Partnership Grants | 5,000,000 | 5,900,000 | 5,500,000 | (400,000) |
| American Indian/Alaska Natives | 0 | 1,000,000 | 700,000 | (300,000) |
| Community Programs to Improve Minority Health | 6,484,000 | 6,300,000 | 6,000,000 | (300,000) |
| Technical Demonstration Program for HIV/AIDS | 200,000 | 200,000 | 0 | (200,000) |
| *(CBC AIDS – Non-add)* | *0* | *0* | *0* | *0* |
| Subtotal, Demonstration Projects | 14,634,000 | 15,700,000 | 14,200,000 | (1,500,000) |
| Health Disparities Activities in MS Delta region | 9,900,000 | 7,400,000 | 0 | (7,400,000) |
| Operating Expenses | 10,604,000 | 10,843,000 | 11,025,000 | 182,000 |
| **TOTAL, Budget Authority** | **$56,388,000** | **$53,993,000** | **$43,775,000** | **($10,218,000)** |
| Non-HIV/AIDS | 46,683,647 | 44,288,647 | 34,957,578 | (9,331,069) |
| HIV/AIDS | 9,704,353 | 9,704,353 | 8,817,422 | (886,931) |
| *(CBC AIDS – non-add)* | *0* | *0* | *0* | *0* |

# OFFICE ON WOMEN'S HEALTH

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $28,205,000 | $28,283,000 | $27,369,000 | -$914,000 |
| FTE | 47 | 47 | 48 | +1 |

## Statement of the Budget Request

The FY 2008 Budget for the Office on Women's Health (OWH) is $27,369,000, a decrease of $914,000 below the FY 2007 CR level.

## Program Description

The Office on Women's Health (OWH) was established in 1991 to improve the health of American women by advancing and coordinating a comprehensive women's health agenda throughout HHS. This structure is consistent with the overarching central direction of the Department's Strategic Plan to function as a single entity - "One HHS." The program fulfills its mission through competitive contracts and grants to develop and implement health programs and policies at both the national and community level, and through national educational campaigns, which provide information about the important steps women can take to improve and maintain their health. OWH facilitates a unified concept of women's health for HHS and provides leadership with one voice, while developing partnership opportunities across agencies and with the private sector. This approach maximizes efficiency and minimizes costs.

**Advance Superior Health Outcomes for Women**

During FY 2006, the National Women's Health Indicators Database – a dynamic database of health statistics – was renamed Quick Health Data Online. This free resource can be accessed at www.womenshealth.gov/quickhealthdata and includes comprehensive data, for both women and men, from 1998-2004 on a variety of health topics. National, regional, state and county date are available and the data can be stratified by gender, race/ethnicity, and age concurrently. The database includes statistics on demographics; mortality; access to care; infectious and chronic disease; reproductive health; maternal health; mental health; prevention; and violence and abuse. User sessions average 5000 per month. OWH is committed to maintaining and expanding this data warehouse in FY 2007 and FY 2008.

Three OWH HIV/AIDS model programs will complete evaluations in 2007 - HIV Prevention in the Rural South, HIV Prevention for Incarcerated/Newly Released Women, and the Model Mentorship Program. In FY 2006, OWH expanded evaluation efforts to include prevention targeting young women attending minority academic institutions (HBCUs, HSIs and TCUs).

For the fourth year, OWH partnered with the National Institutes of Health's National Heart, Lung, and Blood Institute (NHLBI) to sponsor a national awareness campaign called *The Heart Truth* campaign. This campaign educates women in the US about heart disease and provides

tools to help them take action against risk factors. Over 6,000 primary care providers (physicians, cardiologists, OB/GYNs, nurses, nurse practitioners, nurse midwives, residents, fellows, and medical and nursing students) have attended continuing education presentations or trainings using these materials over the last two years. The providers come from urban and rural, academic and community health and hospital settings. Preliminary results show statistically significant knowledge gains were made by those attending the lectures as measured by pretest/posttest.

For the seventh year, OWH will partner with the *Sister to Sister Everyone Has a Heart Foundation* to sponsor their annual Women's Heart Day Campaign in February 2007. In February 2006, over 20,000 people attended the events and over 10,000 people were screened for heart disease risk factors in fourteen cities.

Building on the success of the 2005 National Women's Health Week (NWHW), OWH led HHS' planning for the May 2006 event. More than 1,100 events and outreach activities occurred in all 50 states and some territories and about 140 proclamations were issued. OWH celebrated the fourth annual National Women's Check-Up Day on May 15, 2006. On this day, hundreds of health care providers around the country offered preventive screenings for free or at reduced rates. OWH also conducted the first-ever WOMAN (Women on the Move Across the Nation) Challenge. Over 17,000 women signed up to increase their physical activity to recommended levels.

In FY 2005 and FY 2006, OWH supported the Comprehensive Women's Heart Health Care (CWHHC) grant program. Six funded sites target women who are at high risk for heart disease including women aged 60 years or older, racial and ethnic minority women, and women who live in rural areas. Evaluation of this program is expected to be completed by the end of FY 2007.

OWH anticipates completing evaluations on its mature model programs - CoE and CCOE sites - early in 2007. A new program solicitation for FY 2007 will apply lessons learned and address HHS and OWH priorities in an evolving health and public health system.

The Deputy Assistant Secretary for Women's Health chairs the DHHS Coordinating Committee on Women's Health (CCWH). This committee comprises senior-level women's health professionals and experts from across HHS, fusing women's health research, prevention, services and evaluation. In FY 2007, OWH convened women's health experts from the past twenty years to discuss women's health advances and challenges for the future.

In FY 2006, OWH developed an overweight/obesity initiative by addressing the issue in 16-24 year old minority women. African American, Hispanic, and Native American women have the highest obesity rates. The OWH obesity initiative fosters behavioral changes that will result in women practicing good nutrition, portion control and engaging in daily physical activity. OWH plans to continue this obesity initiative through 2008.

In FY 2007, OWH will develop and implement a sustained lupus awareness and education campaign aimed at reaching health care professionals and the general public, with an emphasis on reaching women at greatest risk for developing lupus.

**OWH Communication Resources**

OWH has strengthened HHS prevention efforts by communicating strategically to the public and health care professionals by providing prevention information tailored to women and girls. OWH maintains the National Women's Health Information Center (NWHIC), which provides health information and referrals to consumers of health care services, health professionals, researchers, educators, and students.

From January - December 2006, NWHIC had 32,435,976 user sessions to the womenshealth.gov website and 2,224,966 user sessions to the girlshealth.gov website, continuing the growth of past years' numbers. For all of 2005, NWHIC had 20 million visitors to the Website and 1.3 million visitors to the girls health site. NWHIC is accessible by a toll-free telephone call to 1-800-994-9662 (TDD: 1-888-220-5446) or through the Internet at *www.womenshealth.gov* (formerly www.4woman.gov). During FY 2005, the results of an evaluation revealed that over 90 percent of NWHIC callers are satisfied with the services. More than 75 percent would very likely use the services again, and more than 70 percent would very likely recommend NWHIC to others.

OWH's www.girlshealth.gov website is the #1 Google return when searching on "girls health." The site was recently rated as one of the top ten teen health web sites by the "Voice of Youth Advocates" publication. 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 *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 is designed to help parents and caregivers of young adolescent girls (ages 9-13) improve family eating and activity habits. Evaluation of the program is under way, and will be completed in FY 2007. The Spanish version of the *BodyWorks* toolkit will be released in mid 2007. In addition, OWH awarded a contract to develop culturally appropriate materials for low literacy and economically disadvantaged parents.

NWHIC includes *For Your Heart,* an interactive website module that provides women with heart disease prevention information, tailored on race/ethnicity, age, menopausal status, and CVD risk factor profile. In FY 2006, new tailored content was developed to educate women with disabilities about reducing their risk of heart disease and stroke. This new content will be uploaded to *For Your Heart* in FY 2007 and pilot tested by a group of women with disabilities.

Rationale for the Budget Request

The FY 2008 Budget for OWH is $27,369,000, a net decrease of $914,000 below the FY 2007 CR level. At this level of funding, OWH will support mandatory salary increases, and grant programs will be reduced proportionately by $1,000,000.

## Performance Analysis

| **Long Term Goal:** 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. | | | |
|---|---|---|---|
| **Program Outcomes** | **FY** | **Target** | **Result** |
| **Objective** - Advance superior health outcomes for women.<br><br>**Outcome** - 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. | *2010* | 68.6% (211/311) | |
| | *2005* | Baseline | Interim Measure 64.3% (200/311) |
| **Data Source:** National Center for Health Statistics | | | |
| **Data Validation:** Program office project officer oversight | | | |
| **Cross Reference:** Healthy People 2010; HHS Strategic Goals; OPHS GPRA Plan; Secretary's 500 Day Plan. | | | |

| **Long Term Goal**: 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. | | | |
|---|---|---|---|
| **Program Outcomes** | **FY** | **Target** | **Result** |
| **Objective -** Advance superior health outcomes for women.<br><br>**Outcome** - Increase percentage of women who are aware of the symptoms and signs of a heart attack.<br><br>**Outcome** - Increase the percentage of women who are aware of the importance of accessing rapid emergency care by calling 911. | | | |
| | *2010* | 61.4% of women (Based on *Healthy People 2010*) | |
| | *2006* | Baseline | 54.5% of women |
| **Date Source:** National Center for Health Statistics | | | |
| **Data Validation:** Program office project officer oversight | | | |
| **Cross Reference:** Healthy People 2010; HHS Strategic Goals; OPHS GPRA Plan; Secretary's 500 Day Plan. | | | |

| **Annual Measure:** Increase the number of users of OWH communication resources (e.g., National Women's Health Information Center; womenshealth.gov website; and GirlsHealth.gov website). | | | |
|---|---|---|---|
| **Program Outcomes** | **FY** | **Target** | **Result** |

| | FY | Target | Result |
|---|---|---|---|
| **Objective** - Increase the number of users of all OWH communication resources.<br><br>**Outcome** - Increased number of users for the National Women's Health Information Center.<br><br>**Outcome** - Increased number of users for the womenshealth.gov website.<br><br>**Outcome** - Increased number of users for the GirlsHealth.gov website. | *2010* | 27.5 million user sessions annually | |
| | *2009* | 26.0 million user sessions annually | |
| | *2008* | 24.5 million users sessions annually | |
| | *2007* | 23.0 million users sessions annually | |
| | *2006* | Baseline | 21.5 million user sessions annually |

**Data Source:** Collected by OWH Programs

**Data Validation:** Program office project officer oversight

**Cross Reference:** Healthy People 2010; HHS Strategic Goals; OPHS GPRA Plan; Secretary's 500 Day Plan.

**Efficiency Measure:** Increase the number of people that participate in OWH-funded programs (e.g., information sessions, web site user sessions, outreach) per million dollars.

| Program Outcomes | FY | Target | Result |
|---|---|---|---|
| **Objective** - Increase the number of people that participate in OWH-funded programs per million dollars spent annually.<br><br>**Outcome** - Increased education and collaboration on women's health. | *2010* | 972,935 people participated per million dollars spent annually | |
| | *2009* | 918,803 | |
| | *2008* | 866,796 | |
| | *2007* | 813,904 | |
| | *2006* | Baseline | 760,658 people participated per million dollars spent annually |

**Data Source:** Collected by OWH Programs

**Data Validation:** Program office project officer oversight

**Cross Reference:** Healthy People 2010; HHS Strategic Goals; OPHS GPRA Plan; Secretary's 500 Day Plan.

Performance Narrative

In response to the OMB PART findings, OWH undertook a strategic planning process to define its two major goals: Develop and Evaluate Model Programs on Women's Health, and Lead Education/Collaboration efforts to improve Women's Health. OWH seeks to identify gaps and influence changes in healthcare for women and girls. OWH developed new annual and long-term outcome measures which link to the program's mission and make it possible to measure progress in achieving long-term performance goals.

OWH is also reviewing program evaluation plans and conducting independent, outcome-based evaluations of its program areas to assess OWH's impact on improving women's health. A women's health priority list was developed that focuses on CVD, diabetes, HIV, mental health, lupus and violence. Additional information about the OWH PART may be found on the website www.ExpectMore.gov.

OWH will begin implementing the Performance Management System (PERMS) in FY 2007. PERMS is a web-based data collection system that OWH contractors and grantees will use to submit their progress reports electronically to a centralized database. PERMS will collect and store quantitative performance information concerning the participants in OWH funded programs for OWH staff to monitor and report findings. OWH will use the data collected from contractors and grantees to calculate its annual efficiency measures. This budget request will improve OWH program performance by focusing resources on fewer initiatives and monitoring program performance and results.

# OFFICE ON WOMEN'S HEALTH
## Program Data

| Activity | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Change +/- FY 2007 |
|---|---|---|---|---|
| Centers of Excellence | $1,710,000 | | | $0 |
| Community Centers of Excellence | 1,050,000 | | | 0 |
| Region VIII Demo Project | 375,000 | | | 0 |
| Ambassadors for Change | 625,000 | | | 0 |
| Rural Frontier Coordinating Ctnrs | 1,450,000 | | | 0 |
| Rural Health Workshop | 250,000 | | | 0 |
| Meeting/Logistics/Support Contract | 300,000 | | | 0 |
| New Comprehensive Model Solicitation | | 4,000,000 | 3,360,000 | (640,000) |
| Adolescent Health | 425,000 | 525,000 | 525,000 | 0 |
| Cardiovascular Disease Programs | 2,108,000 | 1,300,000 | 1,155,000 | (145,000) |
| Maintenance of State/County Data | 393,000 | 410,000 | 410,000 | 0 |
| Osteoporosis | | 1,900,000 | 1,900,000 | 0 |
| Women's Cancer Initiative | 136,000 | --- | --- | 0 |
| Diabetes and Women | 581,000 | 600,000 | 600,000 | 0 |
| Depression and Mental Health | 405,000 | 400,000 | 400,000 | 0 |
| HIV/AIDS in Minority Communities | 1,673,000 | 1,340,000 | 1,125,000 | (215,000) |
| Lupus | 278,000 | 855,000 | 855,000 | 0 |
| Minority Women's Health | 170,000 | 175,000 | 175,000 | 0 |
| Violence Against Women | 432,000 | 525,000 | 525,000 | 0 |
| Nat'l Women's Hlth Info Center | 3,200,000 | 3,200,000 | 3,200,000 | 0 |
| NWHIC Daybooks | 0 | 500,000 | 500,000 | 0 |
| Print Materials | 650,000 | 250,000 | 250,000 | 0 |
| Communications Contract | 300,000 | 300,000 | 300,000 | 0 |
| National Women's Health Week | 250,000 | 250,000 | 250,000 | 0 |
| Meeting Logistics (Div of Policy) | 326,000 | 250,000 | 250,000 | 0 |
| Co-sponsorships (incls IAAs & others) | 500,000 | 500,000 | 500,000 | 0 |
| Operating Expenses | 10,618,000 | 11,003,000 | 11,089,000 | 86,000 |
| **TOTAL, Budget Authority** | $28,205,000 | $28,283,000 | $27,369,000 | ($914,000) |

# OFFICE FOR HUMAN RESEARCH PROTECTIONS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $6,921,000 | $6,989,000 | $7,357,000 | +$368,000 |
| FTE | 33 | 33 | 34 | +1 |

## Statement of the Budget Request

The FY 2008 Budget for the Office for Human Research Protections (OHRP) is $7,357,000, an increase of $368,000 above the FY 2007 CR level.

## Program Description

OHRP was created in June 2000 in order to fulfill HHS responsibilities set forth in the Public Health Service Act. These responsibilities include:

- Develop, monitor, and exercise compliance oversight of HHS regulations for the protection of human subjects who are involved in research conducted or supported by any HHS component;
- Coordinate appropriate HHS regulations, policies, and procedures both within HHS and in coordination with other Federal agencies;
- Establish criteria for Assurances of Compliance (Assurances) with institutions engaged in HHS-conducted or supported research involving human subjects;
- Conduct programs of clarification and guidance for both the Federal and non-Federal sectors with respect to the involvement of human subjects in research;
- Direct the development and implementation of educational and instructional programs and generate educational resource materials relative to human research protections;
- Evaluate the effectiveness of HHS policies and programs for the protection of human subjects;
- Serve as liaison to the Executive Branch, Legislative Branch, and non-governmental entities established to examine ethical issues in medicine and research;
- Exercise leadership in identifying and addressing ethical issues related to the use of human subjects in research;
- Provide staff support for the Secretary's Advisory Committee on Human Research Protections (SACHRP); and
- Continue to enhance the performance, effectiveness and efficiency of the human research subject protection process, through a comprehensive program of education, quality improvement initiatives, a simplified assurance process, proactive compliance oversight, and improved policy and guidance documents.

OHRP is organized into three functional Divisions and is headed by the Office of the Director (OD). 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** – 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. The Director also serves as Executive Secretary of SACHRP and co-chair of Human Subject Research Subcommittee of the National Science and Technology's Committee on Science.

Within the OD, OHRP 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. International objectives are achieved by partnering with international stakeholders in the fields of medical and behavioral research and human research protections.

OD also coordinates responses to requests for OHRP documents and information under the Freedom of Information Act.

In FY 2006, the OD supported three SACHRP meetings; led four meetings of the Human Subjects Research Subcommittee, Committee on Science, National Science and Technology Council; issued a *Federal Register* notice clarifying that the requirements of HHS regulations (45 CFR part 46) must be satisfied for all HHS conducted or supported research covered by an Federalwide Assurance (of compliance), regardless of whether the research is conducted domestically or internationally; participated in several international meetings designed to expand technical support for human subjects protection programs in developing countries and enhance international capacity for ethical review of human subjects research.

In FY 2007 and FY 2008, the OD will not increase the level of activity with respect to SACHRP, Human Subjects Research Subcommittee (HSRS), and the International Activities Program. In FY 2006, the OD received a report with recommendations from the Institute of Medicine regarding the ethical framework for conducting research involving prisoners.

**Division of Policy and Assurances (DPA) –** DPA maintains, develops, promulgates, and updates policy and guidance documents regarding regulatory requirements and ethical issues for biomedical and behavioral research involving human subjects. DPA also coordinates appropriate HHS regulations, policies and procedures with other Departments and agencies in the Federal government, organizes and coordinates consultations with panels of experts for certain research involving prisoners and children, when required by HHS regulations for the protection of human subjects at 45 CFR 46.306 and 46.407, respectively. DPA coordinates responses to requests for information, technical assistance, and guidance from Congress, other HHS agencies, other Federal agencies, and non-governmental entities. DPA also negotiates Assurances of Compliance with research entities; provides liaison, guidance, and regulatory interpretation to research entities, investigators, Federal officials, and the public; maintains and modifies, as necessary, existing assurance mechanisms; operates and maintains a registration system for institutional review boards; and develops and implements new procedures to ensure that HHS's human subjects protection regulations are appropriately and effectively applied to the changing needs of the research community.

In FY 2006, DPA published five policy and guidance documents regarding regulatory requirements, and ethical issues for biomedical and behavioral research involving human subjects. DPA organized and coordinated one consultation with panels of experts for research involving prisoners or children.

In FY 2007, DPA plans to develop and update up to five policy and guidance documents regarding regulatory requirements, and ethical issues for biomedical and behavioral research involving human subjects and up to five guidance documents in FY 2008. DPA expects to organize and coordinate up to two consultations with panels of experts for research involving prisoners or children. DPA also plans to increase the number of institutions electronically submitting Federalwide Assurances (FWA) – new, updates, and renewals – from 68 percent in FY 2006, to 75 percent in FY 2007, and to 85 percent in FY 2008.

**Division of Compliance Oversight (DCO)** – DCO conducts inquiries and investigations into alleged noncompliance 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 conducts a program of not-for-cause surveillance evaluations of institutions. This program provides an important complement to the performance-based quality improvement programs described below. DCO also receives, reviews, and responds to incident reports from Assured institutions. These reports include reports of suspensions or terminations of IRB approval of research, serious or continuing noncompliance, and unanticipated problems involving risks to subjects or others.

In FY 2006, DCO opened 43 new compliance oversight investigations; closed 40 compliance oversight investigations; reduced the volume of open compliance oversight investigations to 25; conducted three not-for-cause compliance oversight evaluation; and received and analyzed about 80 incident reports.

So far in FY 2007, DCO has opened two new compliance oversight investigations; closed 10 compliance oversight investigations; reduced the volume of open compliance oversight investigations to about 20; conducted one not-for-cause compliance oversight evaluation; and received and analyzed about 10 incident reports. In FY 2008, DCO anticipates the same level of activity as in FY 2007.

**Division of Education and Development (DED)** – Universally, education is recognized as one of the most important elements in improving protections for human research subjects. To that end, DED develops and conducts education conferences, gives presentations, develops other training tools, and carries out quality improvement activities to help ensure human research subjects protections. DED provides liaison to Federal officials and guidance and regulatory interpretation to research entities, investigators, and the public regarding ethical issues in biomedical and social/behavioral research involving human subjects. DED also provides technical assistance to institutions engaged in HHS-conducted or sponsored research involving human subjects; maintains, promulgates, and updates educational guidance materials related to protection of human research subjects; and conducts public outreach and education or information programs to promote and enhance public awareness of the activities of OHRP and human subject protections. DED provides staff support to the Human Subjects Research Subcommittee, Committee on Science, National Science and Technology Council.
In FY 2006, OHRP co-sponsored and conducted two 2-day national conferences and two 1-day regional research community forums. OHRP staff also gave more than 100 presentations in FY 2006.

In addition, as part of the OHRP quality improvement program, OHRP initiated regional QA workshops in FY 2006. These QA workshops provide attendees with the necessary information to assess their institution's human subjects protection program and offer tools to facilitate improvement. OHRP conducted six QA workshops in FY 2006.

In FY 2007, OHRP will complete the adaptation of its tri-fold public education pamphlet for Hispanic and Vietnamese audiences and initiated distribution via the OHRP website and in hard copy. This pamphlet provides potential volunteers in communities under represented in research with guidelines to aid in their consideration of participation in research. OHRP will continue with the second phase of the education evaluation project, the collection and analysis of data from a statistically significant number of institutions.

In FY 2007 and FY 2008, OHRP will maintain its education and quality improvement program through regional research community forums, presentations, educational resource materials, and QA workshops and consultations. In addition OHRP will develop the online educational training modules for the research community.

Rationale for the Budget Request

The FY 2008 Budget for OHRP is $7,357,000, an increase of $368,000 above the FY 2007 CY level. This level will allow OHRP to provide mandatory pay increases to maintain staffing and operations at the same level as in FY 2007.

Performance Analysis

| Performance Goal | Results | Context |
|---|---|---|
| Increase the number of institutions electronically submitting Federalwide Assurances (FWAs) for OHRP negotiation and initial approval, and updating or renewal | In FY 2006, OHRP approved 4,341 new, updated, or renewed assurances; 68 percent of these assurances were submitted electronically and 32 percent were submitted in hard (paper) copy. OHRP projects that electronic submission of FWAs will increase to 75 percent in FY 2007, and to 85 percent in FY 2008. | This performance goal refers to improving the process for OHRP to confirm that research institutions engaged in HHS-conducted or supported research involving human subjects appropriately file and update OHRP-approved assurances of regulatory compliance with the HHS Protection of Human Subjects regulations. |
| Protect human subjects from risks caused by regulatory violations through conduct of not-for-cause compliance oversight evaluations as surveillance of institutional operations without any allegation of regulatory violations. | OHRP conducted three not-for-cause compliance oversight evaluations in FY 2006; OHRP has conducted one not-for-cause compliance oversight evaluation so far in FY 2007. OHRP anticipates conducting up to four not-for-cause compliance oversight evaluations in FY 2007 and up to four in FY 2008. | This performance goal refers to completion of not-for-cause compliance oversight evaluations including on-site visits and evaluations through correspondence. This includes a review of IRB records for randomly selected protocols, IRB written procedures, minutes of IRB meetings, and when on-site, interviews with institutional staff involved in research and the IRB process. |

Performance Narrative

FWA: HHS human subject protection regulations require that any institution engaged in non-exempt human subjects research conducted or supported by HHS must submit a written

assurance of compliance to HHS. The FWA provides a simplified procedure for institutions engaged in HHS conducted or supported research to satisfy the assurance of compliance requirements. In January 2005, OHRP announced an enhancement to its web-based electronic submission system to allow users to electronically update and renew their OHRP-approved assurances, in addition to electronically obtaining a new assurance. The more than 8,800 active OHRP-approved assurances currently in the assurance registry support OHRP's mission of strengthening, and providing leadership to, the nation's system for protecting volunteers in research that is conducted or supported by HHS.

The FWA is the only type of new assurance approved by OHRP for federalwide use. This means that other federal departments and agencies that have adopted the Federal Policy for the Protection of Human Subjects (also called the Common Rule) may rely on the FWA for research that they conduct or support.

Not-for-cause compliance oversight evaluations: Not-for-cause compliance oversight evaluations support OHRP's mission to develop, monitor, and exercise compliance oversight of HHS regulations for the protection of human subjects involved in HHS conducted or supported research. Not-for-cause oversight evaluations are conducted in the absence of substantive allegations or indications of non-compliance. Institutions are selected for such an evaluation based on a range of considerations, including: (i) volume of HHS-supported research; (ii) lingering concerns following a previous for-cause compliance oversight evaluation; and (iii) complaints about a human subject protection program that indicate dysfunction without clearly implicating particular regulatory requirements, among others.

OHRP has conducted one not-for-cause compliance oversight evaluation to date in FY 2007 compared to three evaluations conducted in FY 2006 largely due to compliance staff shortages. However, with the recent addition of two compliance staff persons, OHRP anticipates conducting up to four not-for-cause evaluations in FY 2007 and four in FY 2008. We expect that site visits improve the quality of human subject protections at institutions by finding problems with compliance, in some cases preventing harm to human subjects.

# COMMISSIONED CORPS TRANSFORMATION, READINESS AND TRAINING

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $4,128,000 | $4,157,000 | $38,439,000 | +$34,282,000 |
| FTE | 6 | 6 | 124 | +118 |

## Statement of the Budget Request

The FY 2008 Budget for Commissioned Corps Transformation, Readiness and Training is $38,439,000, an increase of $34,282,000 above the FY 2007 CR level.

## Program Description

To protect the health of the American people, the Secretary has decided to transform the US Public Health Service Commissioned Corps 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 be an essential national resource within HHS to meet critical mission requirements and to address clinical public health needs in isolated, hardship, hazardous, and other difficult-to-fill positions.

To be successful, transformation must create and maintain systems whereby the Commissioned Corps can readily support the critical missions of the Department. Included among those needs are positions that are historically difficult to fill, involve significant hardship for the incumbent and his/her family, are in remote/isolated locations and those that subject the officers to hazardous working conditions. At the core of its mission, the USPHS Commissioned Corps provides public health and medical services to underserved populations, exemplified by the types of duty assignments listed above. The new recruitment, assignment, classification, training and career development systems will enable the Corps to rapidly identify specific needs, target recruitment accordingly, assign officers rapidly for 2-4 year tours to address the needs, develop their functional skills as officers, and rotate them out through continued targeted recruitment of replacement officers.

Furthermore, the Department is required to mount robust responses to public health emergencies. The revitalized Corps will consist of an organized, tiered response structure. The teams and the magnitude of the response will be tailored to the severity of the event and the specialties required.

| Team | Arrival On Scene | Deployment Duration |
|---|---|---|
| Health and Medical Response (HAMR) | <12 Hours | Duration of Response |
| Rapid Deployment Force (RDF) (Corps Tier 1) | <24 Hours | 14 days |
| Applied Public Health Teams (APHT) (Corps Tier 2) | <48 hours | 14 days |
| Mental Health Team (MHT) (Corps Tier 2) | <48 Hours | 14 days |
| Corps Augmentation Staff (Corps Tier 3) | <72 hours | 14 days |

The first Corps responders will be members of the Health and Medical Response (HAMR) teams. They can remain on site for the duration of the Federal public health and medical response. These officers are not assigned to any of the OPDIVs or STAFFDIVs of the Department; consequently, their deployment will not draw down on agency resources. They will be highly trained and prepared to respond to a wide array of public health emergencies from routine staff enhancement requests to weapons of mass destruction events. The HAMR teams will be responsible for the majority of Corps responses; as a result, the burden on OPDIVs and STAFFDIVs caused by the depletion of resources due to deployments will be significantly lessened.

In larger responses that will require officers from the Department's OPDIVs, the Corps has organized and trained 5 Rapid Deployment Force (RDF) teams that can respond within 24 hours of an event. The officers on each of these teams train and deploy together as a cohesive unit. Additionally, five specialized teams of Applied Public Health professionals will deploy to affected communities to provide basic public health functions such as infrastructure assessments, vector control, food and water sanitation and environmental health in the wake of a complex disaster. When the situation on the ground warrants, teams of mental health professionals will be deployed to provide clinical services to the affected populations and to responders. Each of these Tier 1 and Tier 2 teams will be augmented by officers from the remainder of the Corps who all meet readiness standards and comprise Tier 3. A limited number of officers whose duties are deemed by the agency Head to be critical to achieving the agency's mission will be exempt from deployment.

This activity provides the necessary force management and operational activities to support the recruitment, assignment/rotation, training, and other functions and systems that are required to assure that the Corps can meet the Department's readiness, deployment and day-to-day mission critical responsibilities.

Funds also support the Office of Force Readiness and Deployment (OFRD), a division in the Office of the Surgeon General. This office coordinates the readiness and response activities for approximately 6,000 active duty Commissioned Corps officers, who are qualified by special training and skills, and are ready to deploy in an emergency situation or under austere conditions. Officers can be mobilized rapidly in times of extraordinary need during natural disasters, public health emergencies, special security events, terrorist attacks, strife, and in response to domestic or international requests to provide leadership and expertise by directing, enhancing, and supporting the missions of the PHS and other HHS agencies, Federal, Tribal, State, and local authorities, and/or other respondents.

OFRD was established to improve HHS's ability to respond to urgent public health needs. All Commissioned Corps officers are considered 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.

Finally, this activity includes funds for the continuation of development of the Information Technology (IT) systems that will support the Officer Profile, Assignment and Deployment systems for the active duty force.

Rationale for the Budget Request

The FY 2008 Budget $38,439,000, an increase of $34,282,000 above the FY 2007 CR level. This Budget provides funds to support a number of Commissioned Corps initiatives.

Secretary Leavitt believes that the USPHS Commissioned Corps, as a uniformed service of health professionals, is an essential national resource to meet critical Federal public health mission requirements, ready to respond rapidly to urgent public health and health care emergencies as well as to meet the day-to-day requirements of Federal agencies for public health expertise and management skills in response to a broad spectrum of needs. Furthermore, officers of the service must be available to address clinical and public health needs in isolated, hazardous, and other hard-to-fill positions, including, when necessary, to address humanitarian, security and defense needs of the Nation, particularly when other resources are not available or are not sufficient.

The essential role of the Commissioned Corps is being demonstrated every day, but particularly during public health emergencies such as during the response to the Gulf Coast Hurricanes in 2005, the anthrax attacks against the Capitol and other sites, and the 9/11 terrorist attacks, to name a few. To make the Corps most able to respond to the challenges of the 21st Century, based on these and other experiences, the size and the force management of the Corps must be reformed. Recruitment must be strengthened to attract those with the best clinical and public health skills; appointment practices must be modernized; selection, assignment and deployment systems must be made more efficient; training and career development must be strengthened in order to promote officer retention; and the Corps' IT systems must be modernized.

As the result of several years of study, the Secretary has made significant decisions about the future development of the Commissioned Corps. Some of these decisions were announced in January 2006. In the beginning of FY 2007, the Deputy Secretary announced extensive new directions for force management reform of the Corps after an extended period of intense policy discussion with the officer Corps and the agencies of the Department. The FY 2008 budget request of $12,000,000 is based on implementing these reforms while continuing to meet the day-to-day requirements for the use of the Corps and its officers. These reforms affect the size of the Corps, its readiness and deployment, its ability to select and assign officers for the positions in which their skills are most needed, and to assure that they continue to develop their skills throughout their careers. The technological systems that support these capabilities must also be enhanced along with the development of new and appropriate policies for administering the Corps.

The growth in the Office of Force Readiness and Deployment (OFRD) staffing and the creation of Health and Medical Response (HAMR) Teams are the result Recommendation 60 from the White House's *Katrina Lessons Learned Report*, which recommended that HHS create a dedicated, full-time response team of Commissioned Corps officers. The HAMR Teams will have four primary duties:

- deploy to domestic and international responses as required by the Secretary;
- obtain training;

- provide training to other Corps officers and Medical Reserve Corps members; and
- keep their clinical and public health skills intact by working in underserved communities.

The FY 2008 Budget of $24,504,000 provides for the salary and benefits for two HAMR teams, each team comprised of 105 members each. The funds will also allow the purchase of equipment caches, rent for warehouse space, and provide training for all team members.

A FY 2008 increase of $726,000 is requested for the addition of 6 FTEs for OFRD that will support the HAMR Teams, as well as the response teams created under Recommendation 57c from the White House's *Katrina Lessons Learned Report*. These personnel will be directly involved in training and logistics support for the HAMR Teams and the other response teams.

Performance Analysis

| **Long Term Goal:** *Increase the size operational capability of the Commissioned Corps.* | | | |
|---|---|---|---|
| **Annual Measure** | **FY** | **Target** | **Result** |
| *Increase the percentage of Officers that meet Corps readiness requirements, thus expanding the capability of the individual Officer. This is an output measure.*<br><br>Explanation: The goal is to increase the number of Officers meeting readiness requirements such that they are effective resources for HHS emergency response. The goal will incorporate all future readiness requirements, including a new standard for physical training in 2007. | *2009* | 85% | |
| | *2008* | 82.5% | |
| | *2007* | 80% | |
| | *2006* | 75% | 73% |
| | *2005* | 70% | 71% |
| | *2004* | 50% | 50% |
| | *2003* | 30% | 35% |
| | *2000* | Baseline | 5% |
| *Increase the percentage of Officers that are deployable in the field, thus expanding the capability of the Corps. This is an output measure.*<br><br>Explanation: The goal is to increase the percent of Officers ready and available to be deployed to the field. For example, Officers must meet readiness requirements, have supervisory approval, and have declared their availability to travel within the timeline for their response tier, either through the Office of Force Readiness and Deployment or through the Agency to which they are assigned. | *2009* | 65% | |
| | *2008* | 60% | |
| | *2007* | 55% | |
| | *2006* | 50% | 50% |
| | *2005* | Baseline | 40% |

| | | | |
|---|---|---|---|
| *Increase the percent of individual responses that meet timeliness, appropriateness, and effectiveness requirements. This is an outcome measure.*<br><br>Explanation: Officers will be deployed as individuals or in small groups when the response is of limited scope, or requires a small number of skill-sets to address a public health need. The Corps emergency response function requires frequent and consistent evaluation to ensure the program can provide a timely, appropriate, and effective response to medical emergencies and urgent public health needs experienced by Federal, State Tribal, or local entities. | *2009* | | |
| | *2008* | | |
| | *2007* | Baseline | |
| *Increase the percent of team responses that timeliness, appropriateness, and effectiveness requirements. This is an outcome measure.*<br><br>Explanation: Response teams will be utilized when the response requires a mix of deployment skill-sets to address a large or complex public health need. The Corps emergency response function requires frequent and consistent evaluation to ensure the program can provide a timely, appropriate, and effective response to medical emergencies and urgen public health needs experienced by Federal, State, Tribal, or local entities. | *2009* | | |
| | *2008* | | |
| | *2007* | Baseline | |
| *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. This is an output measure.*<br><br>Explanation: A goal of the Corps emergency response function is to establish specialized teams that are better able to respond to specific types of events. | *2009* | 36 | |
| | *2008* | 26 | |
| | *2007* | 26 | |
| | *2006* | 10 | 10 |
| | *2005* | Baseline | 0 |
| *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 . This is an output measure.*<br>Explanation: A goal of the Corps emergency response function is to ensure that the specialized teams are fully functional and can provide a timely and appropriate response to medical emergencies and urgent public health needs. | *2010* | 36 | |
| | *2009* | 26 | |
| | *2008* | 26 | |
| | *2007* | 10 | |
| | *2006* | Baseline | 0 |
| *Cost per Officer to attain or maintain readiness requirements. This is an efficiency measure.*<br><br>Explanation: This is determined by the annual OFRD budget dedicated to building and maintaining readiness among the Corps ($1.9 million in FY 2008, and assumed to be flat-line into the future), divided by the number of Officers meeting readiness requirements. | *2009* | $85.96 | |
| | *2008* | $92.78 | |
| | *2007* | $100.47 | |
| | *2006* | $107.17 | $107.17 |
| | *2005* | Baseline | $115.56 |
| | *2004* | N/A | $164.20 |

| | 2003 | N/A | $243.20 |
|---|---|---|---|

**Data Source:** As officers complete readiness requirements, they populate the OFRD web-based database. Verification of completion of online training modules is automatically generated by the contractor hosting the web-based modules. Individual Officer readiness status is calculated from the OFRD web-based database as well as from the online training database. Readiness figures are calculated in real-time throughout the year, however, they are reported at the end of each fiscal year, the end of each calendar year and roughly mid-way through the fiscal year. OFRD is directly responsible for the forming and training of response teams. Therefore, numbers and percentage of existing teams, and their statuses, are directly recorded through interaction with OFRD staff.

**Data Validation:** In addition to populating the OFRD database, Officers submit documentation of readiness measures to the Office of Commissioned Corps Operations for inclusion in electronic Officer Personnel Folders, and to the Medical Affairs Branch for inclusion in official medical records. Data from these sources is used to validate data from the OFRD database. In addition, hard copies of certificates are also used for validation. Readiness figures are calculated in real-time throughout the year, however, they are reported at the end of each fiscal year, the end of each calendar year and roughly mid-way through the fiscal year.

**Cross Reference:** Emergency response and Commissioned Corps renewal is one of the HHS Priority Activities. This is accomplished by developing a deployable mass casualty care capability to enhance medical surge capacity in response to a variety of threat scenarios and aligning the force structure and deployment readiness of the Commissioned Corps with current needs. In sum, this requires having a Commissioned Corps that is bigger, better trained, and deployable. These activities and strategies are part of the Secretary's original 500-day Plan as well as the 250-day update, in the Securing the Homeland sections of both documents.

Performance Narrative

The mission of the Commissioned Corps Readiness and Response Program, in the Office of Force Readiness and Deployment (OFRD), is to provide a timely, appropriate, and effective response by U.S. Public Health Service officers to 1) public health and medical emergencies, 2) urgent public health needs and challenges, and 3) National Special Security Events. To carry out this mission, OFRD functions to ensure that 1) individual Corps officers are appropriately trained and ready to deploy, and 2) the Corps deploys the appropriate team or individual(s) in a timely, appropriate, and effective manner.

For the FY 2008 budget period, a PART review of the Commissioned Corps Readiness and Response was conducted, and a score of adequate was received. The PART acknowledged that each deployment is to a relevant, clearly defined, and unmet need, and performance measures were developed to reflect the Corps transformation from a individual-centric deployment to a team-focused deployment. An evaluation tool is being developed to measure the timeliness, appropriateness, and effectiveness of individual and team responses.

Performance goals, measures and targets have been established within the Corps to also assure that progress is made in achieving the sizing and operational goals established by the Secretary. These goals define the staffing requirements for the Corps for its 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:

- As communicated by Federal, state, and local entities, increased effectiveness of Corps officers in meeting the public health needs of populations impacted by disasters and other urgent public health challenges.
- Collaborative arrangements with a broad variety of federal partners to obtain readiness training at no-cost or low-cost to the office.
- For the last 3 years, OFRD has successfully and dramatically increased the readiness

numbers and standards of Corps officers to match the OMB performance measure – all achieved with no increase in budget or personnel.

- The establishment, following the issuance of the White House Katrina Lessons Learned Report, of response teams that are pre-identified, rostered, trained, and equipped. These performance measures are based on team responses rather than the readiness and deployment of individuals.

As a result of this shift in focus, active duty Commissioned Corps officers can be deployed within hours either as individuals or as purpose-specific strike teams. In the event of a national or international health emergency, the OFRD response can be delivered by pre-identified, trained, and equipped response teams; or it can be "custom-tailored" in that officers who have a wide variety of professional training and experience (e.g., clinical, environmental, regulatory, research) are selected and aggregated as needed. Officers are also utilized in the context of pre-positioned teams for high-profile mass gatherings, such as the Reagan State Funeral, National Political Conventions, Group of Eight Summits, International Monetary Fund meetings, or Presidential Inaugurations; special population needs, such as investigating lead in the blood of small children in Washington, DC; humanitarian assistance, such as for Indonesia after the December 2004 tsunami and the March 2005 earthquake; support for urgent public health needs, such as augmenting the Indian Health Service in remote, isolated sites; and supporting DoD in time of conflict, such as providing officers to rapidly provide readiness support, including dental care and medical clearance for deploying Marines during the Iraq war.

During the Gulf hurricanes of 2005 (Katrina, Rita and Wilma), the Commissioned Corps deployed more than 2,600 officers to Louisiana, Mississippi, Texas and Florida. These officers functioned as liaisons to represent Emergency Support Function #8 at the National Emergency Operations Center, the Secretary's Operations Center, HHS agency Operations Centers, four Secretary's Emergency Response Teams, three Regional Response Coordination Centers, and four State Emergency Operations Centers.

During this multi-State response by more than 2,600 officers, the Commissioned Corps distinguished themselves in hundreds of ways with their exceptional work to support the citizens of Mississippi, Louisiana, Texas and Florida. The dedicated service of Corps officers in this deployment truly made an impact on the health status of the stricken people of the Gulf States. During these events, Corps officers have: treated tens of thousands of people in shelters, vaccinated over 100,000 people, brought safe water to hundreds of thousands, protected the mental health of over 200,000 children, assessed public buildings for tens of thousands of school children, assured safe food and pharmaceuticals for tens of thousands, treated 6,000 animals in distress, and monitored the disease status of millions.

# COMMISSIONED CORPS TRANSFORMATION, READINESS AND TRAINING
## Program Data

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Transformation | $2,926,000 | $2,656,000 | $10,895,000 | +$8,239,00 |
| IT (Transformation) | 0 | 270,000 | 1,105,000 | +835,000 |
| Subtotal | 2,926,000 | 2,926,000 | 12,000,000 | +9,074,000 |
| OFRD | 1,202,000 | 1,231,000 | 1,935,000 | +704,000 |
| HAMR Teams | 0 | 0 | 24,504,000 | +24,504,000 |
| Total | $4,128,000 | $4,157,000 | $38,439,000 | +$34,282,000 |

# NATIONAL VACCINE PROGRAM OFFICE

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $7,004,000 | $7,073,000 | $7,287,000 | +$214,000 |
| FTE | 7 | 7 | 7 | -- |

## Statement of the Budget Request

The FY 2008 Budget for the National Vaccine Program Office (NVPO) is $7,287,000, an increase of $214,000 above the FY 2007 CR level.

## Program Description

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 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.

This plan provides a Departmental framework, including goals, objectives, and strategies, for pursuing the prevention of infectious diseases through immunizations.

NVPO provides coordination and oversight of several critical infectious disease health needs. For example, NVPO is the lead for development and coordination of the HHS Pandemic Influenza Plan, chairs the Secretary's Task Force on Influenza Preparedness, and coordinates communication between vaccine and antiviral drug manufactures and HHS.

NVPO also supports workshops and meetings to engage partners in discussions of important policy and programmatic challenges in immunizations.

NVPO has the lead on a number of vaccine and medical counter-measure action items described in the HSC National Strategy for Pandemic Influenza Implementation Plan.

NVPO also provides funding to support Federal vaccine and immunization-related projects that address gap or high priority areas identified within the National Vaccine Plan and complement the vaccine- and immunization-related mission of the HHS and other Federal agencies.

In addition, the National Vaccine Advisory Committee (NVAC), which advises and makes recommendations to the Assistant Secretary for Health, is supported by the NVPO; the NVPO Director serves as the Secretariat for the Committee.

**Improving and Influencing Policy.** NVPO has been working with NVAC to undertake a comprehensive assessment and evaluation of the influenza "system"in the United States. An annual assessment of lessons learned will be provided to the ASH each June.

NVPO has the lead for pandemic influenza policy issues within the Department. The HHS Pandemic Influenza Plan was published in November 2005.

**Update the National Vaccine Plan**. The National Vaccine Plan was developed in 1994 and provides a framework – including goals, objectives, and strategies – for pursuing the prevention of infectious diseases under which Federal agencies, States, and municipalities, and those in the private sector, such as vaccine companies and health care providers, can undertake their individual activities in a more coordinated way. The development of this plan was mandated in P.L. 99-660 and requires that the NVPO address four key areas: developing new and improved vaccines; ensuring optimal safety and effectiveness of vaccines and immunization; educating the public and members of the health professions on the benefits and risks of immunizations; and achieving better use of existing vaccines to prevent disease, disability, and death.

**Coordinate and oversee vaccine safety issues across the Department, including the initiation of a process leading to the creation of a Department-wide research agenda.** NVPO has undertaken a comprehensive assessment of the Department's vaccine safety system. A cross-Department task force has developed an inventory of currently supported activities, and will develop a report of future research needs. In addition, the National Vaccine Advisory Committee, the Department's designated federal advisory committee on vaccine and immunization policy issues, will provide its outside expert advice on the development of the Department's vaccine safety plan.

**Coordinate International Vaccine Issues with Office of Global Health Affairs**: The NVPO director will continue to co-chair of the Global Health Security Action Group's Technical Working Group on Pandemic Influenza Preparedness. The goal of these discussions is to improve influenza surveillance, prevention, and control efforts globally. In addition, there is a growing need for NVPO involvement in international/developing country vaccine issues and partnerships with the Gates Foundation, UNICEF, and IAVI.

**Coordinate Communications and Public Engagement Activities Across the Department**: NVPO will also lead the Department's communication and public outreach efforts for pandemic influenza. A draft plan has been developed with a two year timeframe for completion of all activities and material development.

In FY 2008, NVPO will continue to:

- Coordinate and integrate activities of all Federal agencies involved in vaccine and immunization efforts.

- Enhance interagency collaboration, so that vaccine and immunization-related activities are carried out in an efficient, consistent, and timely manner.

- Develop and implement strategies for achieving the highest possible level of prevention of human diseases through immunization and the highest possible level of prevention of adverse reactions to vaccines.

- Work to minimize gaps that may exist in Federal planning of vaccine and immunization activities.

Rationale for the Budget Request

The FY 2008 Budget for NVPO is $7,287,000, an increase of $214,000 above the FY 2007 CR level. This level will allow NVPO to provide mandatory salary increases and maintain activities at essentially the same level as in the FY 2007 CR.

Performance Analysis

| Performance Goal | Results | Context |
| --- | --- | --- |
| Develop an HHS vaccine safety plan. | A cross-Department working group has been formed. An inventory of currently supported activities has been completed and development of the research plan is underway. | This performance goal refers to the development of a comprehensive HHS vaccine safety plan, which outlines the goals and future plans of the Department in vaccine safety activities. |

# PUBLIC HEALTH REPORTS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $456,000 | $461,000 | $466,000 | +$5,000 |
| FTE | 2 | 2 | 2 | -- |

## Statement of the Budget Request

The FY 2008 Budget for Public Health Reports is $466,000, an increase of $5,000 above the FY 2007 CR level.

## Program Description

*Public Health Reports* is the journal of the US Public Health Service, and is produced in collaboration with the Association of Schools of Public Health. For more than a century, this bi-monthly peer-reviewed journal has been a highly respected vehicle for academicians, practitioners, planners, legislators, and students of public health. It is the venue of choice for many to publish work and acquire knowledge and skills from reading papers on innovative public health theory, research, and practice activities.

*Public Health Reports* brings important research and discussions of key issues to the public health community. Each issue of *Public Health Reports* examines subject matter needed to understand the issues of health and disease prevention of the American population. Topics such as tobacco control, teenaged violence, occupational injury and disease, housing, immunization, drug treatment and policy, lead screening, Native American health, minority health, infectious disease response and control, violence, human research protection, women's health, fitness, homeland security, medical care delivery and all other public health topics. These papers are written by the leaders in the public health.

## Rationale for the Budget

The FY 2008 Budget for Public Health Reports (PHR) is $466,000, an increase of $5,000 above the FY 2007 CR level. This level will ensure PHR would be able to maintain special projects similar to those enacted in 2007. The Journal would also develop on-line modules, CDs, PodCasts, and other products that could be used by Schools of Public Health in their classroom and distant learning initiatives.

## Performance Analysis

| Performance Goal | Results | Context |
|---|---|---|
| Increase the number of submissions for consideration by *Public Health Reports*. | PHR has met this performance goal. In 2000, there were fewer than 100 submissions. In 2004, there were 253 submissions. In 2005 PHR received 320 submissions, and in 2006 there were 326. In 2008 the Journal can project a similar rate of submission. This is essentially the full capacity of a bi-monthly Journal. | By increasing the number of submissions to consider, PHR has a better selection of papers to draw from when planning issues. Currently, only about 18% of manuscripts submitted are chosen for publication. |
| Improve the desirability of the journal by increasing the number of manuscripts and columns per issue, which will increase the frequency with which PHR is referenced. | The layout of the Journal has been revised and the number of pages increased to accommodate an increased number of manuscripts accepted. In addition, two supplementals were produced instead of one, Also, an audio CD was issued and distributed with work that does not appear in the printed versions of the Journal. | The frequency and duration of referencing of PHR articles indicates fulfillment of the public health practitioner's need for state-of-the-art information. The increased size of the Journal attests to its greater value to the subscriber and to the Department's goal of sharing public health data with the practice community. |
| Publish one to two supplements each year to add even more relevance to the regular issues | In 2006 PHR published a public health history supplement. In 2007, a supplement on HIV behavior surveillance and another one on Hepatitis will be released. A supplement on Nanotechnology and public health is under production for release in 2008. | The history supplement proved very popular among historians and contemporary practitioners alike. It has been adopted as a classroom text by some major schools of public health. It has been a struggle to keep up with the demand. A second edition in soft cover was produced. Over 7,000 copies have been distributed. |

## Performance Narrative

OPHS has a goal of communicating advances in public health science by sharing information on best practices related to improvement of the public's health. *Public Health Reports* (PHR) offers state-of-the-art articles in three main areas: public health practice, research, and commentaries. PHR regularly explores in-depth the threats to the public's health and provides the opportunity for intellectuals, practitioners and researchers to examine and understand key public health issues. The readers and contributors to the Journal's content are on the front line of public health. Unique to this Journal is the work presented in a readable and accessible format, and packaged with appropriate commentary to present balance and context.

In addition to individually submitted articles, each issue of the Journal offers recurring columns such as Law and the Public's Health, NCHS's Dataline, Public Health Chronicles, and a message from ASPH - From the Schools of Public Health. These columns are guest edited by some of the

Nation's leading thinkers and researchers from the best of the Public Health academic and research institutions. Beginning in 2006, PHR introduced a new column called the International Observer that explores developments in international health. Beginning in 2007, a new column titled "Local Acts" which highlights the innovative activities of local health authority was introduced to examine issues specific to the municipal, county, and state departments of health. Under production now, in 2008 a new column on the subject of academic public health education will be introduced.

Live webcasts featuring one selected article from each issue of Public Health Reports are being produced. In February the article featured was how the Baltimore Department of Health introduced Medicare Part D without a single person in the City having to do without their pharmaceutical needs. In April the Maine Department of Health presents the method of developing a state-based surveillance system for carbon monoxide poisoning.

Collaborative agreements have been reached with the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the National Association of Local Boards of Health (NALBOH), and the Council of State and Territorial Epidemiologists (CSTE) so that each member of these organizations receives a printed subscription copy of PHR. This arrangement further strengthens existing partnerships between academia and practice. OPHS will strive to further expand readership and circulation of the Journal.

# OFFICE OF THE PHS HISTORIAN

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $480,000 | $480,000 | $480,000 | -- |
| FTE | 3 | 3 | 3 | -- |

## Statement of the Budget Request

The FY 2008 Budget for the Office of the Public Health Service (PHS) Historian is $480,000, the same as the amount in the FY 2007 CR level. Until now, the Office of the PHS Historian has been funded in the National Institutes of Health (NIH). HHS is proposing that, beginning in FY 2008, funds for this activity be appropriated to the Office of the Secretary.

## Program Description

The Office of the PHS Historian provides historical research for *all* of the PHS OPDIVs, as well as for HHS as a whole. Several studies have demonstrated that knowledge of an agency's history plays a major role in recruitment and retention. Exhibits produced by the Office of the PHS Historian have been used at conferences as recruitment tools and in agency offices as both retention and recruitment tools. The Office of the PHS Historian also works to save historical sites associated with the PHS (including major historical sites, such as Ellis Island in New York City) and to ensure their preservation.

In FY 2007, the Office will initiate and complete both old and new projects, including updating and adding to the collection of oral histories of PHS staff and officers, as well as cataloguing historical documents to enable researchers both in and outside the Federal government to access and analyze information about historical trends and their implications. The website of the Office provides information on the history of HHS and the PHS to researchers both in and outside the government. This latter group includes reporters for major news organizations, physicians in private practice, students and the general public. Maintenance along with upgrading of the website will allow the Office – and, by default, the Department – to publicize their activities, thereby educating more people about the role which the PHS has played in promoting and protecting Americans.

The Office will continue to be available to agencies on an ad hoc basis. The Office expects to produce two new exhibits; collect oral histories from retiring and aging PHS officers; improve and expand the website; create web exhibits on influenza and global health; catalogue and provide access to historical documents; work with Save Ellis Island to restore the PHS hospitals there; and to work closely with agencies and the Office of the Secretary to provide information and analysis of any and all historical trends which have shaped the department and the ways in which this information can be used to plan for the future.

The relationship of the activities of the PHS Historian to the Secretary's 500-Day Plan, Presidential priorities, and government-wide efforts include:

**Presidential Priorities/Preserve America Initiative:** With the issuance of Executive Order 13287, the President reaffirmed the "need for Federal agencies to assume a leadership role in the management of historic properties." The Office of the PHS Historian will provide this leadership in the management of PHS/HHS historic properties by working with Federal agencies such as the National Park Service and private foundations such as Save Ellis Island to ensure that properties are properly maintained and available to the American public.

**The Secretary's 500 Day Plan:** The Office of the PHS Historian serves as the primary repository for documents and objects relating to the history of the PHS and HHS (and its predecessors). It provides background information on any and all department-wide initiatives.

- *Transform the Healthcare System:* Transforming the healthcare system, especially inequalities in healthcare between different populations, requires an in-depth understanding of the roots of these inequalities. The Office will provide the Secretary and PHS agencies with assistance in understanding the causes of these inequalities and approaches which have been used in the past, either successfully or unsuccessfully, to rectify these inequalities.

- *Secure the Homeland:* The Office of the PHS Historian has provided and will continue to provide detailed information about past pandemics of influenza, smallpox and other diseases. This information has been used to help predict possible outcomes for future pandemics. Acting on the Secretary's plan to provide information to state and local authorities to help them plan for a pandemic, the Office has also worked closely with both State and local health departments and will continue to do as new threats unfold.

- *Advance Medical Research:* By highlighting historical trends (in terms of budgets, staffing, interdisciplinary work and research trends), the Office will provide insights into the ways in which medical research is advanced. Access to and analysis of this information has greatly assisted agencies as they assess their past successes and failures and plan future activities.

Rationale for the Budget

The FY 2008 Budget for the PHS Historian is $480,000, the same as the amount in the FY 2007 CR level. Funds will support a staff of three, including salaries, travel, overhead, transcription costs, copying costs and all other costs related to ongoing research activities, and if necessary, contractors to work on projects. This level will allow the Historian to maintain special projects at essentially the same level as the FY 2007 CR Level.

## Performance Analysis

| Performance Goal | Results | Context |
|---|---|---|
| Save historical artifacts and documents in danger of being lost or destroyed. Catalogue these objects so that they are available to researchers and staff. | The Office has met this goal. In FY 2006, the Office stepped in to save the Parklawn Library which held unique documents relating to the history of the PHS. The total number of documents saved number in the thousands; as these documents did not exist elsewhere, their loss would have been incalculable. | By saving—and providing access to—these materials, the Office has ensured that researchers and staff can research and analyze past activities of the Department. |
| Work with different operating divisions of the PHS and HHS to raise the profile of the Department and the PHS among ordinary Americans. | Beginning in December 2006, the Office has worked with the Office of the Secretary providing detailed historical information on past actions by the Federal government during previous influenza pandemics. | Understanding past pandemics—how and why they spread–provides crucial insight into the ways in which a future pandemic may spread. Providing Americans with information about these past pandemics (as was done when the Office of the Secretary used this information in speeches and on their website) is a fundamental aspect of sharing information on best practices related to improving the nation's health. |
| Raise the profile of the PHS by publicizing the past actions of the PHS and HHS through exhibits and speaking events. | In FY 2006, the Office created a banner exhibit which has been used at a wide range of events; staff members of the Office have also spoken at universities, conferences and a range of similar places to raise the profile of the PHS both within and outside the department. The success of these actions is demonstrated by both demands for extra copies of existing exhibits and the repeat invitations made to staff members to speak. | One of the best and most direct ways to reach members of the public health community is by providing access to historical materials directly—at conferences and/or in universities. |

## Performance Narrative

OPHS has a goal of strategically communicating to share information on best practices related to improvement of the public's health. By providing in-depth historical research on and analysis of past practices, the Office of the Public Health Service Historian helps to facilitate this goal.

Throughout FY 2006, the Office has worked with individuals and organizations within and outside of the Federal government to preserve sites and artifacts relating to the history of the PHS and Federal efforts to improve the public's health. The Office has, for example, worked closely with Save Ellis Island but also with other smaller organizations such as the Knappton Cove Heritage Center to provide information on how best to save these sites and how these sites can be used to further knowledge of the history of the PHS among all Americans.

The Office has also worked to publicize information about the history of the PHS by working with reporters, educators, researchers, and members of the Public Health Service. During FY 2006, for example, the Office worked with the National Park Service and a range of similar institutions to learn how to use websites more effectively to reach a wider range of individuals. In FY 2007, the Office will build on this knowledge to create a major web exhibit on the history of influenza and influenza pandemics. This is the first of several planned web exhibits designed to highlight the past activities and successes of the Public Health Service

# OFFICE OF RESEARCH INTEGRITY

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority[1] | [$8,172,000] | [$8,172,000] | [$8,723,000] | [+$551,000] |
| FTE | 23 | 23 | 25 | +2 |

## Statement of the Budget Request

The FY 2008 Budget for the Office of Research Integrity is $8,723,000, an increase of $551,000 above the FY 2007 CR level.

## Program Description

The overall mission of ORI is to promote integrity in the research programs of the Public Health Service, 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 science-based medicine. Since 1999, ORI has placed greater emphasis on educational activities, research, evaluation, and prevention activities. In response to these changes, ORI adopted an action plan to increase resources in these areas. A key part of this plan was the establishment of a research program to study the factors influencing research integrity, an education program on the responsible conduct of research, and ongoing collaborations with ORI's research partners, including the Association of American Medical Colleges, the Council of Graduate Schools, other research associations, academic and scientific societies, numerous individual institutions, and others.

ORI’s budget, resources, and programs are directly relevant to the Department’s interest in the prevention of disease and promotion of health. ORI’s overall mission supports the integrity of PHS 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 closely intertwined with the beneficial products of the research. ORI is also emphasizing prevention in its programs by developing educational resources to support best practices and by supporting 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.

[1] ORI is funded by NIH dollars, which are reflected as non-add.

Rationale for the Budget Request

The FY 2008 Budget for the Office of Research Integrity is $8,723,000, an increase of $551,000 above the FY 2007 CR level. This level will provide mandatory pay increases to allow ORI to increase staff above the FY 2007 CR level and maintain operations at the same level as in the FY 2007 CR.

Performance Analysis

| Performance Goal | Results | Context |
|---|---|---|
| Review and resolve allegations of research misconduct to advance science and medical research | On average over the past 3 years, resolved over 270 allegations of misconduct, made over 10 findings of research misconduct, and retracted or corrected 11 published papers to protect the integrity of the scientific literature | Investigations into research misconduct and resolution of those investigations support public confidence in the research enterprise, remove dishonest investigators from the system, correct the scientific literature, and provide primary and secondary prevention of future misconduct |
| Support the HHS Strategic Plan element on research integrity by providing educational products on the responsible conduct of research and best practices to support science investigators and research administrators in performing high quality research | Through its RCR Resource Development Program ORI has supported the creation of instructional materials on the responsible conduct of research (RCR) by 54 universities and other organizations. Over 30 products are completed to date and are posted on the ORI website for use worldwide. | The Institute of Medicine and studies on research integrity have indicated that questionable research practices undercut the quality and reliability of publicly funded research. Many young investigators do not receive sufficient instruction in the lab to develop sound, quality research practices. To meet this need, ORI has collaborated with the research community to provide quality educational materials for biomedical researchers. |

Performance Narrative

ORI responds to research misconduct and promotes research integrity, thereby directly supporting HHS and OPHS objectives to advance science and medical research, improve the quality of health care (through science-based medicine), and strengthen prevention. ORI efforts to prevent misconduct and promote integrity and responsible research practices strengthen the integrity of the science base, which undergirds the progress in 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 utilizing science-based medical discoveries.

In the 2008 budget, ORI has performance measures that would support or describe the following activities:

- Five or more conferences, meetings, and consultations that support prevention activities in research integrity;
- Five or more contracts, cooperative agreements, grants, or other collaborations to

increase prevention efforts in research integrity;

- Three or more research projects that will strengthen the science base for prevention;
- ORI review and approval of 100 or more research misconduct policies at PHS funded research institutions to ensure institutional compliance with misconduct regulations;
- 150,000 or more visitors to ORI's website or recipients of ORI communications through newsletters, special reports, and email notices;
- Ten or more targeted educational materials and activities;
- Five or more publications or articles published to promote integrity;

Examples of ORI's performance outcomes over the last few years include the following:[1]

- Reviewed 500 allegations of misconduct, opened over 50 formal inquiries and investigations, and made over 20 findings of research misconduct.
- Reviewed over 200 institutional policies and procedures for regulatory compliance and responded to over 10 incidents of possible retaliation against good faith whistleblowers or non-compliance with regulatory requirements.
- Sponsored over 10 workshops and conferences with research institutions, scientific societies, and others on research misconduct, the responsible conduct of research, and the promotion of research integrity.
- Provided funds for development of 20 educational products in Responsible Conduct in Research (RCR).
- Funded 15 or more grants to support research on misconduct, education in research integrity, conflicts of interest, and institutional practices that affect the integrity of the research environment. Initiated or completed studies on: an Institute of Medicine report on "Integrity in Scientific Research: Creating an Environment that Promotes Responsible Conduct"; a survey on the incidence of research misconduct; "Analysis of Guidelines for the Conduct of Research Adopted by Medical Schools or Their Components"; and Integrity Measures Utilized by Research Laboratories.
- Provided on-site or telephonic technical assistance to 25 or more research institutions in handling allegations of misconduct.
- In compliance with statutory and policy requirements, proposed a revised PHS misconduct regulation to adopt the White House Office of Science Technology Policy (OSTP) definition of research misconduct, and to make other changes. This regulation was published in final in May 2005.
- Adopted in 2007 a model policy for research institutions to assist them in implementing the new regulation.

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

- Initiated and completed a new program with the Association of American Medical Colleges (AAMC) to provide funds to academic and scientific societies for the responsible conduct of research. Funded 19 awards through a cooperative agreement with AAMC. T his resulted in over 10 products related to research integrity and the responsible conduct of research. These products are posted on the AAMC website.

- Initiated a collaboration with the Council of Graduate Schools to support ten or more new programs at graduate schools to promote the responsible conduct of research.

- Will provide support for a six day Workshop on Training Faculty to Teach Survival Skills and Ethics to graduate students, postdoctoral fellows, and faculty

Planned performance outcomes in the next few years:

- A major new initiative to train institutional research integrity officers (RIOs) in handling and managing allegations for research misconduct. This program is sorely needed because many of the prior, highly experienced RIOs are past or close to retirement age, which will result in a sharp drop off of highly expert RIOs. This training program will consist of a 3 day boot camp for new and less experienced RIOs. Ultimately, ORI expects to provide much of this training through an interactive website.

- Continuing a collaboration with the National Postdoctoral Association to provide responsible research training to 40,000 postdocs at 135 institutions

- Developing a partnership with the Laboratory Management Institute at the University of California-Davis to provide on-line training in laboratory management to graduate students, postdocs, and faculty

- 50 or more RIOs and legal counsel are expected to receive this training in FY 2007 and 2008

- Continue a collaboration with OHRP to share resources and speakers at workshops and conferences on human subjects, research misconduct, and research integrity. This facilitates the communication of a common message by two Federal offices that have responsibility for research integrity issues, thus benefitting both the Federal government and OHRP's extramural partners.

- ORI will collaborate with the NIH regional seminars by making presentations related to research misconduct, the responsible conduct of research, and conflicts of interest.

- ORI has provided funds to the Federation of American Societies of Experimental Biology to develop and implement an education program on managing conflicts of interest. This is an important initiative because it provides an opportunity for the research community to develop its own resources, which will more likely be accepted by the individual scientists and societies. If well done, it will also provide effective strategies for appropriately managing conflicts.

- Continue to develop the partnership between ORI and extramural programs aimed at the promotion of research integrity and investigation of allegations of scientific misconduct by expanding the publication of resource materials, improving Internet availability of

information, and co-sponsoring at least three conferences and workshops.

- Conduct or complete studies and evaluation reviews or publish findings on the following: a Gallup study on the incidence of research misconduct and a new study on the affect of complainants, or whistleblowers, on their scientific careers when they report allegations of research misconduct.
- In collaboration with the National Institutes of Health and individual institutes, award at least eight grants for research on the commission and prevention of scientific misconduct, promotion of research integrity, and the responsible conduct of research under ORI's research program on research integrity.
- Develop and implement a new collaboration with CGS to institutionalize RCR education in the US graduate schools where most young scientists receive their training.
- Provide technical assistance to at least 30 institutions which conduct investigations into alleged misconduct and need assistance.
- Assess 300 potential allegations of misconduct.
- Open 50 or more inquiries and investigations into alleged misconduct for ORI oversight.
- Take final actions on 20 or more findings of research misconduct involving PHS funding.
- Cause 10 or more articles that misrepresent research results to be corrected or retracted.
- Issue charge letters and defend ORI authorities and actions in specific cases before the Departmental Appeals Board and in civil litigation.
- Review 100 or more institutional policies for compliance with program regulations.
- Respond to 5 or more whistleblower complaints of retaliation and institutional compliance problems.

# OFFICE OF RESEARCH INTEGRITY

## Program Data

| Activity | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Change |
|---|---|---|---|---|
| Oversight and Case Resolution | $1,889,369 | $1,889,369 | $1,889,369 | 0 |
| Assurance and Compliance Program . . . . . . . . . . . . . . . . . | 885,040 | 885,040 | 885,040 | 0 |
| Education and Integrity Program . . . . . . . . . . . . . . . . . | 2,912,026 | 2,912,026 | 2,912,026 | 0 |
| Management of Allegations of Research Misconduct . . . . . . . . | 400,000 | 400,000 | 400,000 | 0 |
| Support Costs . . . . . . . . . . . . . | 2,085,565 | 2,085,565 | 2,636,565 | 551,000 |
| Total . . . . . . . . . . . . . . . . . . . . | $8,172,000 | $8,172,000 | $8,723,000 | $551,000 |

## Workload Data

| Calendar Year | Misconduct Cases | Whistleblower Compliance/ Cases | Policy Reviews | Judicial Litigation |
|---|---|---|---|---|
| 2004 | Queries . . . . . . . . . . . . . 274<br>Cases opened . . . . . . . . . 30<br>Cases closed . . . . . . . . . . 23<br>Assessments Underway . 17<br>Current cases . . . . . . . . . 51 | Opened . . . . . . 7<br>Closed . . . . . . . 4<br>Current . . . . . . 7<br>Assessments:<br>Opened . . . . . 6<br>Closed . . . . . . 6<br>Current . . . . . 0 | Opened . . . 150<br>Closed . . . . 131<br>Current . . . . 26 | Opened . . . . . 5<br>Closed . . . . . . 2<br>Current . . . . . 4 |
| 2005 | Queries . . . . . . . . . . . . . 265<br>Cases opened . . . . . . . . . 30<br>Cases closed . . . . . . . . . . 22<br>Assessments underway . . 16<br>Current cases . . . . . . . . . 59 | Carried into 2005 . . . . . . . 4<br>Opened . . . . . . 2<br>Closed . . . . . . . 3<br>Current . . . . . . 3 | Opened . . . 279<br>Closed . . . . 185<br>Current . . . . 94 | Opened . . . . . 2<br>Closed . . . . . . 0<br>Current . . . . . 6 |
| 2006 (through Dec 31) | Queries.........................266<br>Cases opened..................29<br>Cases closed....................35<br>Assessments underway.....32<br>Current cases..................53 | Carried into 2006................3<br>Opened...........12<br>Closed.............8<br>Current.......... 7 | Opened.........127<br>Closed..........127<br>Current..........0 | Opened.............4<br>Closed.............1<br>Current............4 |

# OFFICE OF PUBLIC HEALTH AND SCIENCE
## FY 2008 PERFORMANCE ANALYSIS

### Statement of Agency Mission

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. OPHS is led by the Assistant Secretary for Health (ASH) whose chief interest is promoting, protecting, and improving the Nation's health. 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.

### Discussion of Strategic Plan

The FY 2008 GPRA plan takes a focused look at the core contributions of OPHS to the Department and the nation in the areas of prevention, health disparities, and public health infrastructure. The goals are drawn from the HHS strategic plan and Healthy People 2010. The FY 2008 Plan sets ambitious goals and challenges for OPHS to demonstrate the impact of its

OPHS programs support the following goals of the HHS strategic plan:

*Goal 1 - Reduce major threats to the health and well-being of Americans*

All OPHS offices contribute to this goal through their programs which primarily focus on prevention.

*Goal 2 - Enhance the ability of the nation's health care system to effectively respond to bioterrorism and other public health challenges*

The National Vaccine Program Office, which is responsible for coordinating HHS, DoD and AID vaccine activities, contributes to this goal through its activities, including stimulating the development of State planning for a influenza pandemic.

The Office of the Surgeon General is responsible for ensuring the deployability of Commissioned Officers to respond to national disasters, public health emergencies, special security and terrorists events, and other incidents. The Office is also responsible for deploying Commissioned Officers for emergencies through the Inactive Reserve Officers initiative.

*Goal 4 - Enhance the capacity and productivity of the Nation's health science research enterprise*

The activities of the Office of Human Research Protections are directed to enforcing the Federal Regulations protecting human research subjects and this objective.

The Office of Research Integrity also has regulations requiring all research institutions to have policies for responding to allegations of scientific misconduct and reviewing them for compliance.

*Goal 6 - Improve the economic and social well-being of individuals, families, and communities, especially those most in need*

The activities of the Office of Minority Health are directed to this objective by addressing health disparities. Other offices, including the Office on Women's Health, the Office of Disease Prevention and Health Promotion, the Office of HIV/AIDS Policy, the President's Council on Physical Fitness and Sports, and the Office of Population Affairs also contribute.

## Discussion of OPHS Performance Plan

The OPHS Performance Plan has three strategic goals: strengthening prevention, closing the health gap, and strengthening the public health and research infrastructures. 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.

Within each strategic goal area, OPHS reports its performance in the following five broad areas.

<u>Shaping Policy at the Local, State, National, and International Level</u>

- **OPHS influences policies, programs, and practices** through review, analysis, and advice on existing policy-related efforts as well as development, coordination, and implementation of new initiatives and activities. OPHS produces a variety of reports which translate state-of-the-art science into documents that are extensively read by legislators, the media, professionals and the public.

- Within this area, OPHS program offices report performance as the number of communities, state and local agencies, Federal entities, NGOs or research organizations that adopt (or incorporate into programs) recommendations, policies, laws or regulations that are generated or promoted by OPHS thorough reports, committees, etc.

<u>Communicating Strategically</u>

- **OPHS increases awareness, understanding, and action on the major public health concerns and health systems** through strategic communications to decision makers, health professionals, and those serving racial/ethnic minority communities to spur responsive policy and programmatic action. OPHS produces key reports, background papers, and journal articles. Several measures go into the reporting by OPHS offices. One is the number of targeted print and educational materials and campaigns, another is the number of regional national workshops and conferences and consultations with professional and institutional organizations. OPHS facilitates the sharing of information from the field on best practices related to the public health improvement.

- **OPHS provides leading Internet portals which ensure that the general public and specific populations have high quality, reliable information for managing health and wellness.** Through internationally-recognized Websites, such as 4Women.gov and healthfinder.gov, OPHS offers selected resources to empower people to make sound decisions for themselves and their loved ones. OPHS offices measure performance based on the number of unique visitors to these web sites.

Promoting Effective Partnerships

- **OPHS establishes and strengthens 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. Within this context, OPHS offices report the number of formal IAAs, MOUs, contracts, cooperative agreements and community implementation grants with governmental and non-governmental organizations that lead to changes in their agendas/efforts related to the public health or research infrastructure.

Building a Stronger Science Base

- **OPHS promotes the collection of health data and the strengthening of data infrastructures** to monitor the health of all Americans, especially specific populations for whom data sources have been weakest, to measure the effects of initiatives and interventions aimed at improving health, and ultimately to provide a sound basis for decision-making.

- **OPHS fosters service demonstration projects, evaluations, and other studies of interventions aimed at improving health and the health care system** to strengthen and expand the science base for decision-making, determine best practices, identify and overcome barriers to health, and assess program and intervention effectiveness. OPHS program offices measure the number of research, demonstration, or evaluation studies completed and findings disseminated and the number of promising practices identified by research, demonstrations, evaluation or other studies.

- **OPHS strengthens the health sciences research enterprise** by protecting the integrity of the research underlying public health policy and clinical treatments, by ensuring that all institutions that conduct research supported by the Public Health Service agencies have an understanding and commitment to research integrity and an administrative process for responding to allegations of scientific misconduct. To promote the responsible conduct of research, ORI conducts oversight review of institutional investigations into alleged misconduct in science, and monitors institutional efforts. OPHS helps to instill confidence by the public and others in research involving human subjects by working to ensure the protection of human research participants in accordance with U.S. laws and regulations.

Leading and Coordinating Key Initiatives Within or on Behalf of the Department

- **OPHS provides the coordination needed for agencies to work as "One HHS" on key**

**Departmental priorities**. *Healthy People 2010*, the nation's third decade-long prevention initiative, harnesses the energies of all of HHS' public health agencies in pursuing and monitoring progress toward national goals and objectives. The development of the 2010 national health goals involved Federal, tribal, State, local and non-governmental organizations. The initiative drives health policy-making in many States, communities and businesses, and provides the basis for curricula in many health professional schools. In FY 2006, OPHS continued the Midcourse Review of the *Healthy People 2010* 28 focus areas.

Other significant leadership includes the Department-wide effort to register Institutional Review Boards and to coordinate pandemic influenza planning.

During FY 2006, OPHS continued to identify agency activities for the elimination of racial and ethnic health disparities that could be replicated would build partnerships in HHS, and will show tangible results in the near future. OPHS will continue to coordinate focused and intensified Departmental strategies aimed at closing the gaps that exist by race and ethnicity for all groups in the 6 priority health issue areas (infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and child and adult immunization).

- **OPHS coordinates Federal efforts that bridge Departments**, such as development of the statutorily mandated *Dietary Guidelines for Americans*, which were released in January 2005. The Guidelines provide the policy basis for all Federal nutrition education activities and are published jointly with U.S. Department of Agriculture. OPHS coordinates President Bush's *Healthier US* initiative that encourages Americans to live healthier lives by improving nutrition, increasing physical activity and reducing youth risk-taking behaviors, such as tobacco and illegal drug use. *Healthier US* is supported by the Departments of Agriculture, Defense, Education, Housing and Urban Development, Labor, Transportation, and Veterans Affairs; the Environmental Protection Agency; and the General Services Administration.

- **OPHS coordinates nationwide efforts in strategic areas**, such as the Minority AIDS Initiative.

## OPHS Overview of Performance

*Strengthening Prevention Efforts*

Activities in this OPHS priority area include coordination of the President's prevention initiative, *HealthierUS*, which uses all of the available resources of the Federal government to alert Americans to the vital health benefits of simple and modest improvements in physical activity, nutrition, and healthy lifestyle choices such as eliminating tobacco and illegal drug use, and preventive screenings. OPHS manages *Healthy People 2010,* which sets out the science and the data to support national health improvement efforts.

*Closing Health Gaps*

OPHS plays a leading role in many efforts to eliminate disparities, including the Leadership Campaign on AIDS, Minority AIDS Initiative, Centers of Excellence in Women's Health and National Community Centers of Excellence in Women's Health.

OPHS communication efforts for special populations include the Office of Minority Health Resource Center, the National Women's Health Information Center, and population-specific sections on 4Women.gov and healthfinder® (including healthfinder® "espanol") and special resources for racial and ethnic minority populations.

*Strengthening the Public Health Infrastructure*

OPHS plays a vital role in building the data systems for understanding the health problems of our growing racial and ethnic minority populations; in promoting the integrity of the scientific research enterprise; and in promoting the development of a balanced national health information infrastructure that serves the public as well as professionals and supports prevention and chronic disease management as well as treatment and administration.

OPHS helps build capacity in State and local agencies and private organizations to support prevention. Some examples include the Leadership Campaign on AIDS to increase the capacity of minority community-based organizations to develop effective and innovative partnerships at the local level to enhance HIV/AIDS services and education and the National American Indian/Alaska Native Health Forum to identify strategies through which State, tribal, and Federal governments can complement and supplement their respective health systems.

OPHS contributions to the scientific research infrastructure include the Federal Research Misconduct Officials Network with representatives from 27 agencies. OPHS enforces the Federal Regulations which protect human subjects participating in biomedical research.

OPHS has had a lead role in the development of key documents and activities related to the national health information infrastructure (NHII), which includes standards, applications, research with emphasis on linkages among consumers/patients, providers, and public health.

OPHS values collaboration and works in partnership with other HHS components, as well as a variety of other Federal agencies (including the Departments of Education, Justice, Labor, Agriculture, Defense, State, Transportation, Commerce, Energy, Housing and Urban Development, and Veterans Affairs; the Environmental Protection Agency; the Federal Emergency Management Agency; and the U.S. Consumer Product Safety Commission), tribal, State and local governments, health departments and agencies, the academic community, health providers, national professional associations, tribal, national and international health-related organizations, community-based organizations, minority community-based organizations, faith-based institutions, the media, advocacy groups, the business community, foundations, the public, Congress, and others. Through its program offices, OPHS has established close ties with stakeholders who are critical to addressing significant public health and science issues in the Nation and around the world.

# OFFICE OF PUBLIC HEALTH AND SCIENCE
## Detail of Performance Measures

| **Strategic Goal #1:** Strengthen Prevention Efforts | | | |
|---|---|---|---|
| Measure | **FY** | **Target** | **Result** |
| Shape policy at the local, State, national and international levels.<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** OPHS will increase the adoption of effective prevention policies as measured by the number of public and private entities at all levels that adopt policies as a result of OPHS efforts.<br>**Additional Information**: The following staff offices contribute to this effort: PCPFS, OPA, OHAP, and ODPHP. The major contributor to this measure is the PCFFS who has a large number of entities participating in the President's Challenge Awards program. | *2008* | 50,000 | |
| | *2007* | 50,000 | |
| | *2006* | 42,000 | 32,409 |
| | *2005* | 40,000 | 32,052 |
| | *2004* | 39,160 | 30,358 |
| | *2003* | 31,330 | 38,124 |

| **Measure** | **FY** | **Target** | **Result** |
|---|---|---|---|
| Communicate strategically.<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, output<br>**Data Source:** OPHS will increase the reach of its prevention communications as measured by customers served through Websites and clearinghouses, by professional and community-based outreach activities, and by targeted prevention communications.<br>**Additional Information**: The following offices contribute to this effort: PCFFS, ODPHP, OHAP, OPA, OSG, OWH, and NVPO. The large numbers reflect visitors to two major Websites: 4woman.gov and Healthfinder.gov. Each site receives more than 11 million visitors a year.<br>*Increase in 2005 results indicates the additional reporting of new Websites – bone health, For Your Heart and girlshealth.gov - for OWH. ODPHP Websites had additional visitors due to the 2005 Dietary Guidelines for Americans. Targets for 2006 and 2007 were adjusted in FY 2006. | *2008* | 51,000,000 | |
| | *2007* | 49,000,000 | |
| | *2006* | 46,000,000 | 47,831,042 |
| | *2005* | 18,019,500 | 43,976,880* |
| | *2004* | 16,835 | 22,929,822 |
| | *2003* | 15,607,000 | 19,029,234 |

| **Measure** | **FY** | **Target** | **Result** |
|---|---|---|---|
| Promote Effective Partnerships<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** OPHS will increase substantive 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 partnership with OPHS<br>**Additional Information**: The following offices contribute to this effort: PCPFS, OHAP, OPA, OWH, and NVPO. Included in this measure are the large number of contributors to the OWH's efforts in implementing the PYPTH campaign and community implementation grants (CoEs and CcoEs).<br>* Decrease in FY 2005 results represent the phasing out of the PYPTH program. PCFFS was responsible for the Increase in Fy 2006 represents bump-up in PCFFS who had 327 50th Anniversary partners. | *2008* | 160 | |
| | *2007* | 334 | |
| | *2006* | 314 | 492* |
| | *2005* | 300 | 199* |
| | *2004* | 208 | 354 |
| | *2003* | 205 | 157 |

| Measure | FY | Target | Result |
|---|---|---|---|
| Strengthen the science base<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** OPHS will increase knowledge about disease prevention and health promotion, including best practices and research needs as measured by the publication of scientific reports and findings from research demonstrations and evaluation studies.<br>**Additional Information**: The following offices contribute to this effort: PCPFS, OHAP, NVPO, OWH. Included in the count are peer-reviewed articles published, research demonstrations or evaluations completed, and the number of promising practices identified.<br>*OWH Centers for Excellence are reporting for the first time. Targets for FY2006 and FY2007 were adjusted in 2006. | *2008* | 200 | |
| | *2007* | *200* | |
| | *2006* | 200 | 205 |
| | *2005* | 26 | 205* |
| | *2004* | 19 | 22 |
| | *2003* | 18 | 17 |

| Measure | FY | Target | Result |
|---|---|---|---|
| Lead and coordinate key initiatives within and on behalf of the Department<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** ODPHP will increase the impact of selected prevention activities through its leadership and coordination as measured by the number of such efforts that are convened, chaired, or staffed by OPHS and the unique contributions of this efforts.<br>**Additional Information**: The following offices contribute to this effort: PCPFS, OHAP, ODPHP, OWH and NVPO. A large effort by the OWH – proclamations issued for National Women's Health Week - is responsible for the increase in activity beginning in FY 2003, and the target has been adjusted accordingly beginning in FY 2004.<br>* FY 2005 results reflect a decrease in proclamations issues for NWHW. Targets for 2006 and 2007 were adjusted in FY 2006. | *2008* | 1,500 | |
| | *2007* | 1,300 | |
| | *2006* | 1,200 | 1,433 |
| | *2005* | 3,250 | 1,291* |
| | *2004* | 3,200 | 3,542 |
| | *2003* | 190 | 1,099 |

| **Strategic Goal #2: Close Health Gaps** | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Shape policy at the local, State, national and international levels.<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** OPHS will increase the adoption of policies that seek to eliminate health disparities as measured by the number of public and private entities at all levels that adopt policies as a result of OPHS efforts.<br>**Additional Information**: OMH and OHAP are the major contributors to this effort. OWH and PCFFS also contribute. Reflected in both the results and target are the number of States and territories that develop/adopt plans for the elimination of health disparities. | *2008* | 92 | |
| | *2007* | 96 | |
| | 2006 | 133 | 88 |
| | *2005* | 35 | 45 |
| | *2004* | 60 | 117 |
| | *2003* | 56 | 132 |

| Measure | FY | Target | Result |
|---|---|---|---|
| Communicate strategically<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, output<br>**Data Source:** OPHS will increase the reach of its prevention communications that promote the elimination of health disparities as measured by customers served through Websites and clearinghouses by professional and community-based outreach activities and by targeted communications.<br>**Additional Information**: In addition to OMH, OWH, ODPHP and PCPFS contribute to this effort through special portals on their Websites that address the needs of specific populations. | 2008 | 1,900,000 | |
| | *2007* | 1,900,000 | |
| | *2006* | 1,640,000 | 1,943,511 |
| | *2005* | 1,469,498 | 1,576,355 |
| | *2004* | 1,455,561 | 1,462,837 |
| | *2003* | 1,487,540 | 1,301,604 |

| Measure | FY | Target | Result |
|---|---|---|---|
| Promote Effective Partnerships<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** OPHS will increase substantive commitments to eliminating health disparities on the part of public and private entities, as measured by the number of these entities that change or strengthen their efforts as a result of partnership with OPHS.<br>**Additional Information**: In addition to OMH, OHAP, OPA and OWH contribute to this effort through formal IAAs, MOUs, contracts and cooperative agreements with governmental and non-governmental organizations that result in changes to their agendas/efforts to address health disparities. | *2008* | 110 | |
| | *2007* | 72 | |
| | *2006* | 131 | 142 |
| | *2005* | 85 | 170 |
| | *2004* | 136 | 224 |
| | *2003* | 132 | 129 |

| Measure | FY | Target | Result |
|---|---|---|---|
| Enhancing the science base<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** OPHS will increase knowledge about health disparities, including best practices and research needs as measured by the publication of scientific reports and findings from research demonstrations and evaluation studies.<br>**Additional Information**: OMH, OWH and PCFS contribute to this effort through publication of peer-reviewed articles/reports; completed demonstration and evaluation studies, and identification of promising practices identified through research and evaluation. | *2008* | 42 | |
| | *2007* | 47 | |
| | *2006* | 38 | 47 |
| | *2005* | 120 | 50 |
| | *2004* | 86 | 80 |
| | *2003* | 43 | 54 |

| Measure | FY | Target | Result |
|---|---|---|---|
| Lead and coordinate key initiatives within and on behalf of the Department<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** ODPHP will increase the impact of selected activities through its leadership and coordination as measured by the number of such efforts that are convened, chaired, or staffed by OPHS and the unique contributions of those efforts<br>**Additional Information**: OMH, OWH, OHAP, and PCPFS contribute to this effort | *2008* | 23 | |
| | *2007* | 86 | |
| | *2006* | 58 | 31 |
| | *2005* | 23 | 18 |
| | *2004* | 25 | 47 |
| | *2003* | 23 | 58 |

**Strategic Goal #3:** Strengthen the Public Health Infrastructure

| Measure | FY | Target | Result |
|---|---|---|---|
| Shape policy at the local, State, national and international levels.<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** OPHS will strengthen the public health information and research infrastructures as measured by the number of public and private entities at all levels that adopt supportive policies, programs, services, laws, regulations and recommendations as a result of OPHS efforts.<br>**Additional Information**: The following offices contribute to this effort: OR, OHRP, OWH, OHAP and OSG. Included in this measurement are the number of Medical Reserve Corps units established, the number of institutional misconduct policies reviewed, and , beginning in FY 2005, the number of IRBs registered with OHRP. | *2008* | 300 | |
| | *2007* | 2,400 | |
| | *2006* | 2,500 | 446 |
| | *2005* | 2,000 | 1,875 |
| | *2004* | 360 | 430 |
| | *2003* | 350 | 351 |

| Measure | FY | Target | Result |
|---|---|---|---|
| Communicate strategically.<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, output<br>**Data Source:** OPHS will increase the reach of its communications that promote stronger public health, health information and research infrastructures, as measured by customers served through Websites and clearinghouses, by professional and community-based outreach activities, and by targeted public health communications.<br>**Additional Information**: The following offices contribute to this effort: OSG, OHRP and ORI. All three offices maintain Websites, and visitors to these Websites are the major contribution to this measure. | *2008* | 1,100,000 | |
| | *2007* | 651,825 | |
| | *2006* | 450,000 | 670,940 |
| | *2005* | 400,000 | 237,279 |
| | *2004* | 230,000 | 144,762 |
| | *2003* | 140,125 | 226,118 |

| **Measure** | **FY** | **Target** | **Result** |
|---|---|---|---|
| Promote Effective Partnerships<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** OPHS will increase substantive commitments to strengthen the public health, health information and research infrastructures on the part of public and private entities as measured by the number of these entities that change or strengthen their efforts as a result of partnership with OPHS<br>**Additional Information**: OHAP is the major contributor to this measure through its partnerships with community-based organizations. OMH's partnerships with State office of minority and similar entities are also counted. | *2008* | 30 | |
| | *2007* | 6 | |
| | *2006* | 11 | 117 |
| | *2005* | 37 | 93 |
| | *2004* | 36 | 76 |
| | *2003* | 34 | 32 |

| Measure | FY | Target | Result |
|---|---|---|---|
| Strengthen the science base<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** OPHS will increase knowledge about public health, health information and research infrastructure, including best practices and research needs, as measured by publication of scientific reports and finds from research demonstrations and evaluation studies.<br>**Additional Information**: Contributors to this measure include OWH (through educational materials developed by the CoE and CcoE and evaluations performed), OHRP, ORI and ODPHP also contributed to this measure.<br>*Dramatic increase in FY2005 and FY 2006 result reflects the additional data cells ODPHP filled in the Healthy People 2010 objectives due to the Midcourse Review. This is a unique activity and will not effect targets for 2007 and 2008. | *2008* | 125 | |
| | *2007* | 67 | |
| | *2006* | 61 | 3,738* |
| | *2005* | 60 | 1,196* |
| | *2004* | 19 | 22 |
| | *2003* | 18 | 17 |

| Measure | FY | Target | Result |
|---|---|---|---|
| Lead and coordinate key initiatives within and on behalf of the Department<br><br>**Long-term target (2008)** – to be determined<br>**Measure Term/Type**: annual, outcome<br>**Data Source:** ODPHP will increase the impact of public health, health information and research infrastructure activities through its leadership and coordination as measured by the number of such efforts that are convened, chaired, or staffed by OPHS and the unique contributions of this efforts.<br>**Additional Information**:OHAP, NVPO and OSG contribute to this effort. The major change in FY 2004 was the reporting by OSG of Inactive Reserve Officers commissioned and the number of activation days. Targets for FY 2005 forward were adjusted accordingly. | *2008* | 7,300 | |
| | *2007* | 6,800 | |
| | *2006* | 6,324 | 3,454 |
| | *2005* | 4,903 | 5,610 |
| | *2004* | 4,161 | 4,163 |
| | *2003* | 13 | 16 |

# EMBRYO ADOPTION AWARENESS CAMPAIGN

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $1,979,000 | $1,980,000 | $1,980,000 | -- |
| FTE | 0 | 0 | 0 | -- |

## Statement of the Budget Request

The FY 2008 request for the Embryo Adoption Awareness Campaign is $1,980,000, the same as the FY 2007 comparable Continuing Resolution (CR) level.

## Program Description

The purpose of the campaign is to educate Americans about the existence of frozen embryos (resulting from in-vitro fertilization) which may be available for donation/adoption.

In FYs 2002, 2004, 2005 and 2006, Congress earmarked funding for embryo adoption campaigns. In each instance the Department issued a request for application (RFA) in the *Federal Register*, announcing the availability of funding and requesting competitive grant applications for public awareness campaigns on embryo adoption. The notices announced that the Department anticipated funding, on a competitive basis, for three or four new projects, each in the range of $200,000 to $250,000. Because the operating authority was dependent on annual appropriations language, the project periods for grants funded in FY 2002 and 2004 were limited to one year. For the first time in FY 2006, the request included funding to continue the program. Based on requests for continued funding, the notice soliciting grant applications for FY 2005 was modified to incorporate a two-year project period for new awards. Projects awarded in FY 2006 are for a two-year project period.

## Performance Analysis

There are an estimated 400,000 frozen embryos in fertility clinics in the United States and increasing public awareness of embryo donation and adoption remains an important goal. This is a relatively new endeavor and funded projects focus on educating couples who have frozen embryos and who may wish to choose to donate them, as well as to inform infertile couples about their availability for adoption.

## Rationale for the Budget

The FY 2008 Budget includes $1,980,000 for the Embryo Adoption Awareness Campaign, the same as the FY 2007 comparable CR level.

In FY 2006, the conference agreement accompanying the Department’s appropriations provided an increase from $992,000 to $1,980,000 to continue the campaign to increase public awareness of embryo donation and adoption. In FY 2006, OPHS awarded six grant projects – three new grants and three grants to continue projects that were begun FY 2005. The continuing grant

projects are engaged in information and educational activities that are specifically directed at potential donors and recipients. It is anticipated that in FY 2007, the three grants that were begun in FY 2006 will continue, and three new projects will be awarded. The FY 2008 request will allow the campaign to maintain the same level of activity.

| Embryo Adoption Awareness | FY 2002 | FY 2003 | FY 2004 | FY 2005 | FY2006 | FY 2007 | FY 2008 |
|---|---|---|---|---|---|---|---|
| Total Number of Grants | 3 | 0 | 4 | 3 | 6 | 6 | 6 |
| New Grants | 3 | 0 | 4 | 3 | 3 | 3 | 3 |
| Continuation Grants | N/A | 0 | 0 | 0 | 3 | 3 | 3 |

# RENT AND COMMON EXPENSES

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Rent: | | | | |
| GDM | $8,850,000 | $9,350,000 | $10,385,000 | $1,035,000 |
| OGC | 4,457,000 | 4,599,000 | 4,702,000 | 103,000 |
| OPHS | 4,881,000 | 5,194,000 | 5,804,000 | 610,000 |
| IGA | 596,000 | 602,000 | 602,000 | 0 |
| DAB | 336,000 | 350,000 | 500,000 | 150,000 |
| Total | 19,120,000 | 20,095,000 | 21,993,000 | 1,898,000 |
| Operations and Maintenance: | | | | |
| GDM | 2,672,000 | 3,025,000 | 3,375,000 | 350,000 |
| Related Services: | | | | |
| GDM | 3,230,000 | 2,874,000 | 3,090,000 | 216,000 |
| OGC | 352,000 | 359,000 | 361,000 | 2,000 |
| Total | 3,582,000 | 3,233,000 | 3,451,000 | 218,000 |
| *Subtotal, GDM only* | *$14,752,000* | *$15,249,000* | *$16,850,000* | *$1,601,000* |
| Common Expenses: | | | | |
| GDM | 3,472,000 | 3,736,000 | 3,342,000 | -394,000 |
| OGC | 543,000 | 554,000 | 564,000 | 10,000 |
| OPHS | 2,916,000 | 3,017,000 | 3,246,000 | 229,000 |
| Total | 6,931,000 | 7,307,000 | 7,152,000 | -155,000 |
| Service and Supply Fund: | | | | |
| GDM | 9,688,000 | 11,056,000 | 14,356,000 | 3,300,000 |
| OGC | 2,146,000 | 2,259,000 | 2,311,000 | 52,000 |
| OPHS | 5,348,000 | 5,630,000 | 5,799,000 | 169,000 |
| IGA | 10,000 | 45,000 | 45,000 | 0 |
| Total | 17,192,000 | 18,990,000 | 22,511,000 | 3,521,000 |
| *Subtotal, GDM only* | *$13,160,000* | *$14,792,000* | *$17,698,000* | *$2,906,000* |
| Totals: | | | | |
| GDM | 27,912,000 | 30,041,000 | 34,548,000 | 4,507,000 |
| OGC | 7,498,000 | 7,771,000 | 7,938,000 | 167,000 |
| OPHS | 13,145,000 | 13,841,000 | 14,849,000 | 1,008,000 |
| IGA | 606,000 | 647,000 | 647,000 | 0 |
| DAB | 336,000 | 350,000 | 500,000 | 150,000 |
| Total | $49,497,000 | $52,650,000 | $58,482,000 | $5,832,000 |

Statement of the Budget Request

The FY 2008 budget for GDM Rent and Common Expenses is $34,548,000, an increase of $4,507,000 over the FY 2007 Continuing Resolution (CR) level. These funds are to cover centralized payments for Rent/ Operations and Maintenance (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.

Program Description

**Rent/O&M and Related Services**

*Rental payments (Rent)* to the General Services Administration (GSA) include funds to cover the rental costs of office space, non-office space, and parking facilities in GSA-controlled buildings. *O&M* (formerly known as Delegated Authority) includes funds to cover the operation, maintenance and repair of buildings for which management authority has been delegated to HHS by GSA; this includes the HHS headquarters, the Hubert H. Humphrey Building. (Note: All Rent amounts are shown in object class 23.1, Rental Payments to GSA; however, O&M amounts are spread across other object classes.) *Related Services* include funds to cover all non-Rent activities in GSA-controlled buildings (e.g., housekeeping, guard services, other security, and building repairs and renovations).

The Office of Facilities Management and Policy (OFMP), in the Office of the Assistant Secretary for Administration and Management, administers both Rent/O&M and Related Services funds for all headquarters facilities occupied by the Office of the Secretary. OFMP also monitors the amount and type of space occupied by each STAFFDIV, and coordinates efforts to achieve the most efficient use of space, while maintaining a quality work environment.

Over the past several years, HHS has completed a number of Humphrey Building improvement projects aimed at enhancing the functionality and physical appearance of the building. These have included traffic and security changes to the Third Street and Independence Avenue entrances to the building, creation of a security-oriented guard's desk in the Great Hall, and installation of glass fragmentation film on all the windows.

**Common Expenses/ 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 telecommunications (e.g., FTS and commercial telephone expenses), Worker's Compensation, postage, printing, Unemployment Insurance, records storage at the National Archives, radio spectrum management services, Federal employment information and services, and the Federal Laboratory Consortium. Payments to the Service and Supply Fund (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, including personnel and payroll services, finance and accounting activities, computer services, reprographics and electronic communication services (e.g., voice-mail and data networking).

## Rationale for the Budget Request

The FY 2008 budget request for GDM Rent/O&M and Related Services and Common Expenses/ SSF Payment is $34,548,000, an increase of $4,507,000 over the FY 2007 CR level.

The Department has long stressed the importance of providing a quality work environment for its employees – an environment that is safe, clean, healthy and meets their job-related needs. The total FY 2008 budget request for GDM Rent/ Building Operations is $16,850,000, an increase of $1,601,000 (10.5%) above the FY 2007 CR level – but the minimum amount required to maintain current services in the Southwest DC Complex. Mandatory costs are rising dramatically, as the result of several factors described below.

- *Rent* – Costs per square foot for GDM space are expected to increase by $1,035,000 in FY 2008, due to increases in GSA's Shell Rent Rates.

- *Building Operations* – Increases in the price of steam supplied from a GSA central steam plant (driven by increases in the cost of natural gas and transportation) and in electricity costs from Pepco (due to higher fuel and transportation costs) are increasing the utility costs in the Southwest DC Complex. Updated wage determinations under the Commercial Facilities Maintenance and Security service contracts are also increasing the costs. A budget increase of $350,000 is required to cover these cost increases.

- *Building Management* – Increases are also being driven by new requirements resulting from the events of September 11, 2001. These include a demand for higher quality guard services, whose costs will continue to increase automatically with each annual contract renewal. GSA has also implemented a number of new security provisions in all Federal buildings, which are reflected in increased rent costs. Mandatory secrity charges from the Department of Homeland Security have also increased. Finally, physical changes to delegated buildings are also required. An aerosol release study is currently being conducted by NIOSH; the results of the study will result in a list of deficiencies that OFMP must correct. In addition, the Homeland Security Presidential Directive #12 (HSPD-12) initiative requires OFMP to purchase new ID badges for all HHS tenants in the SW Complex. This budget request includes $216,000 for mandatory compliance.

If required to operate under a lower budget level, building operations, maintenance and security services would have to be reduced. Examples include: the closure of select entrances to the property, delayed responses to repair building equipment, and reduced daily building operating hours.

The increase in the Common Expenses and SSF Payment is attributable to projected inflation rates, and additional services to be provided by the SSF. (Also see the SSF section of this DM submission.)

## Performance Analysis

*Building Management* – OFMP has committed to a high level of performance in the management of the HHH Building, by ensuring that all requests for building services are acknowledged on the day received and that corrective action is taken within 72 hours. Effective response time is an indicator of the quality of service, which in turn affects employee morale and productivity.

In FY 2001 through FY 2007, all performance targets in this area were achieved. OFMP's current practices and procedures adhere to GSA guidelines that building services complaints be responded to within 72 hours of receipt. To verify performance, an independent analysis of computer-generated data from the CFM contractor's service call system is regularly performed. In order to ensure accuracy, individual work orders (issued as a result of estimates for service) are manually pulled on a random and periodic basis, and performance verified. These reviews have consistently supported the automated reports.

# UNIFIED FINANCIAL MANAGEMENT SYSTEM
(GDM Payment Only)

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget | $3,530,000 | $2,614,000 | $1,687,000 | $-927,000 |
| FTE | – | – | – | – |

## Statement of the Budget Request

GDM requests a total of $1,687,000 to support the Unified Financial Management System (UFMS) – including the new HHS Consolidated Acquisition System (HCAS) – in FY 2008.

## Program Description

The UFMS is being implemented by HHS to replace five legacy accounting systems currently used by the OPDIVs. The UFMS will integrate the Department's financial management structure, and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the OPDIVs, allowing HHS management to substantially reduce the cost of providing accounting service throughout the Department. Similarly, by generating timely, reliable and consistent financial information, UFMS will enable the OPDIVs and program administrators to make more timely and informed decisions regarding their operations.

The UFMS activities are overseen by the UFMS Program Management Office (PMO), located in the Office of the Assistant Secretary for Resources and Technology (ASRT). The PMO is headed by the UFMS Program Director, and manages UFMS's day-to-day program operations and activities – including oversight and execution of all UFMS program funds, within the guidance and direction of ASBTF and two governing bodies: the UFMS Steering Committee, and the UFMS Planning and Development Committee.

The Department launched the UFMS program in late FY 2001, and the UFMS Implementation Plan was approved by the Department in September 2002. The UFMS was fully deployed for the first time in April 2005 at the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). New functionality releases were subsequently implemented for Grants and IVR in October 2005, and for e-Travel in April 2006. The UFMS implementation at all OPDIVs serviced by the Program Support Center (PSC), except the Indian Health Service (IHS), occurred on October 16, 2006. IHS implementation is currently scheduled for October 2007.

## Performance Analysis

Please see the UFMS goals and descriptions on pages 56-58, under the ASRT Detailed Performance Analysis.

Rationale for the Budget Request

The FY 2008 GDM payment to UFMS is projected at $1,687,000, a decrease of -$927,000 from the FY 2007 payment. (NOTE: An additional $400,000 for the staff costs of the PMO is included in the ASRT budget.) This total is composed of three parts: Operations and Maintenance, Administrative Systems Integration, and HCAS. (Initial UFMS Project Development costs will end in FY 2007.)

With the implementation of UFMS at two OPDIVs in FY 2005, UFMS funding needs expanded from development-only to **Operations and Maintenance (O&M)** activities. The scope of O&M services, which are provided by the PSC, include post-deployment support and on-going business operation and technical services. *Post-deployment services* include supplemental functional support, training, change management and technical help-desk services. *On-going business operation services* include core functional support, training and communications, and help-desk services. *On-going technical services* include the operations and maintenance of the UFMS production and development environments, on-going development support, and backup and disaster recovery services. In addition, in accordance with Federal and HHS policy, the designated Certifying Authority and Designated Approving Authority approved the UFMS application to operate through October 2007. Thereafter, when all OPDIVs will be operational on UFMS, a three-year certification will be completed. Such an approval to operate assures that the necessary security controls have been properly reviewed and tested, as required by the Federal Information Security Management Act (FISMA). GDM requests $1,392,000 to support O&M efforts in FY 2008.

With the implementation of a modern accounting system, HHS must also consolidate and implement the automated administrative systems which share information electronically with UFMS. Therefore, in FY 2007 UFMS begins a separate budget line item for **Administrative Systems Integration (ASI)**, to fund the integration of such systems and ensure that only one set of integration points per system is prepared. These systems will improve the business process flow within the Department, improve funds control, and provide a state-of-the-art financial management system encompassing finance, budget, acquisition, travel and property. As the UFMS project nears completion, the integration of administrative systems is the next step in making these processes more efficient and effective. GDM requests $136,000 to support ASI efforts in FY 2008.

The **HHS Consolidated Acquisition System (HCAS)** initiative is a new Department-wide contract management system that will integrate with UFMS, beginning in FY 2008. The applications within HCAS are Compusearch PRISM and a portion of the Oracle Compusearch Interface (OCI). PRISM is a Federalized contract management system that helps streamline the procurement process. The implementation of PRISM will include the functionality of contract writing, simplified acquisitions, electronic approvals and routing, pre-award tracking, contract monitoring, post-award tracking, contract closeout and reporting. Major functions will include the transfer of iProcurement requisitions for commitment accounting and funds verification to PRISM, and transmission of award obligations from PRISM to Oracle Financials.

Both the Department and the individual OPDIVs and STAFFDIVs will realize the following benefits once HCAS is fully implemented and integrated with UFMS:

- Commitment accounting
- Integration with other HHS administrative systems

- Decreased operational costs
- Increased efficiency and productivity
- Improved decision-making – unified systems
  - Data integrity
  - Reporting
  - Performance measurement
  - Financial accountability
- Standardization
  - Business processes
  - Information Technology
- Consistent customer service levels
- Personnel efforts refocused on value-added tasks
- Knowledge sharing
- System-enabled work
  - HHS acquisition personnel – contracting
  - Customers in requirement preparation – requisitioning
- Organizational drivers and goals will be met (e.g., President's Management Agenda, "One HHS," OMB Line of Business)

The HCAS team is working closely with both the UFMS PMO and the HHS PMO to ensure a smooth rollout of PRISM and iProcurement. An integrated team, including personnel from UFMS, Acquisition and Assets, has been formed to ensure maximum utilization of in-house expertise. GDM requests $159,000 to support HCAS efforts in FY 2008.

# OFFICE OF THE SECRETARY

## UFMS PAYMENTS
INCLUDING HCAS IN FY 2008

| | FY 2006 Actuals | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| GDM 1/ | $3,530,000 | $2,614,000 | $1,687,000 | $-927,000 |
| ASPR (PHSSEF) | 209,000 | 178,000 | 126,000 | -52,000 |
| OMHA | 489,000 | 381,000 | 334,000 | -47,000 |
| ONC | 107,000 | 83,000 | 35,000 | -48,000 |
| OIG | 2,178,000 | 1,518,000 | 1,067,000 | -451,000 |
| OCR | 249,000 | 172,000 | 129,000 | -43,000 |
| SSF | 21,000 | 0 | 19,000 | 19,000 |
| TOTAL, OS 1/ | $6,783,000 | $4,946,000 | $3,397,000 | $-1,549,000 |

1/ Excludes costs for the UFMS Program Management Office, which are reflected in the ASRT budget.

# HIV/AIDS IN MINORITY COMMUNITIES

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $51,855,000 | $51,891,000 | $51,891,000 | -- |
| FTE | -- | -- | -- | -- |

## Statement of the Budget Request

The FY 2008 Budget for the HIV/AIDS in Minority Communities initiative – also known as the Minority AIDS Initiative (MAI) – is $51,891,000, the same as the FY 2007 comparable CR level.

## Program Description

In 1999, the Congressional Black Caucus initiated a partnership with HHS to significantly increase the national response to the HIV/AIDS epidemic in racial and ethnic minority communities. The disproportional impact of this epidemic on these populations warranted a new HIV/AIDS campaign. The partnership identified the following issues as priorities:

- Developinng, monitoring, and exercising compliance oversight of HHS regulations for the protection of human subjects who are involved in research conducted or supported by any HHS component;
- 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 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 must be maintained to 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. These targeted investments have been successful in identifying and addressing key barriers to allowing the Department's programs to effectively reach and serve communities of color.

Funds received by the Office of the Secretary for the MAI are disbursed to the Public Health Service agencies in HHS, who then award the funds through grants and/or contracts to support hundreds of organizations across the country.

## Rationale for the Budget Request

The FY 2008 planning level is $51,891,000, the same as the FY 2007 comparable CR level. At this funding level, the same level if funding will be available to be disbursed to agencies to

respond to the HIV/AIDS epidemic in minority communities.

Performance Analysis

| Performance Goals | Results | Context |
|---|---|---|
| The Minority AIDS Initiative continues to enable HHS to increase the access of racial and ethnic minority communities to HIV/AIDS prevention, care, treatment and research. In the next 12 months, the MAI will embark upon two major projects, African American women in the South project and the African American MSM initiative. | The CDC has released surveillance and epidemiological reports and data that indicate that HIV infection of African American women living in the South is out-pacing other regions of the country. The rate and incidence of HIV infections and new AIDS cases among African American MSMs is also occurring at an alarming rate.. Therefore, two new initiatives will be developed to reduce new infections and to ensure that HIV positive persons have complete access to care and treatment services. | The two new initiatives will establish an HHS integrated strategy for positioning prevention and treatment for a more effective means of assessing and evaluating programs and activities targeting these populations. This will enable HHS to better understand the impact of the Federal investment to these populations and to determine what further actions are necessary to abate or significantly reduce any negative outcomes of this effort. |

Performance Narrative

Following are examples of programs that have been funded with these MAI resources.

**Capacity Development in Rural and Moderate Incidence Areas**. This initiative represents a commitment by the Department to address the need for capacity development and technical assistance for minority populations affected by HIV/AIDS outside of the highest incidence urban areas. There are significant pockets of HIV disease in second-tier cities with populations of less than 100,000 or 250,000, as well as in more rural areas in the southeastern and mid-western US While the Department's immediate focus is on the highest incidence cities, this could be expanded to address similar needs in lower population areas where minorities are disproportionately affected by HIV/AIDS.

The Department has expanded efforts to provide technical assistance to highly depressed rural communities. There is a need to increase the number of health officials and to open additional primary health care centers in rural communities. Planning is underway to develop an infrastructure in these communities. The HIV/AIDS epidemic in minority populations in rural areas is particularly acute, in settings that are often under served and resource poor, this intervention can help before the HIV/AIDS incidence increases to the first tier levels.

**Technical Assistance and Training Activities**. MAI funds are being used to expand technical assistance and capacity building activities for organizations serving racial and ethnical minorities disproportionately impacted by HIV/AIDS. Recently, training centers from the Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), and Office of Population Affairs (OPA) have formed a formal partnership which supports collaborations 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 treating HIV, as well as aiding HHS in activities which promote and support the Department's policy, "Advancing HIV Prevention." This policy has a four-part focus:

- incorporation of routine HIV prevention interventions in all clinical settings;
- integration of prevention intervention supporting HIV-positive individuals as a routine part of care;
- promotion of voluntary HIV testing of all pregnant women; and
- promotion of aggressive use of rapid HIV testing technology in both clinical and non-traditional settings.

**Assessment and Accountability.** The Office of HIV/AIDS Policy in OPHS has begun the development of a Data Retrieval System which will capture data related to all grants, cooperative agreements and other contracted activities related to the delivery of HIV/AIDS prevention, care and treatment services. This data system will be built in three phases:

- integrating data from all HHS portfolios related to directly funded programs and activities;
- establishing linkages with States and territorial jurisdictions which have received Federal funds, for inclusion of their Federal-funded programs and activities; and
- building the capacity to integrate and cross-reference biological and behavioral research linked to HIV/AIDS prevention, care and treatment services and activities.

**Prevention.** Since the inception of the HIV/AIDS epidemic, CDC has been the sole purveyor of HIV testing services. However, over the past five years there has been a move to expand HIV testing services beyond the clinical and laboratory settings. Satellite service sites and mobile health vans have provided new access into difficult to reach communities and population groups. Unfortunately, these strategies often lack the clinical structure to adequately meet the HIV testing needs of many communities. These strategies impose challenges related to confidentially and privacy. In 2002, OraSure introduced the OraQuick® Rapid HIV-1 Antibody Test – the first FDA-approved and CLIA-waived rapid point-of-care test – to aid in the diagnosis of infection with HIV-1, using a finger stick and venipuncture whole blood specimen. In 2004, OraSure launched the OraQuick® ADVANCE™ HIV-1/2 Antibody Test – the first oral fluid rapid HIV test and the only FDA-approved test which can be used on oral fluid, plasma, finger stick and venipuncture whole blood specimens. This technology has allowed public health officials to conduct HIV testing in both clinical and non-traditional settings. OPA, through its Family Planning Clinics, is now providing rapid HIV testing as part of its HIV prevention services. Rapid HIV testing is also now being provided in many SAMHSA-funded/ State-run and private-sector facilities and institutions that provide substance abuse prevention treatment.

**Outreach and Partnership Building.** An integral part of OPHS's 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. Towards this end, several efforts are underway which have facilitated the creation of new partnerships and initiatives. At the national level, dialogues with the Salvation Army and the US Congress of Catholic Bishops have resulted in these faith-based organizations adopting HIV awareness, education and/or prevention activities which target their employees,

clients and members. Concurrently, the HHS Regional Offices have reached hundreds of leaders, faith and community-based groups 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.

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

| Agency | FY 2001 | FY 2002 | FY 2003 | FY 2004 | FY2005 | FY 2006 | FY 2007[1] | FY 2008[1] |
|---|---|---|---|---|---|---|---|---|
| CDC | $16,250 | $15,641 | $15,641 | $10,500 | $9,850 | $8,500 | | |
| SAMHSA | 11,500 | 12,000 | 12,000 | 11,000 | 11,345 | 9,500 | | |
| HRSA | 6,100 | 6,200 | 5,600 | 6,900 | 8,205 | 8,637 | | |
| NIH | — | — | — | — | — | — | | |
| IHS | 1,100 | 1,450 | 1,450 | 1,500 | 2,096 | 1,963 | | |
| OS | 15,050 | 14,700 | 13,363 | 18,554 | 19,661 | 22,090 | | |
| *OPHS:* | | | | | | | | |
| *OHAP* | *3,420* | *3,200* | *1,863* | *2,914* | *2,956* | *6,335* | | |
| *OMH* | *7,800* | *7,900* | *7,900* | *8,000* | *7,650* | *7,000* | | |
| *OPA* | *3,000* | *3,000* | *3,000* | *6,000* | *6,000* | *6,100* | | |
| *OWH* | *500* | *600* | *600* | *1,640* | *3,055* | *2,655* | | |
| *ASPE* | *330* | — | — | — | — | — | | |
| Eval Set-aside | — | — | 1,021 | 1,090 | 1,258 | 1,165 | | |
| **TOTAL** | **$50,000** | **$49,991** | **$49,075** | **$49,544** | **$52,415** | **$51,855** | **$51,891** | **$51,891** |

1/ Allocation to be determined.

# PHS EVALUATION SET-ASIDE

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | | | | |
| *ASPE (GDM)* | $6,726,000 | $6,726,000 | $0 | -$6,726,000 |
| | | | | |
| Reimbursbale Authority | $39,552,000 | $39,552,000 | $46,756,000 | +$7,204,000 |
| *ASPE* | *$34,500,000* | *$34,500,000* | *$41,604,000* | *+$7,104,000* |
| *OPHS* | *$4,552,000* | *$4,552,000* | *$4,552,000* | – |
| *ASRT* | *$500,000* | *$500,000* | *$600,000* | *+$100,000* |
| FTE *(ASPE only)* | *108* | *108* | *108* | – |

Statement of the Budget Request

The FY 2008 request for GDM's Public Health Service (PHS) Evaluation Set-Aside funds is $46,756,000, an increase of $7,204,000 above the comparable FY 2007 Continuing Resolution (CR) level. The FY 2008 amount reflects the transfer of funding for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) from the GDM appropriation; all funding for ASPE operations will now be centralized in PHS Evaluation funds.

Program Description

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

**Assistant Secretary for Planning and Evaluation (ASPE)**

ASPE examines broad issues that cut across agency and subject lines, as well as new policy approaches that are developed outside existing programs. It has three overarching goals:

- Provide policy-relevant information on national trends in public and private health and human service programs;
- Analyze the potential government and private sector costs and benefits of proposed public sector policy changes to these programs; and
- Identify emerging policy issues and potential solutions.

The need for coordinated, objective, and high-quality policy research, data collection, analysis and evaluation continues to be especially important in light of the dramatic changes occurring in health care and human services, and in the characteristics of the populations served by HHS.

Policy evaluation focuses on the following areas:

**Health Policy** – Health Policy research includes health care financing and public health issues. In FY 2008, the Office of Health Policy will dedicate its research efforts to supporting several priorities identified by the Secretary, including continuing to support implementation of the Medicare Prescription Drug benefit, evaluate and refine provisions of the Medicare Modernization Act of 2003 (MMA) that were implemented previously, and strengthen the Medicare program. The Office of Health Policy will also continue to develop new options for providing health insurance for the uninsured, and evaluate effective methods of disease prevention and health promotion. In addition, ASPE will continue ongoing research and policy development activities on behalf of the Secretary as required.

**Human Services Policy** – Human Services Policy research focuses on low-income and other vulnerable populations, including families, children, youth and homeless individuals. In FY 2008, the Office of Human Services Policy will focus its research efforts on priorities articulated in the Secretary's 500-Day Plan and his 250-Day Update, including protecting life and human dignity by promoting economic self-sufficiency among families receiving welfare through enhanced work requirements and supports, healthy marriage education, and fatherhood initiatives; promoting children's safety and stability by streamlining the foster care system and removing barriers to foster care services and placements; helping parents and families understand the importance of a stimulating environment and cognitive development in the earliest years of life; strengthening Head Start and child care; supporting the First Lady's initiative on Helping America's Youth; and expanding choices for individuals in federal programs by increasing participation of faith-based and community groups. The Office of Human Services Policy also will emphasize healthy living and prevention of risky behaviors, through research focused on the incidences and consequences of unintended pregnancies especially among unmarried adolescents.

**Disability, Aging, and Long-Term Care Policy (DALTCP)** – DALTCP research and analysis will continue to address the health care and long-term support needs of individuals with chronic illness and disability in both institutional and community-based settings. A major theme of DALTCP is the production of information which can be used by policymakers at the federal, state, and community level, as well as providers and consumers, to increase the availability and affordability of an array of high-quality long-term care services and reduce barriers to consumer choice and independence. This portfolio addresses active aging, financing, system design, service delivery, quality, staffing and coverage issues.

**Science and Data Policy** – Science and Data Policy research and analysis is designed to ensure policy research and analyses in support of a wide range of science policy and data policy issues within HHS. Research activities promote the availability of high quality data, information and analytical resources for policy formulation and decision making, address critical information gaps in science policy and data policy in a coordinated fashion, support departmental and interagency policy development, and enhance HHS research and analytical capabilities.

**Research Coordination** – ASPE has also taken a lead role in ensuring that the Department's investment in health and health services research supports the Secretary's research priorities in the most efficient and effective manner. ASPE senior staff work with other OS components to develop the basic framework of the Department's research priorities and themes that serve to organize agency research budget submissions for FY 2008. This process aims to ensure that agency research efforts are consistent with Secretarial and Departmental priorities and do not duplicate effort. ASPE continues to work to achieve efficient leveraging of the Department's health and health services research portfolio by identifying areas where efficiencies could be

achieved through collaboration, and by identifying better ways to translate the findings of Department-sponsored research into practice.

**ASPE Research and Evaluation Program** – ASPE's research and evaluation program, authorized by section 241 of the US Public Health Service Act, has a significant impact on the improvement of policies, programs and services of the department through the systematic collection of information on program performance. Evaluation set-aside funds are primarily utilized to: (1) gauge program effectiveness, (2) improve performance measurement, (3) perform environmental assessments, and (4) provide program management authorized under the Act. ASPE research and evaluation activities include:

- Continuing evaluation and analytical efforts in risk assessment, risk management, and risk communication, regulatory science, and the impact of biomedical investment and related issues in science and technology policy.

- In support of the Value-Driven Health Care Initiative, ASPE will conduct a number of projects, including assessing ongoing public and private initiatives to collect and publish meaningful price/quality information and analyzing local area health markets to better understand health care costs and quality transparency issues.

- Funding ongoing and new efforts to promote active aging, by increasing the proportion of older Americans who stay active and healthy, including those who provide informal care to friends and family members.

- Continuing evaluation and analytical efforts in issues related to national vaccine policy, food, drug, and medical product safety, and national prescription drug policy including pharmaceutical economic, drug cost, and utilization studies, international drug studies, and pharmaceutical research and development issues.

- Continuing evaluations, analyses, and policy research to support efforts to plan and prepare for public health threats from bioterrorism, natural disasters, and a potential disease pandemic.

- Continuing evaluation and development efforts in chronic disease prevention and health promotion. ASPE will continue to provide support for the Secretary's *STEPS to a HealthierUS* chronic disease prevention and health promotion activities and will continue to provide support for the Secretary’s other obesity related initiatives.

- Continuing evaluation efforts of critical public health initiatives and issues including the effectiveness of mental health and substance abuse programs and policy including studies that investigate the state of the mental health workforce and how it can be bolstered.

- Supporting ASPE evaluation efforts for improving the effectiveness and efficiency of the health system through the accelerated adoption of information technology. ASPE will continue evaluation activities in support of the President's and the Secretary's priority to accelerate the development and use of information technology in health care, long-term care and public health.

- Supporting ASPE crosscutting evaluation and analytical efforts to improve data and information for decision making in health and human services, including creating and

improving critical data bases, addressing critical policy information gaps in a coordinated fashion, improving the utility of core HHS data and statistical systems for policy research through integration, data standards and data access, and improving the quality of health and human services administrative data.

- Continuing research and evaluation on abstinence education programs that complement the work to rigorously evaluate the community-based abstinence education program and other teen pregnancy prevention efforts that ASPE manages but is funded separately. Also continuing evaluation of critical research to collect data on both asset- (positive) and risk-based adolescent behaviors.

- Continuing research on understanding of the effects of family formation and healthy marriage and responsible fatherhood in protecting family interests, the well-being of children and public health. ASPE also will evaluate programs for incarcerated and re-entering fathers and their partners funded through ACF's Responsible Fatherhood, Marriage and Family Strengthening grants.

- Continuing evaluations in critical areas of child well-being and early childhood development, including measuring and documenting indicators of child learning and health and well-being and improvements in child outcomes.

- Continuing leadership through strategic planning, research and policy development activities to implement an agenda to end chronic homelessness and address family homelessness. ASPE will continue to fund research and evaluations, take a lead on identifying key policy issues, and serve as the Department's coordinating body for activities and programs of the U.S. Interagency Council on Homelessness and the Secretary's Workgroup on Ending Homelessness.

- Continuing research on poverty, low-income populations and government policies that foster self-reliance and reward work, including welfare reform and child support enforcement. ASPE also will continue research, evaluation and analytical efforts on policies to enhance the economic well-being of low-income families and their children, including improved strategies for supporting working families and helping the hard to employ, and improved data on transitions to self-sufficiency among low-wage workers.

- Supporting Department-wide efforts to improve emergency preparedness, including assisting in the design and development of a steamlined human services enrollment and benefit delivery system for future disasters.

- Supporting the capacities of low-income families for ownership through evaluation and analytical efforts to improve data on assets and financial practices of low-income families, the institutions with which they interact, the effects of means-tested policies, and the effectiveness of program interventions.

- Developing and analyzing policy options and data sources for measuring and reducing racial and ethnic health disparities in health and human services, including methodologies for assessing special populations.

- Continuing to provide a leadership role on the HIV/AIDS Program Coordination Team in examining the Department's HIV/AIDS programs for opportunities in cross-department

collaboration to ensure efficiency and effectiveness.

- Continuing to work with the Department of State on the implementation of the President's Emergency Plan.

*Strengthening and Modernizing the Medicare Program*

- Working with the Centers for Medicare and Medicaid Services (CMS) to improve choices for Medicare beneficiaries under the MMA's Medicare Advantage (MA) and Prescription Drug Benefit provisions.

- Working with the FDA to evaluate pharmaceutical therapeutic class definitions currently used in the private sector in order to inform plans development of formularies under the new Medicare Part D prescription drug benefit. Separately, ASPE will also study the markets offering prescription drug plans, Medicare drug card pharmaceutical pricing, and beneficiary participation in Part D.

- Analyzing Graduate Medical Education (GME) payments to understand what educational costs Medicare pays for, alternative methods of financing GME, and GME's influence on the make-up of the physician workforce.

- Working to improve the quality of health care by evaluating the Medicare Quality Improvement Organizations' evaluation methodology, investigating health care marketplace competition, and researching the effects of health care spending on the economy.

- Conducting analysis toward refining and improving Medicare's payment systems under the traditional fee-for-service program, including refining certain aspects of Medicare's prospective payment systems for hospital outpatient services and for home health care, as well as payment for physician services.

- Conducting analyses of pay for performance programs in the public and private sectors and analyzing options for the Medicare program.

- Conducting qualitative and quantitative analysis, coordinating cross-cutting health policy issues, and assuring their integration into the regulatory processes, legislative proposals and other policy support activities required by the Secretary.

*Increasing Access to Health and Long-Term Care Services*

- ASPE will continue to conduct detailed analysis of the population without health insurance to help construct policies aimed at most efficient approaches to expand coverage options and will develop research on the best ways to pool individuals so as to effectively spread insurance risk and help lower the cost of health insurance. In addition, ASPE will continue the ongoing analysis of the Medicaid undercount in the Current Population Survey, examining the various methodologies for correcting the undercount in an effort to improve survey measurement techniques and ensure use of the most accurate data on the size and characteristics of the uninsured.

- ASPE will continue to research, develop and analyze policy options to improve the quality of health care for all Americans.

- ASPE will continue its ongoing research efforts to study, analyze, and evaluate consumer driven options for organizing, delivering and financing home and community-based support for people who use long-term care services. Work under this theme will include continuation studies of the national Cash and Counseling demonstration, as well as supporting technical assistance and evaluation funds for the new Cash and Counseling expansion into eleven additional states. ASPE's research in the area of community based supports will include additional work on adult day services, an important component of consumer and family-responsive community care.

- The budget will support ASPE research and demonstration activities to study and promote quality in the delivery of nursing home services. Studies will address a range of quality initiatives already underway, staffing activities, and continued analyses of nursing home litigation and the role of physicians in nursing homes.

- ASPE will conduct research to gain insight into how consumers and case managers select nursing homes, what information they use and how they access it.

- In FY 2008, ASPE will work with AoA, AHRQ, NIA, NCHS and other partners to continue design work and planning for a nationally-representative survey of out-of-home residential services for older individuals with some need for assistance with daily living. This survey will go beyond facilities commonly known as "assisted living" to include an array of facility types.

- FY 2008 funding will support new and ongoing research activities to address the recruitment and retention of a qualified, stable frontline workforce to provide long-term supports in institutional and community settings, including strengthening the basic data infrastructure. Research conducted under this priority area will include collaborative efforts with other HHS agencies as well as other Departments within the Administration.

- The budget will support ASPE research efforts to develop and analyze policy options and identify barriers, with the goal of expanding long-term care planning opportunities for individuals. Consistent with the Deficit Reduction Act (DRA), additional work will be undertaken in up to ten additional states, in collaboration with HHS partners, to enhance long-term care awareness and education among consumers. In addition, ASPE will provide leadership for the implementation of the Long-Term Care Partnership provisions of the DRA.

- Funding in FY 2008 will support the design and testing of a nationally representative survey of non-nursing home residential settings for long-term care users. The information collected for this survey will support a range of policy activity that will be undertaken to address the aging of the baby boomers.

- The FY 2008 budget will support Congressionally-requested ASPE research on advance directives and hospice services, to provide policymakers with sound information on death and dying related issues, and to advance medical research and science.

*Preventing Disease/Illness*

- Funding will provide for ongoing and new efforts to promote active aging, by increasing the proportion of older Americans who stay active and healthy, including those who provide informal care to friends and family members.

- The FY 2008 budget will support ASPE continuing policy research and analytical efforts in issues related to national vaccine policy, food, drug and medical product safety, and national prescription drug policy including pharmaceutical economic, drug cost and utilization studies, international studies, and pharmaceutical research and development.

- ASPE will continue policy research and development efforts in chronic disease prevention and health promotion. ASPE will continue to provide support for the Secretary's *STEPS to a HealthierUS* chronic disease prevention and health promotion activities.

- ASPE will continue policy research and development efforts in critical public health issues such as mental health and substance abuse.

- ASPE will begin implementation of a demonstration project aimed at preventing falls in the elderly; falls are a significant risk and frequently result in the need for ongoing health and long-term care services, at great personal and societal cost.

*Accelerating the Adoption of Information Technology in Health Care*

- The FY 2008 budget will support ASPE policy research efforts for improving the effectiveness and efficiency of the health system through the accelerated adoption of information technology. ASPE will continue policy research and evaluation activities in support of the President's and the Secretary's priority to accelerate the development and use of information technology in health care and public health.

- ASPE will support implementation of the Secretary's overall goal of accelerating the development and use of an electronic health information infrastructure, with a focus on improving the tools for communicating patient information during transitions from hospitals to nursing homes and post-acute care settings.

- The FY 2008 budget will support ASPE's research to develop a business case for using information technology in long-term care settings.

- The budget will support ASPE crosscutting research and analytical efforts to improve data and information for decision making in health and human services, including creating and improving critical data bases in health and human services, addressing critical policy information gaps in a coordinated fashion, improving the utility of core HHS data and statistical systems for policy research through integration, data standards and data access, and improving the quality of health and human services administrative data.

*Improving Child, Family and Community Well-Being*

- ASPE will continue to address changing family structure issues through research in

support of healthy two-parent married families to improve economic self-sufficiency, family stability, child well-being and public health. ASPE will build on its past extensive work with the goal of developing sound policies on family formation and healthy marriages. This will include studying family strengths associated with marriage, particularly the contributions of fathers, building a baseline of potential users of healthy marriage services, examining the successes and challenges of providing healthy marriage services to incarcerated individuals and their partners, evaluating grants funded through the Responsible Fatherhood grant program, and increasing our knowledge of the long-term health consequences of childhood family structure.

- The FY 2008 budget will support research to understand and address economic trends and forces, with a view toward reducing the number of people living in poverty, particularly children in working families. ASPE will examine ways to promote the economic self-sufficiency and well-being of vulnerable families, children and individuals by continuing research on policies and programs that enhance self-sufficiency, including promoting financial literacy and asset accumulation in the low-income population, evaluating programs designed to enhance employment outcomes for low-income parents who face serious obstacles to steady work, continuing research on the causes, consequences and remedies of poverty, and examining and improving the methodologies for analyzing and modeling poverty and the effectiveness of tax, transfer and programs serving the poor. Part of this research will be carried out through the Poverty Research Centers, which recruit, mentor, and train young poverty scholars and researchers.

- ASPE will continue research and evaluation activities designed to improve the safety, stability and healthy development of children and youth. ASPE will examine programs and policies that affect foster and adoptive home supply and assess child welfare privatization efforts. Research also will examine ways to improve permanency planning for at-risk children, promote healthy youth development and improve child well-being through program interventions.

- ASPE also will continue to take a leadership role in developing a research and evaluation portfolio on homelessness and coordinating the Department's efforts to implement the agenda to translate existing research findings into more effective program strategies for providers and practitioners who deal with homeless populations. Activities will include continuing work related to ending chronic homelessness, including evaluating the joint HUD/HHS/VA Collaboration Initiative, studying homeless families, individuals and homeless families that include veterans and youth aging out of foster care who are at high risk for homelessness, and developing strategies to assist policymakers and providers in their efforts to improve programs and services for homeless persons. Another priority area is research on children who have been abused and neglected and become part of the child welfare system, and whose safety and health is of utmost importance.

*Reducing Health Disparities*

- ASPE will continue to research, develop and analyze policy options to reduce racial and ethnic health differences. The FY 2008 budget will support ASPE research and data policy efforts to develop and analyze policy options and data sources for measuring and reducing racial and ethnic health disparities in health and human services, including methodologies for assessing special populations.

- ASPE will continue to explore policy options for increasing access to high quality cost-effective health care for American Indians/Alaska Natives to address continuing health disparities.

- ASPE will continue its leadership role in the Ryan White CARE Act (RWCA) reauthorization preparations through the RWCA Working Group and working directly with ASL. Collaborating with ASL and bipartisan leaders on Capital Hill, ASPE is developing and analyzing policy options designed to address critical issues of sufficiency, coordination and duplication.

*Expanding Opportunities for Faith-Based and Community Organizations*

- ASPE will continue to support efforts to expand faith-based and community partnerships in providing effective health and human services. This will include examining the roles, successes and challenges experienced by faith-based and community organizations in recovery efforts following Hurricanes Katrina and Rita and identifying the range of social service programs which use vouchers to deliver program services with a view toward assessing their effectiveness both in delivering needed services and expanding client choice of faith-based providers.

- ASPE will examine the barriers and related issues for Faith-Based Organizations in accessing federal grants and fully participating in HHS grant programs for which they are eligible.

- The FY 2008 budget also will support ongoing efforts to promote and expand opportunities for faith-based and community organizations and continue to support strategic planning, research and policy development activities in this area.

*Strengthening Management*

- ASPE will continue to provide the leadership role on the HIV/AIDS Program Coordination Team. Specifically, ASPE will continue to examine the Department's HIV/AIDS programs for opportunities for cross-department collaboration in ensure efficiency and effectiveness.

*Responding to Bioterrorism and other Public Health Emergencies*

- ASPE's work with the Department of State on the implementation of the President's Emergency Plan will continue.

- ASPE will continue to coordinate and carry out research and analyses to support departmental "lessons learned" activities and assessments to improve preparedness, response and recovery efforts and to develop policies and procedures for future efforts.

- ASPE will use FY 2008 funds for policy research efforts to strengthen and improve strategic planning, monitoring and evaluation for assuring adequate prevention, detection and monitoring capabilities for planning, preparing, and responding to public health threats from bioterrorism, natural disasters, and a potential disease pandemic, including the development of appropriate research data bases, methodologies and data sources.

**Office of Public Health and Science (OPHS)**

OPHS has had a fundamental role in the PHS Evaluation Set-Aside program at HHS since the program's inception. Within OPHS, the Office of Disease Prevention and Health Promotion (in conjunction with the OPHS Budget Office) coordinates the Evaluation Set-Aside Program for the Assistant Secretary for Health. Each fiscal year, OPHS offices submit proposals to utilize these funds to support comprehensive, far-reaching evaluation projects to further the mission of HHS. Decisions on the FY 2007 allocation have not yet been made, however, initiatives supported in FY 2006 include:

- Evaluating the effectiveness of institutional efforts to educate their staffs on their policies for dealing with research misconduct and research integrity;
- Evaluating and improving the responsiveness of State emergency preparedness plans to meet the needs of underserved racial and ethnic minority communities;
- Evaluating and assessing the benefits of effectively employing stages of change approaches and translate science-based interventions into practice and behavioral change among children and adolescents to improve nutrition – an evaluation of the Arkansas school BMI project;
- Evaluating Healthy People, Places and Practices in the Community – evaluating and assessing the feasibility and benefits of effectively translating science into practice and behavioral change at the regional and community level;
- FDA Health and Diet Survey: Dietary Guidelines Supplement 2006 – to assess the effectiveness of activities to inform the American public about the *2005 Dietary Guidelines for Americans*;
- An assessment of the impact of improved HHS planning and coordination and concurrent improvements in tribal coordination and cohesion of health and wellness programs on reductions in health disparities Among American Indians and Alaska Natives; and
- Implementing a cross-site evaluation of Title XX Adolescent Family Life care and demonstration projects.

**Assistant Secretary for Resources and Technology (ASRT)**

In FY 2008, $600,000 will be utilized to fund program evaluation activities within the Office of the Assistant Secretary for Resources and Technology. These funds will cover staff focused on program evaluation activities (such as PART) in the PHS agencies, and continued development and operation of an electronic performance tracking system for such programs, similar to systems used by a number of other Federal agencies.

Rationale for the Budget

The FY 2008 request for GDM's PHS Evaluation funding is $46,756,000, an increase of $7,204,000 over the FY 2007 CR level. This amount includes the shift of all ASPE budget authority into PHS Evaluation Funds. This level will allow ASPE, OPHS, and ASRT to continue a variety of independent policy research and evaluation activities and projects which

impact the improvement of HHS programs and services.

In FY 2008, $2,000,000 of ASPE's total PHS Evaluation funding will be directed towards ensuring that both the President's goal of accelerating the use of electronic health records (EHR) and the Secretary's initiative to transform health care through health information technology (HIT) are addressed in the FY 2008 research agenda. Efforts will include the economics of HIT, the business case for EHRs in different health and long-term care settings (e.g., institutional, inpatient and large and small ambulatory care settings), issues associated with the adoption of HIT in a variety of settings, factors associated with successful HIT implementations, privacy and technology issues, and outcome and impact studies.

Another key area of emphasis will be to conduct research and analysis in support of the Secretary's initiative to promote a more value-driven health care (VDHC) system, which is based on four cornerstones:

- health IT;
- measurement and publication of health care prices;
- measurement and publication of health care quality; and
- creation of positive incentives for participation in a VDHC system.

ASPE will develop and refine policies to promote and facilitate the adoption of VDHC throughout the health care system and increase the use of value-based purchasing principles in Medicare and other HHS-administered health programs.

# ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
## Detailed Performance Analysis

**Long Term Goal:** Advise and support the Secretary of Health and Human Services on policy development in health, disability, aging and long-term care, human services, and science and data.

| Annual Measure | FY | Target | Result |
|---|---|---|---|
| Provide analysis (policy research and evaluation studies) and leadership that contributes to the development of sound Department and public policy | 2008 | same as FY 07 | 2008 |
| | 2007 | same as FY 06 | 2007 |
| | 2006 | same as FY 05 | 2006 |
| | 2005 | same as FY 04 | 2005 |
| | 2004 | Demonstrate impact of policy analysis and leadership on formulation of public policy | 2004 |
| Maintain human and technological capacity to respond to planning and analytical needs of the Secretary. | 2008 | same as FY 07 | 2008 |
| | 2007 | same as FY 06 | 2007 |
| | 2006 | same as FY 05 | 2006 |
| | 2005 | same as FY 04 | 2005 |
| | 2004 | Analytic support contributes to the development of analyses for the Secretary. Hire and train staff | 2004 |
| **Data Source:** see Performance Narrative | | | |
| **Data Validation:** see Performance Narrative | | | |
| **Cross Reference:** HHS Strategic Plan and Secretary's 500-Day Plan | | | |

Performance Narrative

The following achievements describe the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) success in meeting the performance goals stated above.

Goal 1. Provide analysis (policy research and evaluation studies) and leadership that contributes to the development of sound Department and public policy.

Due to its strong analytic capacity, ASPE continued to play a major role in policy formulation as indicated by the following examples:

- Continued support of the Secretary in his role as a Medicare and Social Security Trustee through numerous research and other activities:

  -- ASPE sponsored two technical review panels to assist the Medicare Trustees in improving their forecasting methodologies. The first panel produced a report with 19 recommendations to the Trustees on how to improve their forecasting methodology for long run health spending. Many of these recommendations have been or are being implemented. The second panel endorsed an economic model developed by CMS to forecast long run health spending.

-- In 2005, to inform the decisions of the Medicare Trustees, ASPE, 1) sponsored an actuarial analysis to examine changes in the growth of health spending (and especially drug spending) among different payers (e.g., Federal, State, major private payers, et cetera) and across different parts of the country, and 2) performed in-house research on how spending on health care affects the broader U.S. economy.

-- Annually, ASPE reviews the drafts of the Medicare and the Social Security Trustee Reports to verify that the forecasting methodologies are technically sound and that the information and concepts presented are clear and concise.

- Numerous quick-turnaround policy analyses used to inform and support the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), including the new prescription drug (Part D) benefit, and the President's plan for modernizing and improving Medicaid and the State Children's Health Insurance Program (SCHIP). For example, ASPE-sponsored provided continuous monitoring and evaluation of Part D plans' customer service and pharmacist call lines; ASPE sponsored research allowed senior officials to evaluate policy options intrinsic to the definition of regions under the Medicare Advantage (MA) and prescription drug benefit plans (PDPs); ASPE also made significant contributions to the design of the risk adjustment mechanism that will adjust payments to PDPs to reflect beneficiary health status.

- ASPE played a key role in the Department's effort to monitor the implementation of Medicare Part D by providing a weekly analysis of trends in key data elements and a weekly summary of key implementation issues and events.

- Numerous quick turnaround analyses of economic and policy issues related to innovation to support the Department's role in Trade policy efforts; and economic analyses to support price transparency policy development.

- ASPE continues to lead the second generation Cash and Counseling project, in collaboration with the Robert Wood Johnson Foundation and AoA. In 2006, the project had major administrative and legislative policy impact. Findings were incorporated into CMS's new 1915(c) waiver application and template. In addition, the DRA included new opportunities for states to offer self-directed individual budget options for long-term care in the community under Medicaid state plan amendments. Finally, the new Money-Follows-the-Person grant program included in the DRA provides incentives for states to offer Cash and Counseling type approaches.

- ASPE's leadership to implement the Long-Term Care Awareness Campaign, coupled with extremely positive evaluation results in the initial six states, was a key factor in the DRA provision expanding the Campaign effort to all the states over the next five years. The campaigns to date have led to significant increases in planning activities related to long-term care such as the purchase of the long-term care insurance, with 15% increases in policies purchased in the campaign States.

- The DRA modified Medicaid law to enable the Long-Term Care Partnership to be an option in all states, based on ongoing policy research and analysis conducted by ASPE.

- ASPE is conducting research this year on MMA implementation issues, including

evaluation of the potential of competitive bidding or other efficiency / effectiveness reforms to address a potential triggering of MMA Section 801, an evaluation of the implementation of pay-for-performance in non-Medicare settings and its implications for Medicare, and a six-State study of the impact of the Part D benefit on dual eligibles with mental illness or who are substance abusers, and the States and providers who serve them.

- An in-depth evaluation of the SCHIP program in 10 States providing findings for policymakers that can be used to make improvements in a program designed to provide health care coverage to low-income, uninsured children.

- Policy analyses used in developing the President's proposal to provide new tax credits to make private health insurance more affordable for Americans who do not have employer-sponsored health insurance.

- Policy analysis and research regarding the effectiveness of Health Savings Accounts in controlling health care costs and expanding coverage to the uninsured.

- ASPE led analytical efforts to support HHS/Katrina "lessons learned" activities to improve preparation and response capabilities.

- ASPE has expanded its Katrina recovery work by serving as the Department's focal point for recovery data. Using numerous data sources, ASPE developed a pre (August 2005) and near term post (October 2005) analysis of health services infrastructure and spending in Louisiana and Mississippi; the numbers were updated weekly and sent to the President's designee at the Department of Homeland Security.

- ASPE led an interagency team effort to analyze proposals for the reauthorization of the Ryan White CARE Act and consider changes to maximize the effectiveness of CARE Act programs. The results of the analysis is being used to inform policymakers on implementation issues related to reauthorization of the CARE Act.

- ASPE implemented a Congressionally-mandated, Department-wide review of health care regulations and guidance to identify strategies for simplifying and reducing the costs of regulation while maintaining high quality care and patient protections. The findings from this examination will provide information that can be used to guide future development of health care regulations and assess their regulatory impact.

- Ongoing analysis of the Medicaid undercount in the Current Population Survey, examining the various methodologies for correcting the undercount, with the goal of improving survey measurement techniques and ensuring use of the most accurate data on the size and characteristics of the uninsured for the purposes of informing policy development.

- ASPE's evaluation of a demonstration to reduce the incidence of falls among the elderly living at home in the community will assist policy makers seeking cost-effective interventions to promote health and well being in the community.

- ASPE's studies of informal care givers (including international descriptive work and the funding and analysis of a supplement to the National Long-Term Care Survey continue to

support program and policy activities related to the implementation of the National Family Care giver Support Initiative.

- ASPE supported the analysis of its new, nationally representative survey of the paraprofessional long-term care workforce in nursing homes—the first time such a study has been undertaken.

- As a result of ASPE-funded research examining the Texas Money Follows the Person Initiative (Rider 37), the State Department of Human Services moved to make this a permanent program rather than one only tied to the bi-ennial appropriations bill.

- ASPE supported research into physician discipline and oversight activities has generated and maintains a one of a kind administrative data set that HHS and other policy makers are using to improve the utility, quality and timeliness of State Medical Board information reporting.

- ASPE’s research on community alternatives for children with severe mental illness will support the implementation of a new DRA authorized demonstration to offer community alternatives to this population.

- ASPE funded the development of TechForLTC.org website; it is the first and only source of comprehensive information on available technologies for use in long-term care settings.

- Long-term care providers and researchers are now using an ASPE-funded publication "Measuring Long-Term Care Work" extensively to improve direct service workforce availability and capability in support of the President's New Freedom Initiative.

- ASPE’s research findings on the relationship between criminal background checks and abuse/neglect in nursing homes will assist states in carrying out these requirements. Also in the nursing home quality area, ASPE is completing a study of nursing home divestitures.

- ASPE staff continue to support and staff the Medicaid Commission, specifically planning two meetings focused on Medicaid long-term care issues, and identifying speaker panels to present at those meetings. ASPE continues to support staff detailees to the Medicaid Commission.

- ASPE-funded research on health information technology in post-acute and long-term care has:

  -- stimulated consideration of the post-acute and long-term care sectors in public and private sector policy discussions regarding the use of health information technology (HIT);
  -- highlighted the need to conform federally-required patient assessment forms with HIT standards;
  -- created a method to standardize, using content and messaging standards, the nursing home minimum data set; and
  -- created an inter-agency relationship with ASPE and CMS through which the comparability across federally-required patient assessments instruments via the

use of HIT standards is being explored.

- ASPE's study of the benefits of medical innovation and specifically the role of prescription drugs and drug coverage in promoting the health of seniors has supported the Administration in its implementation of related provisions of the MMA.

- In FY 2005, ASPE began funding a project to design evaluations of the Medicare Quality Improvement Organization (QIO) program. ASPE plans to continue to develop this body of work in FY 2006 and 2007, potentially informing refinements of the QIO's ninth scope of work, which will be drafted during FY 2008. ASPE anticipates funding longer-term evaluation projects related to health care quality improvement that may extend beyond FY 2007.

- An ASPE document, *Guide to Analyzing the Cost-Effectiveness of Community Public Health Prevention Approaches*, provides practical steps to help program managers and evaluators understand, design, and perform cost-effectiveness evaluations of community public health prevention programs was completed and placed on the ASPE website.

- Supporting the Administration's disease prevention efforts, an ASPE/HHS led effort in partnership with the Federal Trade Commission to conduct a workshop examining marketing practices of food and beverages to children and adolescents and childhood obesity.

- An ASPE evaluation of the *Steps to a HealthierUS* and*Healthy People 2010* initiatives in support of the Administration's health promotion and chronic disease prevention efforts.

- Supporting the Administration's focus on disease prevention and health promotion, ASPE provided oversight to the selection of awardees for Secretary's Innovation in Prevention Awards and planning in conjunction with the 3rd National Prevention Summit.

- Supporting the Security and Prosperity Partnership of North America (a multi-lateral agreement among the U.S., Mexico, and Canada), ASPE led the U.S. delegation to an expert round table meeting on experiences and challenges in the prevention and treatment of Type 2 diabetes among the indigenous populations in the U.S. and Mexico.

- ASPE worked with the Office of Minority Health and other HHS components to establish the HHS American Indian/Alaska Native Health Research Advisory Council as a mechanism to obtain input from Tribal leaders on how to target research resources on health topics that would be most useful for them and for the Administration.

Analytical, evaluation and policy development efforts in the science and data policy area have led to major improvements in information for decision-making in policy formulation in health and human services, science policy and program management and evaluation across HHS, including:

- ASPE leadership and collaborative information policy efforts between the HHS Data Council and the National Advisory Committee on Vital and Health Statistics have resulted in "Information for Health," a highly regarded framework for improving health through enhancements in the National Health Information Infrastructure (NHII). The concepts and framework included in the report have been incorporated in health

information technology initiatives including the President's Electronic Health Records Initiative and the Secretary's Health Information Technology Strategy.

- The HHS Data Council has developed the web-based Gateway to HHS Statistics and Data on the Web, an integrated, one stop HHS-wide website that provides user- friendly access to the wide range of statistics and data developed by HHS agencies. The Statistics Gateway includes the ability to search and display relevant information, a metadirectory of HHS Statistical Resources, and links to data policy websites and is designed to provide information for policy development and decision making in health and human services. Gateway has been expanded to include minority data and health insurance data websites.

- ASPE led and conducted the policy research and economic analyses that led to the President's Electronic Health Record initiative and Executive Order, as well as the HHS Secretary's health information technology initiative. ASPE also leads monitoring, evaluation and economic activities in this area.

- ASPE supported the prescription drug economic analyses that supported the Secretary's and the President's report on drug importation.

- ASPE conduced a series of analyses relating to the demand, supply and economics of the vaccine production and distribution in the U.S. to support HHS policy to ensure an adequate supply.

- ASPE's data enhancement initiatives are leading to improved data for policy relating to health insurance, prescription drugs, income and asset data and the elimination of race and ethnic disparities.

Policy research and evaluation studies in the human services policy area have contributed to policy formulation across a number of areas:

- ASPE participated in workgroups in support of the Secretary's Transformation Action Team efforts to improve emergency preparedness efforts throughout the Department. This included development of a survey to gather information on programs and disaster needs. ASPE tabulations and summaries of written responses to the survey from Operating and Staff Divisions as well six other federal departments and agencies were used to inform the Department's response to the White House report, "The Federal Response to Hurricane Katrina: Lessons Learned." ASPE staff also developed a Request for Information (RFI) designed to seek input from all sectors – public and private – about creating a new electronic benefit transfer system capable of delivering multiple human services benefits to disaster victims.

- ASPE staff played a key role in the final negotiations of the welfare reauthorization provisions of the Deficit Reduction Act of 2005 (DRA) through modeling the impacts of various policy options and providing analyses and decision options for senior policymakers. ASPE staff also participated in policy discussions with ACF in drafting interim final regulations to implement the DRA provisions and prepared analyses of various policy options to assist in Departmental clearance of the regulation.

- ASPE's research on the effects of marriage on family economic well-being, which provided a robust indication that married parents tend to be better off than both single

and cohabiting parents, and that these benefits extend to disadvantaged parents families as well, supported the President's Healthy Marriage agenda as a means of strengthening families and improving the well-being of children. It also supported Congressional interest in providing new funding for marriage promotion and fatherhood activities through the Deficit Reduction Act of 2005. In addition, ASPE is actively working with ACF to implement and assess the effectiveness of healthy marriage and responsible fatherhood grantee programs established by the recently-passed welfare reauthoriztion legislation.

- ASPE-funded research on state policies to promote marriage, showing that while states are actively engaged in a variety of activities to promote healthy marriages they lack the funds and research base to fully pursue this agenda, provides support for the Healthy Marriage agenda.

- ASPE's staff analysis of foster care financing issues has supported the Administration's legislative proposal on the issue.

- Findings from ASPE's research on state experiences and perspectives on reducing out-of-wedlock childbearing – that the Bonus to Reward Decrease in Illegitimacy Ratio did not influence state activities and initiatives on this issue – were used to support the Administration's legislative proposal to eliminate the $100 million incentive fund and its inclusion in the Deficit Reduction Act of 2005 (DRA).

- A series of reports from ASPE-funded research projects on post-adoption services and adoption subsidies and on involving fathers in child welfare case management are now being used extensively by state and local agencies to change policies and practices.

- The Federally-funded demonstration grants on the overlap of child maltreatment and domestic violence, in which ASPE participated, has led to the recent reauthorization, within the Violence Against Women Act, of a new grant program supporting local jurisdictions in addressing this multidisciplinary problem.

- As a result of the findings from the National Evaluation of Welfare to Work Strategies, that programs that moved clients into work as soon as possible were more cost effective in promoting self-sufficiency than programs that only emphasized long-term education and training, the Administration's welfare reauthorization principles encouraging states to adopt a "work-first" approach were incorporated into the DRA and resulting interim final rules.

- Findings from an ASPE study on health care coverage among child support-eligible children lead to the development of the Administration's legislative proposal to seek medical child support from both parents, not just the custodial parent, as appropriate.

- ASPE's analysis of State-reported Temporary Assistance for Needy Families (TANF) microdata led to the development and use of a model showing the impacts of various proposals on state work participation rates. The model also was used to provide post-DRA technical assistance to states in estimating the number of adults in the TANF caseload they would have to engage in work activities each month in order for states to avoid penalties under the Deficit Reduction Act.

- ASPE's analysis of research data on health and employment among TANF recipients contributed to the development of policies which were incorporated in the interim final regulations affecting work participation requirements for TANF adults with disabilities.

Goal 2. <u>Maintain human technology capacity to respond to planning and analytical needs of the Secretary.</u>

In FY 2007, ASPE continued to build a strong analytical capacity. Policy support services provided simulation modeling, statistical analysis, and other technical and analytic services needed in order to carry out policy research. The goal was to ensure efficient, reliable, and timely analytic support, while offsetting increases in costs through the introduction of cost-saving technologies. These services support internal Department-wide data policy and coordination in data policy, including interagency data collection and data standards, as well collaborative efforts between HHS and the health industry.

- ASPE continues to support academic research on poverty and promote secondary analysis of under-utilized but rich data sets.

- ASPE continues to support the collection and analysis of data in the National Nursing Home Survey, the National Home and Hospice Survey, the National Long-Term Care Survey, and the Health Interview Survey. ASPE also participates in efforts to broaden the frame for the Nursing Home Survey to include other out-of-home institutional long-term care services.

- ASPE also continues to support the collection of data in the National Survey of Family Growth (NSFG), the Panel Study of Income Dynamics (PSID), the Early Childhood Longitudinal Study - Birth Cohort (ECLS-B), and the National Longitudinal Study of Adolescent Health.

- ASPE is supporting the next phase of the development and implementation of a new, nationally representative survey of the paraprofessional long-term care workforce-the next phase will survey workers in community long-term care agencies This survey builds on the first phase, during which nursing home workers were surveyed.

- ASPE is supporting and providing leadership for a nationally representative survey of residential settings for older adults with long-term care needs.

- ASPE continues to support and guide the development of the Older Americans Chartbook, through collaborative leadership of the Interagency Forum on Aging Related Statistics.

- ASPE continues to develop human and technological capacity in identifying the number of individuals without health insurance to aid in targeting policies designed to cover the uninsured. This includes an ASPE-lead collaboration between CMS, the Census Bureau, and other parties to identify the true number of uninsured individuals on Census Bureau surveys, as well as studies that compare the size and composition of the uninsured across four major government surveys.

- ASPE has also obtained and utilized a model that allows the specification of a health insurance plan and produces a premium cost, which furthers ASPE's ability to conduct

policy analysis on covering the uninsured. ASPE is also supporting the development of a public-use file of data from the Congressionally-mandated SCHIP Evaluation.

- ASPE utilized its actuarial support contract to develop and analyze policies to cover the uninsured and to target subsidies for that population. These analyses were central to informing policy makers about this critical policy area. ASPE continues to use this contract in numerous ways, including an analysis of the Massachusetts universal coverage reform demonstration.

- ASPE compiles and submits to the White House weekly data on the recovery of the health and long-term care systems of Mississippi, Louisiana, and, specifically, the New Orleans metropolitan area.

# OS SERVICE AND SUPPLY FUND

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $59,330,000 | $73,773,000 | $73,386,000 | -$387,000 |
| FTE | 145 | 170 | 171 | +1 |

## Statement of the Budget

The FY 2008 budget for the Office of the Secretary (OS) Service and Supply Fund (SSF) is $73,386,000, a decrease of $387,000 below the FY 2007 Continuing Resolution (CR) level. This budget provides funding to support the provision of common services to Federal customers within HHS and other Federal agencies. Services provided include: Acquisition Integration and Modernization, Audit Resolution, Claims, the Commissioned Corps Force Management (CCFM), Competitive Sourcing, Departmental Contracts Information System (DCIS), Information Technology Service Center (ITSC), the Small Business Office, Tracking Accountability of Government Grants System (TAGGS), and the Web Communications Division.

## Program Description

This section describes the OS components funded through the Department's 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 the Department's Operating Division (OPDIVs) and the Office of Inspector General (OIG).

The SSF does not have its own appropriation, but is funded entirely through charges to its customers (HHS's OPDIVs and STAFFDIVs, plus other Federal agencies) for their usage of products and services, as approved by the SSF Board of Directors. The products and services funded through the SSF are grouped into cost centers that are fully costed and managed as self-sustaining business lines.

## Performance Analysis

**Acquisition Integration and Modernization (AIM):** Creates a seamless integration of acquisition policies, procedures and contract vehicles to serve employees, customers and vendors. AIM leverages HHS spending opportunities, captures knowledge within the acquisition workforce, and seizes opportunities to adopt best practices. The AIM activity was added to the SSF effective October 1, 2004.

In FY 2006 and FY 2007, contractor support was obtained to achieve the following milestones: developing standardized policies in the areas of purchase cards, acquisition plans, interagency contracting, and earned value management; establishing emergency contracting procedures; developing an emergency contracting website; identifying emergency contracting training opportunities; and sustaining an AIM website, newsletter, and knowledge repository. Many of

these efforts require changes to HHS' Acquisition Regulations (HHSAR), which is also encompassed in the AIM framework, to ensure that standardization is captured in a codified fashion, readily accessible by all HHS Operating Divisions. To that end, an updated version of the HHSAR was published in the Federal Register on December 20, 2006.

Consistent with the Presidents Management Agenda (PMA) and in line with the FY 2007 Departmental Objectives, HHS is committed to measuring performance and assessing progress. To that end, an HHS Acquisition Dashboard has been developed to measure OPDIV acquisition performance and assess progress on a semi-annual and annual basis. AIM activities are one of the four acquisition initiatives encompassed in the dashboard framework. A pilot assessment was conducted in September 2006, at which time enhancements were incorporated into the process, thereby facilitating the conduct of the first official semi-annual assessment which commenced on October 1, 2006 and will end on March 31, 2007.

**Audit Resolution:** Provides leadership in resolving crosscutting findings as mandated by P.L. 96-304 and P.L. 98-502. Audit Resolution reviews and resolves audit reports containing monetary and/or systemic findings of grantee and contractor organizations affecting the programs of more than one OPDIV or Federal agency. Recommends corrections and ensures corrective action is taken on deficiencies in grantee/contractor accounting systems, internal controls, or other management systems. Audit Resolution assists OPDIVs on the PMA scorecard initiative to reduce improper payments which include: completing program risk assessments, developing appropriate methodologies for estimating improper payments, and engaging in contract recovery auditing activities. Additionally, Audit Resolution provides functional leadership for completing and coordinating with OIG the Annual Management Report on Final Action to Congress on audit findings and with OMB on the annual update to the A-133 Compliance Supplement.

**Claims:** The Claims Branch of the Program Support Center (PSC) moved to the Office of General Counsel's (OGC) General Law Division, Claims and Employment Law Branch, on October 1, 2004, following a business case analysis performed by the PSC. During FY 2005, when 407 new claims were received, the transfer to OGC allowed streamlined operations and the elimination of certain duplicated functions, which resulted in more expeditious adjudication and settlement of claims. A pilot Early Offers Program resulted in yet more efficient and expedited processing of claims via earlier evaluation of claims by a team of attorneys and paralegals. In FY 2006, 475 claims were received claiming more than $1.8 billion (about two-thirds of which reflected claims from 893 Community Health Centers deemed eligible for Federal Tort Claims Act coverage with more than 3,000 delivery sites throughout the nation). The backlog of 297 pending administrative torts from calendar year 1997 to 2001 (reduced to 66 cases by the end of FY 2005) was further reduced to 23 cases. Moreover, of the medical malpractice claims filed and administratively denied by the Claims branch in FY 2005, approximately 61 percent thus far have not resulted in federal court litigation. This trend is expected to continue for medical malpractice claims denied in FY 2007 and beyond.

**Commissioned Corps Force Management:** The Commissioned Corps Force Management (CCFM) provides personnel support to active-duty and retired PHS Commissioned Officers, and force management activities for the Corps as a whole. Force management of the Corps is administered by two offices within the Office of Public Health and Science (OPHS), the Office of Commissioned Corps Force Management (OCCFM), who reports to the Assistant Secretary for Health and the Office of Commissioned Corps Operations (OCCO) with the Office of the Surgeon General (OSG). OCCFM develops policies and proposes regulations in order to carry

out a comprehensive force management program for the Corps. The office establishes time lines, performance standards, and measurements of the evaluation of the operations and management of the Corps, and works closely with the OSG to facilitate operations and implementation policies and programs. OCCO provides advice on matters related to the day-to-day management of the Corps. OCCO provides for the delivery of training and for career development, manages systems for the selecting personnel for appointment, promotion, assimilation, and award recognition; and manages personnel administration systems for the assignment of Corps members.

The following program initiatives are planned:

- Development of recruitment strategies and materials for targeted health professional categories (Physicians, Nurses, Dentists, Pharmacists);

- Modernization and development of new communication methods for the Corps personnel policies and guidance;

- Modernization of the Commissioned Corps Payroll System (Commissioned Corps Payroll Modernization Project), including software, application rights, back-up equipment, annual operating costs, and conversion of the legacy WANG payroll database to a new Oracle database;

- Development of an on-line Basic Officer Training Course (BOTC) and provision of informational products to Commissioned Officers about the mission and support services of the Corps. An estimated 4,000 officers currently require this valuable training experience, which is a requirement of the Secretary's Commissioned Corps Transformation Initiative; and

- Assessment and Review of Commissioned Corps Policy Tools, including the Commissioned Officers Effectiveness Reports (COERs) assessment tool and the Commissioned Corps Personnel Manual (CCPM). The CCPM will be updated to reflect the realignment of the Corps, as identified in the Secretary's 500-Day Plan, and will be supported in an electronic format in compliance with e-gov initiatives.

**Competitive Sourcing:** Provides support for the activities related to the President's Management Agenda competitive sourcing goal for the Department. The activity was added to the SSF effective on October 1, 2005, with the purpose of maintaining a database to gather Federal Activities Inventory Reform (FAIR) Act inventory data at all levels of the Department. During FY 2006, the Office of Management and Budget developed an Oracle based database, the FAIR Act Automated Data Collection System. The FAIR Act Automated Data Collection System permits collection of FAIR Act inventory data at all levels throughout the Department. In compliance with P.L. 105-270, Competitive Sourcing populates the database with the Department's competitive sourcing data, providing accurate, accessible reporting capabilities and linkage of data to the Department's competitive sourcing plans 100 percent of the time.

| **Long Term Goal: Maintain FAIR Act database.** | | | |
|---|---|---|---|
| **Annual Measure** | **FY** | **Target** | **Results** |
| Provide information that is current and accessible to OPDIV competitive sourcing managers. | 2007<br>2006<br>2005 | 95%<br>95%<br>NA | <br>100%<br>NA |
| **Data Source:** Access information from FAIR Act database. | | | |
| **Data Validation:** Computation (rate of access per the database to total OPDIV competitive sourcing managers). | | | |

| **Long Term Goal: Develop Congressional competitive sourcing database.** | | | |
|---|---|---|---|
| **Annual Measure** | **FY** | **Target** | **Results** |
| Submit complete information to OMB by OMB's deadline. | 2007<br>2006<br>2005 | Deadline<br>Deadline<br>NA | Dropped<br>Goal met<br>NA |
| **Data Source:** Date information is sent to OMB. | | | |
| **Data Validation:** Date information is sent to OMB. | | | |

**Departmental Contracts Information System (DCIS):** Provides a central repository for HHS-wide procurement data, and is the primary system used by HHS to fulfill procurement reporting requirements to the Federal Procurement Data System Next Generation/OMB (FPDS-NG), which is mandated by Public Law 93-400. Compiles contract information to produce geographically based reports to the Office of Management and Budget (OMB) and Congress under P.L. 93-400. DCIS provides procurement information for Freedom of Information Act (FOIA) requests from OMB, the Congress, State governments, and HHS management.

In FY 2006 and FY 2007, contractor support was obtained to provide IT support services to the Departmental Contracts Information Systems (DCIS). The contractor provided services that includes: Application software enhancements to make for a smooth delivery of HHS and Federal customer procurement data to the FDPS-NG, application software maintenance, systems environment and data base maintenance, training support for system users, systems operation support and system security. In FY 2007 and FY 2008, the DCIS contractor will deploy and disseminate additional standard reports and an ad hoc reporting system, to be programmed in ORACLE Discoverer.

**Information Technology Service Center:** Provides common IT infrastructure and technology services to selected OPDIVs (ACF, AoA, AHRQ, HRSA, SAMHSA, OIG, OS and PSC), including e-mail, Internet access; wide area network (WAN) and local area networks (LAN) services; application and web hosting; personal computers, commercial off-the-shelf (COTS) software, Help Desk services, Call Center services, and IT training. The ITSC manages the Departmental network (HHS-Net) for all OPDIVs and in FY 2007 will begin managing the enterprise-wide e-mail system for the Department.

ITSC focuses upon three key areas: Maintain the Security of the Operating Environment; Reduce Costs While Improving Service; and Utilize Achieve Situational Awareness to proactively manage the environment.

In October 2005, ITSC awarded a new support contract that is significantly different from prior support contracts. The new contract implements a contractor-owned, contractor-operated model. In this model all IT assets, i.e., computers, printers, network equipment, are provided by the contractor. This puts the onus for performance on the contractor, since it owns the equipment. The contract is performance based, with appropriate incentives and disincentives based on the achievement of the specified service levels. Contract performance levels are very ambitious, in many cases raising the "industry best practices" performance bar, and must be fully met at day 120 of the contract. Approximately 85 percent of the services provided in the contract are firm-fixed price (FFP), at levels that are comparable to the best offered in the private sector. The FFP rates decline over the life of the contract, providing ITSC with predictable cost savings each year of the contract. To demonstrate contract performance levels and to improve overall customer satisfaction, the ITSC measures 18 different service levels.

| **Long Term Goal: Improve customer satisfaction by fixing reported problems during the first contact with the customer. This is related to the goal of improving service while reducing costs.** | | | |
|---|---|---|---|
| **Annual Measure** | **FY** | **Target** | **Results** |
| Increase the percentage of user problems resolved during the first contact with the user. The industry standard is 65%. | 2008<br>2007<br>2006<br>2005<br>(baseline) | 85%<br>85%<br>65%<br>65% | Dec 2008<br>Dec 2007<br>74%<br>22% |
| **Data Source:** The ITSC call center trouble ticket database. | | | |
| **Data Validation:** The measure will be calculated based on the total number of trouble tickets opened and closed during the initial customer contact, compared to all tickets received during the period. | | | |

A key factor in the success of the program is the shift to a "high-tech, low-touch" model, which maximizes the use of technology. In most cases the need to send technicians to user locations is obviated by the ability to remotely manage network connected devices from a central operations center. Under the new contract, performance for first-call resolution was reported beginning in April 2006; the 74% reported above is an average of the ensuing six months. Each individual month exceeded our goal of 65%, with the lowest individual month being September 2006, when 70% of calls were resolved in the first call. After the end of the fiscal year, performance in this area has continued to improve, with the December 2006 rate for first-call-fix being 94%. These performance results clearly show the new contract is performing more than three times better than the previous contract, and is achieving results in this area that are significantly above the standards for the industry. In FY 2007 and FY 2008, ITSC will complete work on the rationalization and standardization of the network infrastructure inherited from its customers via consolidation, improving quality of service and further driving costs down. Additionally, ITSC will work to mature the Applications Hosting line of business, affording customer organization the opportunity to move business applications to a secure data center designed explicitly for this purpose.

**Small Business Office:** The Office of Small and Disadvantaged Business Utilization (OSDBU) were established in 1979 under P.L. 95-507, the Small Business Act (SBA). The Small Business Office was added as an activity of the Service and Supply Fund, effective on May 18, 2005. The Small Business Office provides leadership, guidance and recommendations to insure that small businesses are given an equitable opportunity to participate in the provision of goods and services to HHS.

In compliance with the SBA, the Small Business Office:

- Engages in strategic acquisition activities with the HHS Operating Divisions;
- Forecasts procurement activities;
- Conducts outreach efforts to educate the small business community about potential contracting opportunities within HHS, such as small business fairs and procurement conferences, enhanced informational website for internal and external partners, trade group seminars, conventions, forums, and one-on-one counseling;
- Builds and sustains a strong subcontracting and mentor program, including 8(a), Small Disadvantaged, Women-Owned, HUBZone and Service-Disabled Veteran Owned;
- Serves as the small business contact for the Department with other Federal partners, public and private interests and the small business community; and
- Reviews and oversees OPDIV contractual activities to insure fair, proportionate small business procurement opportunities.

The Department's small business goals are determined by the Small Business Act, as negotiated with the Small Business Administration. The Small Business Office has the following goals and targets:

| **Long Term Goal: Provide technical assistance that results in OPDIVs meeting or exceeding small business goals in compliance with the Small Business Act.** | | | |
|---|---|---|---|
| **Annual Measure** | **FY** | **Target** | **Results** |
| Develop a best practices tool to educate and inform contracting officers. | **2008** | **10% of HHS acquisitions staff** | **Dec 2008** |
| | **2007** | **10% of HHS acquisitions staff** | **Dec 2007** |
| **Data Source:** HHS University training classes. | | | |
| **Data Validation:** HHS University/ Small Business Office. | | | |
| Hold monthly vendor outreach sessions to educate small business owners on the Federal contracting process and contracting opportunities. | 2008 | 11 out of 12 months | Dec 2008 |
| | 2007 | 11 out of 12 months | Dec 2007 |
| | 2006 (baseline) | 11 out of 12 months | 11 out of 12 months |
| **Data Source:** Small business vendor outreach sessions. | | | |
| **Data Validation:** Vendor outreach surveys. | | | |
| Meet or exceed the Department's Small Business acquisition goals, as determined by the Small Business Act and the Small Business Administration. | 2008 | 20% of total contract dollars | Dec 2008 |
| | 2007 | 20% of total contract dollars | Dec 2007 |
| | 2006 (baseline) | 20% of total contract dollars | 23% |
| **Data Source:** Department DISC System. | | | |
| **Data Validation:** Final HHS report to the Small Business Administration. | | | |

**Tracking Accountability in Government Grants System (TAGGS):** TAGGS is the primary database of grant data for the Department of Health and Human Services (HHS). The publicly searchable database houses information on HHS discretionary and mandatory grants awards from 1995 to present. As the largest grant-making agency in the Federal government, providing over $200 billion annually to both domestic and foreign grantees for U.S. health assistance programs, TAGGS is essential to fulfilling key Departmental grants and financial management objectives, and will serve in a key capacity in facilitating HHS' compliance with Public Law 109-282, "The Federal Funding Accountability and Transparency Act of 2006." TAGGS achieved and surpassed its FY 2006 performance target to load grant project abstracts for 55 percent of total FY 2006 TAGGS grant awards, completing the fiscal year with a 63.2 percent outcome.

The FY 2006 project abstract goal supports the Department's objective to improve the service of management functions and administrative operations for the support of the Department's mission. Although basic grants award data has been submitted to TAGGS since 1995, increased number of grants abstracts enables users to review the specific objectives and activities of a greater percentage of awards, providing the following advantages:

- Users can learn more about the funded projects, including improved funding transparency. The information also assists HHS management with grant administration oversight.
- Supports the Department's strategic objective to consolidate grants systems, with all project abstracts will be extracted from the ACF GATES and NIH IMPAC II systems.
- Supports expanded Department objectives to improve financial performance, in support of A-123 goals to track and monitor internal system controls to maintain and improve data quality and integrity.
- Provides supporting data for key HHS financial management systems, such as the Unified Financial Management System (UFMS) to track grant expenditures in accordance with specific budget and appropriation guidelines. Data from TAGGS may be cross-referenced with UFMS to monitor grants management controls.

| **Long Term Goal: Increase the transparency off HHS grant funding activities to the public and other Federal agencies.** | | | |
|---|---|---|---|
| **Annual Measure** | **FY** | **Target** | **Results** |
| Increase the percentage of new fiscal year grant projects in the database with searchable descriptive abstracts/ synopses accessible to users of the TAGGS internet site. | 2008<br>2007<br>2006 | 75%<br>65%<br>55% | Dec 2008<br>Dec 2007<br>63.2% |
| **Data Source:** The TAGGS back-end database. | | | |
| **Data Validation:** The abstract percentage measure will be calculated based on the total number of awards in the TAGGS system for the target fiscal year, and the number of those awards with corresponding grant project abstracts loaded in the TAGGS database. | | | |
| **Cross Reference:** 20 Department-wide objectives, FY 2006. Objective 16: Improve grants management operation and oversight. | | | |

For FY 2007, TAGGS plans to achieve a 65 percent grant project abstract target, an increase of 10 percent over the FY 2006 target. Prior to the success of Web service interfaces between ACF GATES and TAGGS for abstract data submissions, HHS primarily received grant project abstract data from NIH's IMPAC II, which focuses primarily on HHS research and research-related grants. TAGGS is now moving to ensure that grant project abstract information for HHS' demonstration and/or service grants are included in the database to the fullest extent possible, so that users will be provided with the full breadth of specific information for all of the HHS diverse grant programs.

**Web Communications Division:** The work of the Web Communications Division grows out of and builds upon the Web Portal Project, funded under the IT Security and Innovation Fund in FY 2004. The Web Communications Division is responsible for redesigning and refocusing the HHS website to be topics-based and citizen-centric, leveraging existing HHS web content, and empowering users to locate information easily across the entire Department.

Specific projects of the Web Management Team include: establishment and application of Web standards and guidance; promulgation of Department-wide Web governance; creation and management of cross-government Web sites (e.g., PandemicFlu.gov, AIDS.gov); managing, consulting and approval of HHS-wide sites; implementation of a Content Management System; application of the Google search engine (including specialized configurations); implementing a comprehensive Web utilities management tool; management of an enterprise-wide QA knowledge base; and managing the renewal of the portal collaborative application. Website quality and utility will be increased by providing page and link context and gradual reorganization by topic. This work will be guided by usability testing. The Web Communications Division is working to improve content feedback scores submitted by site visitors, and to reduce duplicate content efforts across the Department. During FY 2006, the Web Communications Division successfully handled a 33% increase over FY 2005 in the number of requests for Web-related services (e.g., content updates, redesigns, refreshes, usability testing).

Rationale for the Budget

The FY 2008 budget is $73,386,000, a decrease of -$387,000 over the revised FY 2007 budget of $73,773,000. This decrease reflects net pay increases of $545,000, contract decreases for ITSC, OCCFM, and TAGGS of -$1,535,000, and other net increases of $603,000.

Statement of Changes

| | |
|---|---|
| FY 2007 Estimate, per FY 2006 Congressional Justification | $65,613,000 |
| Net Change, FY 2007 | +8,160,000 |
| FY 2007 Revised Estimate | $73,773,000 |
| Net Change, FY 2008 | -387,000 |
| FY 2008 Estimate | $73,386,000 |

Details, FY 2007 Net Change:

| | |
|---|---|
| Department e-mail system | $2,648,000 |
| Increased business, ITSC Core service | 2,563,000 |
| Blackberry support service | 1,934,000 |
| Pay | -229,000 |
| Contracts | 1,743,000 |
| Other Decreases | -499,000 |
| Total Change, FY 2007 | $8,160,000 |

Details, FY 2008 Net Change:

| | |
|---|---|
| Pay | $545,000 |
| Other increases | 603,000 |
| Contracts | -1,535,000 |
| Total Change, FY 2008 | $-387,000 |

OFFICE OF THE SECRETARY SERVICE AND SUPPLY FUND

**FY 2006 REVENUE DISTRIBUTION**
($000)

| ACTIVITY | ACF | AHRQ | AoA | CDC | CMS | FDA | HRSA | IHS | NIH | OS | SAM-HSA | Other | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AIM | $11 | $11 | $2 | $207 | $44 | $120 | $44 | $251 | $292 | $31 | $22 | $0 | $1,035 |
| Audit Resolution | 498 | 0 | 56 | 70 | 243 | 1 | 36 | 45 | 242 | 0 | 53 | 0 | 1,244 |
| Claims | 0 | 0 | 0 | 9 | 0 | 21 | 417 | 214 | 8 | 0 | 0 | 0 | 669 |
| CCFM | 0 | 36 | 0 | 2,335 | 266 | 2,043 | 1,354 | 6,147 | 1,174 | 419 | 135 | 3,024 | 16,933 |
| Competitive Sourcing | 6 | 1 | 1 | 41 | 23 | 48 | 9 | 71 | 84 | 19 | 3 | 0 | 306 |
| DCIS | 8 | 8 | 2 | 147 | 31 | 85 | 31 | 178 | 207 | 22 | 15 | 0 | 734 |
| ITSC | 7,603 | 1,824 | 549 | 599 | 326 | 675 | 1,228 | 1,071 | 1,157 | 12,104 | 2,924 | 629 | 30,689 |
| Small Business | 27 | 41 | 5 | 338 | 252 | 216 | 92 | 181 | 1,224 | 0 | 84 | 0 | 2,460 |
| TAGGS | 19 | 9 | 7 | 81 | 87 | 23 | 160 | 75 | 303 | 9 | 94 | 0 | 867 |
| Web Comm. | 87 | 20 | 8 | 604 | 329 | 681 | 133 | 1,080 | 1,167 | 247 | 37 | 0 | 4,393 |
| TOTAL OS SSF | $8,259 | $1,950 | $630 | $4,431 | $1,601 | $3,913 | $3,504 | $9,313 | $5,858 | $12,851 | $3,367 | $3,653 | **$59,330** |

OFFICE OF THE SECRETARY SERVICE AND SUPPLY FUND

**FY 2007 REVENUE DISTRIBUTION**
($000)

| ACTIVITY | ACF | AHRQ | AoA | CDC | CMS | FDA | HRSA | IHS | NIH | OS | SAM-HSA | Other | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AIM | $11 | $11 | $2 | $210 | $44 | $121 | $44 | $254 | $299 | $31 | $22 | $0 | $1,049 |
| Audit Resolution | 523 | 0 | 59 | 84 | 257 | 1 | 44 | 54 | 275 | 0 | 65 | 0 | 1,362 |
| Claims | 1 | 0 | 0 | 9 | 20 | 37 | 552 | 317 | 42 | 13 | 0 | 0 | 991 |
| CCFM | 0 | 39 | 0 | 2,472 | 282 | 2,163 | 1,433 | 6,507 | 1,243 | 442 | 142 | 3,201 | 17,924 |
| Competitive Sourcing | 4 | 1 | 0 | 23 | 13 | 27 | 5 | 40 | 48 | 11 | 1 | 0 | 173 |
| DCIS | 8 | 8 | 2 | 152 | 32 | 88 | 32 | 184 | 215 | 22 | 16 | 0 | 759 |
| ITSC | 7,609 | 2,216 | 721 | 2,548 | 1,386 | 3,521 | 1,742 | 3,310 | 0 | 15,843 | 3,462 | 0 | 42,358 |
| Small Business | 26 | 39 | 5 | 329 | 244 | 210 | 89 | 176 | 1,191 | 0 | 82 | 0 | 2,391 |
| TAGGS | 19 | 9 | 7 | 82 | 88 | 23 | 162 | 76 | 310 | 9 | 95 | 0 | 880 |
| Web Comm. | 117 | 27 | 11 | 809 | 440 | 912 | 178 | 1,448 | 1,563 | 331 | 50 | 0 | 5,886 |
| TOTAL OS SSF | $8,318 | $2,350 | $807 | $6,718 | $2,806 | $7,103 | $4,281 | $12,366 | $5,186 | $16,702 | $3,935 | $3,201 | **$73,773** |

OFFICE OF THE SECRETARY SERVICE AND SUPPLY FUND

**FY 2008 REVENUE DISTRIBUTION**
($000)

| ACTIVITY | ACF | AHRQ | AoA | CDC | CMS | FDA | HRSA | IHS | NIH | OS | SAM-HSA | Other | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AIM | $11 | $11 | $2 | $214 | $45 | $124 | $45 | $259 | $304 | $32 | $23 | $0 | $1,070 |
| Audit Resolution | 549 | 0 | 62 | 88 | 270 | 1 | 46 | 57 | 288 | 0 | 68 | 0 | 1,429 |
| Claims | 1 | 0 | 0 | 8 | 20 | 37 | 543 | 312 | 41 | 13 | 0 | 0 | 975 |
| CCFM | 0 | 38 | 0 | 2,460 | 281 | 2,153 | 1,427 | 6,477 | 1,237 | 440 | 142 | 3,187 | 17,842 |
| Competitive Sourcing | 4 | 1 | 0 | 23 | 13 | 27 | 5 | 40 | 48 | 11 | 1 | 0 | 173 |
| DCIS | 8 | 8 | 2 | 155 | 33 | 90 | 33 | 188 | 221 | 23 | 16 | 0 | 777 |
| ITSC | 7,363 | 2,145 | 698 | 2,569 | 1,397 | 3,545 | 1,706 | 3,346 | 0 | 15,356 | 3,352 | 0 | 41,477 |
| Small Business | 27 | 40 | 5 | 333 | 247 | 213 | 90 | 178 | 1,205 | 0 | 83 | 0 | 2,421 |
| TAGGS | 20 | 9 | 7 | 83 | 89 | 24 | 164 | 77 | 315 | 9 | 96 | 0 | 893 |
| Web Comm. | 126 | 29 | 12 | 870 | 473 | 981 | 192 | 1,557 | 1,679 | 357 | 53 | 0 | 6,329 |
| TOTAL OS SSF | $8,109 | $2,281 | $788 | $6,803 | $2,868 | $7,195 | $4,251 | $12,491 | $5,338 | $16,241 | $3,834 | $3,187 | **$73,386** |

## DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT
(Excluding Service and Supply Fund)

| | FY 2006 Actual [1] | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Immediate Office of the Secretary | 65 | 68 | 74 |
| Public Affairs | 29 | 30 | 30 |
| Legislation | 24 | 24 | 26 |
| Planning and Evaluation | 108 | 108 | 108 |
| Resources and Technology | 136 | 137 | 138 |
| Administration and Management | 122 | 127 | 129 |
| Intergovernmental Affairs | 36 | 36 | 36 |
| General Counsel | 379 | 377 | 381 |
| Departmental Appeals Board | 63 | 65 | 75 |
| Office on Disability | 4 | 4 | 4 |
| Global Health Affairs | 52 | 52 | 54 |
| Public Health and Science | 303 | 303 | 431 |
| President's Council on Bioethics | 10 | 10 | 10 |
| Center for Faith-Based Initiatives | 4 | 6 | 6 |
| Total, GDM *(excluding SSF)* | 1,335 | 1,347 | 1,502 |

Average GS Grade

| | |
|---|---|
| 2004 | GS-12/3 |
| 2005 | GS-12/2 |
| 2006 | GS-12/2 |
| 2007 | GS-12/2 |
| 2008 | GS-12/2 |

[1] FY 2006 FTE shown here reflect corrections to coding errors contained in the FY 2008 President's Budget Appendix.

# DETAIL OF POSITIONS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Executive Level I | 1 | 1 | 1 |
| Executive Level II | 1 | 1 | 1 |
| Executive Level III | – | – | – |
| Executive Level IV | 9 | 9 | 9 |
| Executive Level V | – | – | – |
| Subtotal | 11 | 11 | 11 |
| Total – Executive Level Salaries | $1,636,000 | $1,663,000 | $1,696,000 |
| SES Subtotal | 71 | 72 | 73 |
| Total – ES Salaries | $9,763,000 | $10,068,000 | $10,412,000 |
| GS-15 | 166 | 172 | 183 |
| GS-14 | 267 | 266 | 283 |
| GS-13 | 329 | 333 | 356 |
| GS-12 | 307 | 298 | 319 |
| GS-11 | 116 | 120 | 128 |
| GS-10 | 6 | 5 | 6 |
| GS-09 | 112 | 110 | 117 |
| GS-08 | 52 | 48 | 52 |
| GS-07 | 66 | 65 | 70 |
| GS-06 | 13 | 15 | 16 |
| GS-05 | 11 | 10 | 10 |
| GS-04 | 1 | 1 | 1 |
| GS-03 | – | – | – |
| GS-02 | – | – | – |
| GS-01 | – | – | – |
| Subtotal | 1,446 | 1,443 | 1,541 |

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Commissioned Corps | 118 | 128 | 222 |
| Ungraded | 80 | 91 | 91 |
| Total positions | 1,726 | 1,745 | 1,938 |
| Total FTE usage, end of year | 1,335 | 1,347 | 1,502 |
| Average ES salary | $137,504 | $139,838 | $142,635 |
| Average GS grade | GS-12/2 | GS-12/2 | GS-12/2 |
| Average GS salary | $69,384 | $71,219 | $73,356 |
| Average Special Pay (Commissioned Corps) | $82,214 | $83,858 | $85,535 |
| Average Ungraded | $47,284 | $48,230 | $49,677 |

## NEW POSITIONS REQUESTED

| | FY 2008 | | |
|---|---|---|---|
| Positions | Grade | Number | Annual Salary |
| Administrative Appeals Judge (DAB) . . . | AAJ-6 | 2 | $155,200 |
| Attorney (DAB) . . . . . . . . . . . . . . . . . . . | GS-12/5 | 6 | $78,000 |
| Legal Technician (DAB) . . . . . . . . . . . . | GS-8/5 | 1 | $48,800 |
| Clerk (DAB) . . . . . . . . . . . . . . . . . . . . . . | GS-4/5 | 1 | $31,750 |
| Policy Analyst (OPHS) . . . . . . . . . . . . . | CO-06 | 2 | $115,554 |
| Policy Analyst (OPHS) . . . . . . . . . . . . . | CO-05 | 2 | $97,046 |
| Recruitment Specialist (OPHS) . . . . . . . . | CO-05 | 2 | $97,046 |
| Human Resource Specialist (OPHS) . . . . | CO-05 | 2 | $97,046 |
| Policy Analyst (OPHS) . . . . . . . . . . . . . | CO-04 | 1 | $82,191 |
| Recruitment Specialist (OPHS) . . . . . . . . | CO-04 | 1 | $82,191 |
| Human Resource Specialist (OPHS) . . . . | CO-04 | 1 | $82,191 |
| Policy Analyst (OPHS) . . . . . . . . . . . . . | CO-03 | 1 | $65,159 |
| Team Commander (OPHS) . . . . . . . . . . . | CO-06 | 2 | $115,554 |
| Deputy Team Commander (OPHS) . . . . . | CO-06 | 2 | $115,554 |
| Operations Chief (OPHS) . . . . . . . . . . . . | CO-06 | 2 | $115,554 |
| Planning Chief (OPHS) . . . . . . . . . . . . . | CO-06 | 2 | $115,554 |
| Logistics Chief (OPHS) . . . . . . . . . . . . . | CO-06 | 2 | $115,554 |
| Administrative Chief (OPHS) . . . . . . . . . | CO-06 | 2 | $115,554 |
| Safety Officer (OPHS) . . . . . . . . . . . . . . | CO-06 | 2 | $115,554 |
| Chief Medical Officer (OPHS) . . . . . . . . | CO-06 | 2 | $115,554 |
| Chief Nurse (OPHS) . . . . . . . . . . . . . . . | CO-06 | 2 | $115,554 |
| Chief Pharmacist (OPHS) . . . . . . . . . . . . | CO-06 | 2 | $115,554 |
| Chief Health Officer (OPHS) . . . . . . . . . . | CO-06 | 2 | $115,554 |
| Chief Applied Health Officer (OPHS) . . . | CO-06 | 2 | $115,554 |

| | | | |
|---|---|---|---|
| Physician (OPHS) .................. | CO-05 | 8 | $97,046 |
| Physician (OPHS) .................. | CO-04 | 8 | $82,191 |
| Nurse/Nurse Practioner (OPHS) ....... | CO-05 | 10 | $97,046 |
| Nurse/Nurse Practioner (OPHS) ....... | CO-04 | 14 | $82,191 |
| Nurse/Nurse Practioner (OPHS) ....... | CO-03 | 20 | $65,159 |
| Nurse/Nurse Practioner (OPHS) ....... | CO-02 | 20 | $59,694 |
| Pharmacist (OPHS) ................. | CO-05 | 2 | $97,046 |
| Pharmacist (OPHS) ................. | CO-04 | 6 | $82,191 |
| Pharmacist (OPHS) ................ | CO-03 | 6 | $65,129 |
| Dentist (OPHS) ................... | CO-05 | 2 | $97,046 |
| Dentist (OPHS) .................... | CO-04 | 3 | $82,191 |
| Dentist (OPHS) .................... | CO-03 | 3 | $65,129 |
| Occupational Health Specialist (OPHS) . | CO-05 | 2 | $97,046 |
| Occupational Health Specialist (OPHS) . | CO-04 | 2 | $82,191 |
| Occupational Health Specialist (OPHS) . | CO-03 | 2 | $65,129 |
| Occupational Health Specialist (OPHS) . | CO-02 | 2 | $59,694 |
| Veternarian (OPHS) ................ | CO-05 | 1 | $97,046 |
| Veternarian (OPHS) ................ | CO-04 | 2 | $82,191 |
| Veternarian (OPHS) ................ | CO-03 | 1 | $65,129 |
| Mental Health Specialist (OPHS) ...... | CO-05 | 3 | $97,046 |
| Mental Health Specialist (OPHS) ...... | CO-04 | 3 | $82,191 |
| Mental Health Specialist (OPHS) ...... | CO-03 | 2 | $65,129 |
| Medical Records Specialist (OPHS) .... | CO-05 | 3 | $97,046 |
| Medical Records Specialist (OPHS) .... | CO-04 | 3 | $82,191 |
| Medical Records Specialist (OPHS) .... | CO-03 | 2 | $65,129 |
| Laboratory Specialist (OPHS) ......... | CO-05 | 1 | $97,046 |
| Laboratory Specialist (OPHS) ......... | CO-04 | 1 | $82,191 |
| Laboratory Specialist (OPHS) ......... | CO-03 | 1 | $65,129 |

| | | | |
|---|---|---|---|
| Laboratory Specialist (OPHS) . . . . . . . . . | CO-02 | 1 | $59,694 |
| Environmental Health Specialist (OPHS) | CO-05 | 2 | $97,046 |
| Environmental Health Specialist (OPHS) | CO-04 | 2 | $82,191 |
| Environmental Health Specialist (OPHS) | CO-03 | 2 | $65,129 |
| Environmental Health Specialist (OPHS) | CO-02 | 2 | $59,694 |
| Disaster Engineer (OPHS) . . . . . . . . . . . . | CO-05 | 1 | $97,046 |
| Disaster Engineer (OPHS) . . . . . . . . . . . . | CO-04 | 1 | $82,191 |
| Disaster Engineer (OPHS) . . . . . . . . . . . . | CO-03 | 1 | $65,129 |
| Disaster Engineer (OPHS) . . . . . . . . . . . . | CO-02 | 1 | $59,694 |
| Epidemiologist (OPHS) . . . . . . . . . . . . . . | CO-05 | 1 | $97,046 |
| Epidemiologist (OPHS) . . . . . . . . . . . . . . | CO-04 | 1 | $82,191 |
| Epidemiologist (OPHS) . . . . . . . . . . . . . . | CO-03 | 1 | $65,129 |
| Epidemiologist (OPHS) . . . . . . . . . . . . . . | CO-02 | 1 | $59,694 |
| Food Safety Officer (OPHS) . . . . . . . . . . | CO-05 | 2 | $97,046 |
| Food Safety Officer (OPHS) . . . . . . . . . . | CO-04 | 2 | $82,191 |
| Food Safety Officer (OPHS) . . . . . . . . . . | CO-03 | 2 | $65,129 |
| Food Safety Officer (OPHS) . . . . . . . . . . | CO-02 | 2 | $59,694 |
| Operations Officer (OPHS) . . . . . . . . . . . | CO-05 | 2 | $97,046 |
| Operations Officer (OPHS) . . . . . . . . . . . | CO-04 | 2 | $82,191 |
| Operations Officer (OPHS) . . . . . . . . . . . | CO-03 | 2 | $65,129 |
| Operations Officer (OPHS) . . . . . . . . . . . | CO-02 | 2 | $59,694 |
| Planning Officer (OPHS) . . . . . . . . . . . . . | CO-05 | 2 | $97,046 |
| Planning Officer (OPHS) . . . . . . . . . . . . . | CO-04 | 2 | $82,191 |
| Planning Officer (OPHS) . . . . . . . . . . . . . | CO-03 | 1 | $65,129 |
| Planning Officer (OPHS) . . . . . . . . . . . . . | CO-02 | 1 | $59,694 |
| Administrative Officer (OPHS) . . . . . . . . | CO-05 | 1 | $97,046 |
| Administrative Officer (OPHS) . . . . . . . . | CO-04 | 1 | $82,191 |
| Administrative Officer (OPHS) . . . . . . . . | CO-03 | 2 | $65,129 |

| | | | |
|---|---|---|---|
| Administrative Officer (OPHS) . . . . . . . . | CO-02 | 2 | $59,694 |
| Logistics Officer (OPHS) . . . . . . . . . . . . . | CO-05 | 2 | $97,046 |
| Logistics Officer (OPHS) . . . . . . . . . . . . . | CO-04 | 2 | $82,191 |
| Logistics Officer (OPHS) . . . . . . . . . . . . . | CO-03 | 2 | $65,129 |
| Logistics Officer (OPHS) . . . . . . . . . . . . . | CO-02 | 2 | $59,694 |
| TOTAL . . . . . . . . . . . . . . . . . . . . . . . . . . . | | 232 | |

## 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 | FUNDING |
|---|---|---|
| President's Council on Bioethics | The Council was created by President Bush in 2001 to advise him on bioethical issues related to advances in biomedical science and technology. The President has extended the Council's charter through September 30, 2007. Funding for the Council (including 18 members and 13 staff) comes entirely from HHS. | $2,500,000 |
| HSPD-12 Implementation | These funds will be used to fund the HHS Program Management Office for Homeland Security Presidential Directive 12 (HSPD-12), which requires Federal agencies to issue PIV-2 compliant ID cards to all HHS contractors and employees by October 2008. | $2,088,000 |
| 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. | $200,000 |
| 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. | $154,000 |
| TOTAL | | $4,942,000 |

In FY 2008, the GDM request reflects the conversion of the five following Taps to GDM direct budget authority:

- Energy Program Review (ASAM);
- Safety, Health and Environmental Management (ASAM);
- Safety Management Information System (ASAM);
- Human Capital Initiative (ASAM), and
- Media Outreach (ASPA).

These Taps, which total $287,000 in FY 2007, will no longer be funded from reimbursable authority contributions by other OPDIVs to GDM. Therefore, comparable adjustments for FY 2006 – FY 2008 have been made across the Department to reflect this change.

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

# OFFICE OF MEDICARE HEARINGS AND APPEALS


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## FY 2008 PROPOSED APPROPRIATION 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), $70,000,000, to be transferred in appropriate part from the Federal Hospital Insurance and the Federal Supplemental Medical Insurance Trust Funds.*

AMOUNTS AVAILABLE FOR OBLIGATION

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| General funds: | | | |
| Annual appropriation | $ — | $ — | $ — |
| Trust funds: | | | |
| Annual appropriation | 60,000,000 | 59,400,000 | 70,000,000 |
| Rescission pursuant to P.L. 109-149 | -600,000 | — | — |
| Subtotal | 59,400,000 | | |
| Section 202 transfer to CMS | -41,000 | — | — |
| Subtotal, adjusted trust funds/ budget authority | 59,359,000 | 59,400,000 | 70,000,000 |
| Unobligated balance lapsing | -570,000 | — | — |
| Total obligations | $58,789,000 | $59,400,000 | $70,000,000 |

## SUMMARY OF CHANGES

| | | |
|---|---|---|
| 2007 | General funds appropriation | $0 |
| | HI/ SMI adjusted trust funds transfer | 59,400,000 |
| | Total adjusted budget authority | 59,400,000 |
| 2008 | Request – General funds | 0 |
| | Request – HI/ SMI trust funds transfer | 70,000,000 |
| | Total estimated budget authority | 70,000,000 |
| | Net change | +$10,600,000 |

| | 2007 Current CR Base | | Change from Base | |
|---|---|---|---|---|
| | (FTE) | Budget Authority | (FTE) | Budget Authority |
| Increases: | | | | |
| A. Built-in: | | | | |
| 1. Annualization of January 2007 pay raise (2.2%) | (360) | $28,000,000 | (+22) | +$407,000 |
| 2. Effect of January 2008 pay raise (3.0%) | (360) | 28,000,000 | (+22) | +629,000 |
| 3. Within-grade increases and career ladder promotions | (360) | 28,000,000 | (+22) | +564,000 |
| Subtotal | | | | 1,600,000 |
| B. Program: | | | | |
| 1. Contractual Services | ( – ) | 14,000,000 | ( – ) | +7,400,000 |
| 2. New personnel | (360) | 28,000,000 | (+22) | +2,000,000 |
| Subtotal | | | | 9,400,000 |
| Total increases | | | | 11,000,000 |
| Decreases: | | | | |
| A. Built-in: | | | | |
| 1. Supplies and Materials/ Equipment | ( – ) | 2,000,000 | ( – ) | (400,000) |
| Net change | (360) | | (+22) | $10,600,000 |

BUDGET AUTHORITY BY ACTIVITY
(Dollars in thousands)

| | FY 2006 Actual | | FY 2007 CR | | FY 2008 Budget | |
|---|---|---|---|---|---|---|
| | FTE | Amount | FTE | Amount | FTE | Amount |
| Total budget authority ....... | 274 | $59,359 | 360 | $59,400 | 382 | $70,000 |

# BUDGET AUTHORITY BY OBJECT

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Full-time Equivalent Employment | 360 | 382 | 35 |
| Average SES salary | $129,284 | $136,653 | +$7,369 |
| Average GS grade | 13.2 | 13.5 | 0.3 |
| Average GS salary | $77,456 | $83,656 | +$6,200 |
| Personnel compensation: | | | |
| Full-time permanent | $28,000,000 | $30,000,000 | $2,000,000 |
| Other than full-time permanent | 0 | 0 | 0 |
| Other personnel compensation | 0 | 0 | 0 |
| Subtotal, personnel compensation | 28,000,000 | 30,000,000 | 2,000,000 |
| Civilian personnel benefits | 7,000,000 | 8,600,000 | 1,600,000 |
| Benefits to former personnel | 0 | 0 | 0 |
| Subtotal, Pay costs | 35,000,000 | 38,600,000 | 3,600,000 |
| Travel | 325,000 | 325,000 | 0 |
| Transportation of things | 75,000 | 75,000 | 0 |
| Rental payments to GSA | 7,000,000 | 7,140,000 | 140,000 |
| Rental payments to others | 0 | 0 | 0 |
| Communications, misc charges | 1,000,000 | 860,000 | -140,000 |
| Printing and reproduction | 0 | 0 | 0 |
| Other contractual services: | | | |
| Advisory and assistance services | 1,000,000 | 1,000,000 | 0 |
| Other services | 6,000,000 | 13,650,000 | 7,650,000 |
| Purchases of goods and services from Government accounts | 6,000,000 | 6,000,000 | 0 |
| Operation and maintenance of facilities | 1,000,000 | 750,000 | -250,000 |
| Research and development contracts | 0 | 0 | 0 |
| Medical care | 0 | 0 | 0 |
| Operation and maintenance of equipment | 0 | 0 | 0 |
| Subsistence and support of persons | 0 | 0 | 0 |
| Subtotal, Other contractual services | 14,000,000 | 21,400,000 | 7,400,000 |
| Supplies and materials | 1,000,000 | 900,000 | -100,000 |
| Equipment | 1,000,000 | 700,000 | -300,000 |
| Grants, subsidies and contributions | 0 | 0 | 0 |
| Subtotal, Non-pay costs | 24,400,000 | 31,400,000 | 7,000,000 |
| **Total, Budget Authority** | **$59,400,000** | **$70,000,000** | **$10,600,000** |

## SALARIES AND EXPENSES
(Budget Authority)

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Personnel compensation: | | | |
| Full-time permanent (11.1) | $28,000,000 | $30,000,000 | $2,000,000 |
| Other than full-time permanent (11.3) | 0 | 0 | 0 |
| Other personnel compensation (11.5/11.8) | 0 | 0 | 0 |
| Subtotal, personnel compensation (11.9) | 28,000,000 | 30,000,000 | 2,000,000 |
| Civilian personnel benefits (12.1) | 7,000,000 | 8,600,000 | 1,600,000 |
| Benefits to former personnel (13.0) | 0 | 0 | 0 |
| Subtotal, Pay costs | 35,000,000 | 38,600,000 | 3,600,000 |
| Travel (21.0) | 325,000 | 325,000 | 0 |
| Transportation of things (22.0) | 75,000 | 75,000 | 0 |
| Rental payments to others (23.2) | 0 | 0 | 0 |
| Communications, misc charges (23.3) | 1,000,000 | 860,000 | -140,000 |
| Printing and reproduction (24.0) | 0 | 0 | 0 |
| Other contractual services: | | | |
| Advisory and assistance services (25.1) | 1,000,000 | 1,000,000 | 0 |
| Other services (25.2) | 6,000,000 | 13,650,000 | 7,650,000 |
| Purchases of goods and services from Government accounts (25.3) | 6,000,000 | 6,000,000 | 0 |
| Operation and maintenance of facilities (25.4) | 1,000,000 | 750,000 | -250,000 |
| Research and development contracts (25.5) | 0 | 0 | 0 |
| Medical care (25.6) | 0 | 0 | 0 |
| Operation and maintenance of equipment (25.7) | 0 | 0 | 0 |
| Subsistence and support of persons (25.8) | 0 | 0 | 0 |
| Subtotal, other contractual services | 14,000,000 | 21,400,000 | 7,400,000 |
| Supplies and materials (26.0) | 2,000,000 | 1,600,000 | -400,000 |
| Subtotal, Non-pay costs | 17,400,000 | 24,260,000 | 6,860,000 |
| **Total Salaries and Expenses** | **$52,400,000** | **$62,860,000** | **$10,460,000** |

## AUTHORIZING LEGISLATION

| | 2007 Amount Authorized | 2007 CR | 2008 Amount Authorized | 2008 Budget |
|---|---|---|---|---|
| Medicare Prescription Drug, Improvement, and Modernization Act of 2003 . . . . . . . . . . . . . . . . . | Indefinite | $59,400,000 | Indefinite | $70,000,000 |

# APPROPRIATIONS HISTORY TABLE
(Non-Comparable)

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| FY 2006 | | | | |
| Appropriation | $80,000,000 | $60,000,000 | $75,000,000 | $60,000,000 |
| Rescission | – | – | – | -600,000 |
| FY 2007 | | | | |
| Appropriation | $74,250,000 | $70,000,000 | $70,000,000 | |
| CR | – | – | – | $59,400,000 |
| FY 2008 | | | | |
| Appropriation | $70,000,000 | | | |

# OFFICE OF MEDICARE HEARINGS AND APPEALS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $59,359,000 | $59,400,000 | $70,000,000 | +$10,600,000 |
| FTE | 274 | 360 | 382 | +22 |

Statement of the Budget Request

A total of $70,000,000 is requested from the Federal Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) Trust Funds, for the Office of Medicare Hearings and Appeals (OMHA) to hear cases under title XVIII of the Social Security Act, and related provisions in title XI of that Act.

Program Description

The creation of OMHA was mandated 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 HHS. Since FY 1995, such appeals had been processed by ALJs at SSA, under an annual Interagency Agreement with HHS's Centers for Medicare & Medicaid Services (CMS). This responsibility was transferred to OMHA on October 1, 2005, as mandated by MMA.

MMA also mandated that the Secretary of HHS place the ALJ function in an administrative office organizationally and functionally separate from CMS, and which reports directly to the Secretary. Therefore, the OMHA Transition office was created in July 2004, to manage the transfer of the ALJ appeals function from SSA, establish OMHA, and enable OMHA to begin hearing ALJ cases during the last quarter of FY 2005. The newly hired Chief ALJ assumed full responsibility for OMHA operations in March 2005, and OMHA officially opened its doors on July 1, 2005 to begin processing Medicare appeals. OMHA is now in its second year of operation, and as of January 3, 2007, has received over 37,000 Medicare Part A, B, C and D appeals cases from across the United States, containing approximately 146,000 claims.

Additionally, P.L. 106-554, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), also mandates that ALJ-level Medicare appeals be heard within 90 days after receipt of a request from a Medicare appellant for such an appeal. (SSA's processing time for such appeals was 1-2 years.) This requirement became effective when CMS issued final regulations regarding the establishment of the new second level of Medicare appeals (Qualified Independent Contractors, or QICs). The QICs for Part A was established in May 2005; the QICs for Part B was established in January 2006.

**Mission Statement**

The mission of OMHA is to provide the basic mechanisms through which individuals and organizations who are dissatisfied with Medicare determinations affecting their rights to, or their

participation in, the Medicare program may administratively appeal these determinations, in accordance with the requirements of the Administrative Procedures Act and the Social Security Act.

As required by MMA, OMHA is organizationally and functionally separate from CMS. Under direct delegation from the Secretary, OMHA administers the hearings and appeals program nationwide for the Medicare program. OMHA issues decisions on highly complex, appealed determinations involving Parts A, B, C and D of Medicare, on Medicare entitlement appeals, and on Income Related Monthly Adjustment Amount cases.

**Medicare Appeals Process**

More than 42 million Americans currently receive Medicare benefits. On an annual basis, carriers and intermediaries process approximately 1 billion claims for payment, with carriers processing Medicare Part B claims (84 percent) and intermediaries generally processing Medicare Part A claims (16 percent). Of the 1 billion total claims, carriers and intermediaries approve payment for approximately 900 million (90 percent), and deny payment for approximately 10 million (10 percent).

Claims submitted for Medicare items and services are denied for a variety of reasons. The most common reasons for denying a claim are:

- the services provided were determined to not have been medically necessary for the beneficiary;
- Medicare did not cover the services; or
- the beneficiary was not eligible for the services.

A majority of all denials are for Medicare Part B claims processed by the Medicare carriers. Historically, approximately 14 percent of all Medicare Part B claims are denied at the initial level, while approximately 8 percent of all Medicare Part A claims are denied at the initial level.

Generally, beneficiaries, providers and suppliers have the right to appeal denied claims if their appeals are (1) filed within the required timeframes, and (2) satisfy the “amount in controversy” requirements. This first level of appeal, called a **redetermination**, is heard by the appropriate carrier or intermediary. Beneficiaries can assign their appeal rights to the provider or supplier that furnishes the item or service in question. As a result, the current appeals process is dominated by provider or supplier appellants, with a smaller subset of beneficiaries bringing appeals on their own behalf. Therefore, the actual number of individual beneficiaries involved in a specific appeal varies, since a specific provider or supplier may group appeals, or beneficiary appellants may aggregate their claims to meet the dollar threshold requirements.

Under new rules mandated by BIPA, if the carrier or intermediary renders a decision upholding the denial of payment, the provider, supplier or beneficiary may then request a second level of appeal. This second level, called a **reconsideration**, is conducted by Qualified Independent Contractors (QICs). If a QIC again upholds the denial, the provider, supplier or beneficiary may then submit an appeal at the third level of the appeals process, the **ALJ** level. From July 1, 2005 to January 3, 2007, a total of 37,000 Medicare Parts, A, B, C, and D appeals from across the United States containing approximately 146,000 claims. (Typically less than 1 percent of Part B claims denied at the initial level are forwarded to the ALJ hearing level; less than .06 percent of Part A claims denied at the initial level make it to the ALJ hearing level.)

If the appellant is not satisfied with the decision at the ALJ level of appeal, the appellant may appeal to the fourth level, the **Medicare Appeals Council (MAC)**, part of the Departmental Appeals Board. If the appellant is not satisfied with the decision by the MAC, the final level of appeal is a lawsuit through the **Federal District Court**.

Although there are slight differences in the appeal flow for Medicare Part C appeals, they follow an approximately equivalent process, coming to Independent Review Entities (IREs) instead of QICs at the reconsideration level, before coming to the ALJ level.

**OMHA Organization and Locations**

Section 931 of the MMA requires the Secretary to "provide for an appropriate geographic distribution of administrative law judges....throughout the United States, to ensure timely access to such judges." Therefore, after examining data from SSA, the decision was made to organize OMHA as follows: one Immediate Office (or Central Office) and four field offices, which are geographically dispersed and staffed with ALJs who conduct impartial "de novo" hearings and make decisions on appealed determinations involving Medicare eligibility. The Central Office is located in Arlington, Virginia; the Atlantic Field Office is co-located with the Arlington Office. The three other field offices include the Southern Field Office in Miami, Florida; the Midwestern Field Office in Cleveland, Ohio; and the Western Field Office in Irvine, California.

The new OMHA locations are organized around the HHS Regional Offices, since Medicare contractors and providers are very familiar with the HHS regional structure. The three large OMHA Field Offices (Cleveland, Irvine and Miami) receive case workloads from their respective HHS Regions. The role of the fourth, and smaller, OMHA Field Office is to: hear cases from the metropolitan Washington DC area; address cases that are so complex as to interfere with the larger Field Offices' abilities to meet the mandated 90-day timeframe; and provide support to the Field Offices as caseloads fluctuate. The role of the Field Offices is to be a coordinating site for hearings to be held at locations throughout the country, either via video-teleconferencing (VTC) or in-person, near appellants' homes.

With the BIPA 90-day hearing timeframes, an extraordinarily large number of ALJs would be required if they were to travel from location to location to hear cases. The MMA legislation directed HHS to consider the feasibility of "conducting hearings using tele- or video-conference technologies." Therefore, OMHA utilizes VTC and telephone hearings extensively to provide appellants with more timely hearings, closer to their homes, and with vastly more access points than what SSA provided with more than 300 hearing office locations. 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 access for appellants that is equal to or better than what they experienced at SSA.

OMHA hired 54 ALJs (49 Supervisory ALJs , 4 Managing ALJs and 1 Chief ALJ) in its initial FY 2005 staffing level. In FY 2006, the number of ALJs increased to 67 to assist OMHA in meeting the 90-day case processing deadline. In FY 2007, OMHA is staffing the remaining 5 ALJ teams bringing the total number of ALJs to 72. The additional teams will not only support the Medicare Parts A, B, and C but also the additional work associated with the new Part D and Income Related Monthly Adjustment Amount (IRMAA) cases.

## Caseload Projections

From July 1, 2005 to September 30, 2006, OMHA received approximately 29,000 appeals containing 118,000 claims. In the 1st quarter FY 2007, OMHA received approximately 8,000 appeals containing 28,000 claims. This already represents a 43% increase in the number of appeals and a 21% increase in the number of claims nationwide.

OMHA will continue to monitor the caseload across the 72 ALJ teams and will adjust resources as necessary to continue to meet the statutory 90-day case processing timeframe. OMHA tracks its caseload by utilizing the Medicare Appeals System (MAS) developed and operated by CMS. (CMS charges OMHA for system operation, maintenance and enhancements, plus licensing fees.)

### Performance Analysis

In CY 2006, OMHA participated in the Program Assessment Rating Tool (PART) process and was rated as "Results Not Demonstrated." The overall assessment identified a lack of performance measures. In response to the PART findings, in June 2006 OMHA awarded a contract to Strategic Management Systems, Inc., to assist in developing and implementing OMHA's strategic plan, performance measures and efficiency measures.

In January 2007, OMHA completed its initial Strategic Plan, including organizational performance measures, for FYs 2007-2012. OMHA will implement its new performance measures on April 1, 2007, and will include a table of the measures, supporting workload data, and an outline of strategic objectives in its FY 2009 budget submission.

From July 1, 2005 to September 30, 2006, the average timeframe for processing BIPA cases was 84 days. In the 1st quarter of FY 2007, the average timeframe for processing BIPA cases was 49 days.

### Workload Statistics

The following figures are for the period July 1, 2005 – January 3, 2007:

| **Appeal Information** | **Total** |
|---|---|
| Number of appeals received | 37,700 |
| Number of claims received (one appeal may consist of several claims) | 146,427 |
| **Hearing Information** | |
| Number of hearings held | 9,998 |
| **Timeliness** | |
| Goal: Maintain 90-day adjudication time frames | |
| FY 2006 Target (number of days) | 90 |
| Actual | 84 |
| FY 2007 Target (number of days) | 90 |
| Actual (1st Quarter) | 49 |

Rationale for the Budget Request

The FY 2008 budget includes funding for a number of critical OMHA initiatives:

- OMHA will require 382 FTE to ensure the timely adjudication of all Medicare appeals, including additional Prescription Drug Benefit (Part D) claims and the Income Related Monthly Adjustment Amount (IRMAA) cases.
- OMHA will require the continued legal and administrative support provided by approximately 140 contractors working across the four offices nationwide to ensure the timely adjudication of appeals and strict adherence to all financial and administrative management internal controls.
- OMHA will implement a Nationwide Quality Assurance program to monitor compliance with legislative mandates and associated regulations, identify process/procedural issues, and implement a nationwide training program for all OMHA employees.
- In conjunction with CMS, OMHA will participate in the implementation of electronic file imaging within the Medicare Appeals System, to support end-to-end electronic case management across the field offices. Incorporating electronic imaging into OMHA's business processes will improve coordination of cases across the sites, and assist OMHA in implementing a Continuity of Operation Plan. Such a plan will aid OMHA in reallocating its workload in the event of an emergency at one or more of its field offices.
- OMHA also plans to design, develop, integrate, test and implement a Decision Generation and Storage System (DGSS), to assist its legal staff in conducting research, analyzing issues, and drafting decisions during the processing and adjudication of Medicare appeals, and to provide a readily searchable archive of previous OMHA decisions.
- OMHA will partner with CMS to develop an electronic interface from the DGSS to the Medicare Appeals System to provide a seamless transfer of legal information to and from both systems.
- OMHA will implement a centralized video teleconferencing control system to remotely connect, monitor, troubleshoot and control more than 40 VTC hearing rooms nationwide.
- OMHA will maintain interactive Internet and Intranet sites to improve communication with the public on Medicare and, specifically, adjudication/ case processing information to all.

In order for OMHA to be able to meet the BIPA requirement that ALJ-level cases received from a QIC be heard within 90 days after receipt, OMHA will require funding of $70,000,000 in FY 2008 to ensure appropriate levels of staffing and investments in technology. With this funding level, OMHA will be able to process the full ALJ appeal workload for Medicare Parts A, B, C and D cases received through the QICs and IREs along with the IRMAA cases, by utilizing state-of-the-art technology and increasing access to hearing sites and services by appellants. Medicare appellants will thus be assured of high-quality decisions, delivered in a more timely fashion – a tremendous benefit for all Medicare beneficiaries.

## DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Medicare Hearings and Appeals . . . | 274 | 360 | 382 |

Average GS Grade

| | |
|---|---|
| 2006. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | GS-12/7 |
| 2007 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | GS-13/2 |
| 2008 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | GS-13/5 |

## DETAIL OF POSITIONS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| AL-1 | 1 | 1 | 1 |
| AL-2 | 4 | 4 | 4 |
| AL-3 | 49 | 65 | 67 |
| Subtotal, ALJs | 54 | 70 | 72 |
| SES | 3 | 3 | 3 |
| GS-15 | 4 | 7 | 7 |
| GS-14 | 16 | 20 | 24 |
| GS-13 | 14 | 17 | 17 |
| GS-12 | 40 | 40 | 42 |
| GS-11 | 60 | 60 | 72 |
| GS-10 | 0 | 0 | 0 |
| GS-09 | 49 | 49 | 51 |
| GS-08 | 56 | 62 | 62 |
| GS-07 | 26 | 32 | 32 |
| GS-06 | 0 | 0 | 0 |
| GS-05 | 0 | 0 | 0 |
| GS-04 | 0 | 0 | 0 |
| GS-03 | 0 | 0 | 0 |
| GS-02 | 0 | 0 | 0 |
| GS-01 | 0 | 0 | 0 |
| Subtotal | 265 | 287 | 307 |
| Ungraded Positions | 0 | 0 | 0 |
| Total Positions | 322 | 360 | 382 |
| Total FTE usage, end of year | 274 | 360 | 382 |
| Average SES salary | $129,284 | $136,653 | $140,752 |
| Average GS grade | GS-12/7 | GS-13/2 | GS-13/5 |
| Average GS salary | $76,598 | $77,456 | $83,656 |

## NEW POSITIONS REQUESTED

| | FY 2008 | | |
|---|---|---|---|
| Position Title | Grade | Number | Annual Salary |
| Supervisory Judge . . . . . . . . . . . . . . . . . | ALJ-3 | 2 | $121,400 |
| Attorney . . . . . . . . . . . . . . . . . . . . . . . . | GS-14/5 | 4 | $106,000 |
| Attorney . . . . . . . . . . . . . . . . . . . . . . . . | GS-12/5 | 2 | $74,000 |
| Attorney . . . . . . . . . . . . . . . . . . . . . . . . | GS-11/5 | 12 | $65,800 |
| Paralegals . . . . . . . . . . . . . . . . . . . . . . . . | GS- 9/5 | 2 | $65,800 |
| TOTAL . . . . . . . . . . . . . . . . . . . . . . . . . . | | 22 | |

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

# OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

FY 2008 Budget — Page

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## FY 2008 PROPOSED APPROPRIATION LANGUAGE

*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 an interoperable national health information technology infrastructure, $89,872,000: Provided, That in addition to amounts provided herein, $28,000,000 shall be available from amounts available under section 241 of the Public Health Service Act to carry out health information technology network development.*

# AMOUNTS AVAILABLE FOR OBLIGATION[1]

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| General funds: | | | |
| Annual appropriation . . . . . . . . . . . . . . . . . . | $42,800,000 | $42,372,000 | $89,872,000 |
| Rescissions pursuant to PL 109-148 . . . . . | -428,000 | | |
| Section 202 transfer to CMS . . . . . . . . . . . | -29,107 | | |
| Adjusted Budget Authority . . . . . . . . . . . . . | $42,342,893 | $42,372,000 | $89,872,000 |
| Unobligated balance lapsing . . . . . . . . . . . . | 14,007 | – | – |
| Total obligations . . . . . . . . . . . . . . . . . . . . . | $42,328,886 | $42,372,000 | $89,872,000 |

[1]Excludes reimbursable activities carried out by this account and evaluation fund transfers.

# SUMMARY OF CHANGES

| | | |
|---|---|---|
| 2007 | Continuing Resolution | $42,372,000 |
| | Total estimated budget authority | 42,372,000 |
| 2008 | Budget | 89,872,000 |
| | Total estimated budget authority | 89,872,000 |
| | Net change | +$47,500,000 |

| | 2007 CR Budget Base | | Change from Base | |
|---|---|---|---|---|
| | (FTE) | Budget Authority | (FTE) | Budget Authority |
| Increases: | | | | |
| A. Built-in: | 28 | | +10 | |
| 1. Salaries | | $3,953,000 | | +$89,000 |
| 2. Benefits | | 1,119,000 | | +25,000 |
| Subtotal | | $5,072,000 | | +$114,000 |
| B. Program: | | | | |
| 1. All other | | $37,300,000 | | +$47,386,000 |
| Total increases | | | +10 | $47,500,000 |
| Net change | | | +10 | $47,500,000 |

## BUDGET AUTHORITY BY ACTIVITY

(Dollars in thousands)

| | FY 2006 Actual | | FY 2007 CR | | FY 2008 Budget | |
|---|---|---|---|---|---|---|
| | FTE | Amount | FTE | Amount | FTE | Amount |
| Total budget authority . . . . . . . . | 6 | $ 42,343 | 28 | $ 42,372 | 38 | $89,872 |
| [Evaluation Funds; non-add] . . . | | [$18,900] | | [$18,900] | | [$28,000] |

## BUDGET AUTHORITY BY OBJECT

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Full-time equivalent employment | 28 | 38 | +10 |
| Average SES salary | $163,530 | $167,519 | +$3,989 |
| Average GS grade | 13.7 | 15.6 | +2.1 |
| Average GS salary | $96,010 | $130,694 | +$34,684 |
| Personnel compensation: | | | |
| Full-time permanent | $3,898,000 | $3,987,000 | +$89,000 |
| Other than full-time permanent | – | – | – |
| Other personnel compensation | 55,000 | 55,000 | – |
| Subtotal | 3,953,000 | 4,042,000 | +89,000 |
| Civilian personnel benefits | 1,119,000 | 1,144,000 | 25,000 |
| Benefits to former personnel | – | – | – |
| Subtotal, pay costs | 5,072,000 | 5,186,000 | +114,000 |
| Travel | 100,000 | 100,000 | – |
| Transportation of things | – | – | – |
| Rental payments to GSA | 400,000 | 400,000 | – |
| Communications, utilities, miscellaneous charges – | – | – | – |
| Printing and reproduction | – | – | – |
| Advisory and assistance services | 21,200,000 | 35,761,000 | +14,561,000 |
| Other services | 15,600,000 | 48,425,000 | +32,825,000 |
| Purchases of goods and services from Government accounts | – | – | – |
| Research and development contracts | – | – | – |
| Subtotal, other contractual services | – | – | – |
| Supplies and materials | – | – | – |
| Equipment | – | – | – |
| Grants, subsidies and contributions | – | – | – |
| Subtotal, non-pay costs | 37,300,000 | 84,686,000 | +47,386,000 |
| Total budget authority | $42,372,000 | $89,872,000 | +$47,500,000 |

# SALARIES AND EXPENSES
(Budget Authority)

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Personnel compensation: | | | |
| Full-time permanent (11.1) | $3,898,000 | $3,987,000 | +$89,000 |
| Other than full-time permanent (11.3) | – | – | – |
| Other personnel compensation (11.5/11.8) | 55,000 | 55,000 | – |
| Subtotal, personnel compensation (11.9) | 3,953,000 | 4,042,000 | +89,000 |
| Civilian personnel benefits (12.1) | 1,119,000 | 1,144,000 | +25,000 |
| Benefits to former personnel (13.0) | – | – | – |
| Subtotal, pay costs | 5,072,000 | 5,186,000 | +114,000 |
| Travel (21.0) | 100,000 | 100,000 | – |
| Transportation of things (22.0) | – | – | – |
| Rental payments to others (23.2) | 400,000 | 400,000 | – |
| Communications, utilities, miscellaneous charges (23.3) | – | – | – |
| Printing and reproduction (24.0) | – | – | – |
| Other contractual services: | | | |
| Advisory and assistance services (25.1) | 21,200,000 | 35,761,000 | +14,561,000 |
| Other services (25.2) | 15,600,000 | 48,425,000 | +32,825,000 |
| Purchases of goods and services from Government accounts (25.3) | – | – | – |
| Operation and maintenance of facilities (25.4) | – | – | – |
| 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 | – | – | – |
| Supplies and materials (26.0) | – | – | – |
| Subtotal, non-pay costs | 37,300,000 | 84,686,000 | +47,386,000 |
| Total Salaries and Expenses | $42,372,000 | $89,872,000 | +$47,500,000 |

## AUTHORIZING LEGISLATION

| | 2007 Amount Authorized | FY 2007 CR | 2008 Amount Authorized | 2008 Budget |
|---|---|---|---|---|
| Office of the National Coordinator for Health Information Technology . . | $ – | $42,372,000 | $ – | $89,872,000 |

# APPROPRIATIONS HISTORY TABLE
(Non-Comparable)

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| FY 2006 | | | | |
| Appropriation | $75,000,000 | $46,100,000 | $32,800,000 | $42,800,000 |
| Rescission | | | | -$428,000 |
| Transfer to CMS | | | | -29,107 |
| FY 2007 | | | | |
| Appropriation | $89,872,000 | $86,070,000 | $51,313,000 | $42,372,000[1] |
| FY 2008 | | | | |
| Budget | $89,872,000 | | | |

[1] FY 2007 Continuing Resolution

# OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $ 42,343,000 | $ 42,372,000 | $89,872,000 | +$47,500,000 |
| *Evaluation Funds* | *$18,900,000* | *$18,900,000* | *$28,000,000* | *+$9,100,000* |
| FTE (including reimbursables) | 6 | 28 | 38 | +10 |
| [HCFAC account] | [$490,000] | [$490,000] | [$490,000] | [–] |

Statement of the Budget Request

The FY 2008 total program level request for the Office of the National Coordinator for Health Information Technology (ONC) is $117,872,000 – including $89,872,000 in budget authority and $28,000,000 in PHS evaluation funds; the total does not include $490,000 in expected HCFAC funds. This is a total increase of $56,600,000 above the comparable FY 2007 Continuing Resolution (CR) level.

These funds will accelerate the momentum that has been building over the last two years in support of both a National effort to implement an interoperable health information infrastructure, and the adoption of health IT technologies in the public and private healthcare sectors. Reaching this goal will reduce medical errors, improve quality, and produce greater value for all Americans.

Program Description

According to the Institute of Medicine, the U.S. health care delivery system is an information-intensive industry that is complex and highly fragmented, with an estimated spending level of $1.7 trillion in 2003. This fragmented health care system also contributes to the untimely deaths of an estimated 50,000 - 100,000 Americans each year. In January 2004, the President announced a health information technology (IT) plan that called for the development and implementation of a strategic plan to guide the nationwide implementation of interoperable health IT in both the public and private health care sectors, in order to prevent medical errors, improve quality and produce greater value for health care expenditures.

The President subsequently issued Executive Order 13335, which required the Secretary of HHS to appoint a national health information technology coordinator. The National Coordinator's role is to provide leadership for the development and nationwide implementation of an interoperable health IT infrastructure, which will improve the quality and efficiency of health care and, in particular, reduce medical errors, lower costs and provide better information for consumers and physicians. The President called for health information to follow patients throughout their care in a seamless and secure manner.

In July 2004, the National Coordinator released a "Framework for Strategic Action," which outlined 4 goals and 12 strategies to guide the development of a full strategic plan for national health care adoption. The strong support for the Framework created a unique opportunity for

accelerating the Nation's health IT agenda and will result in significant improvements in the quality, safety, and efficiency of health care and of individual and community health over the next decade.

ONC was officially established within the Office of the Secretary and formally announced in the Federal Register in August 2005. ONC was also designated as a separate HHS Staff Division and appropriation within the Office of the Secretary, with responsibility for its own operations.

In partnership with other government agencies, ONC issued a Request for Information (RFI) asking for input on how best to build, operate, and sustain a nationwide health information network to share clinical data in a secure and interoperable manner. The RFI drew more than 500 responses and the subsequent summary report was released to the public, describing a broad set of initiatives necessary to support the implementation of health IT. ONC began work to coordinate with public and private partners in the following areas:

- *Standards Harmonization* – To evolve and evaluate a process to harmonize industry-wide health IT standards.
- *Certification Commission for Healthcare Information Technology (CCHIT)* – To develop and implement a certification process for EHRs and health information networking.
- *Privacy and Security* – To evolve and advance plans to address variations in organization-level business policies and State laws related to privacy and security practices that might pose challenges to interoperable health information exchange.
- *Nationwide Health Information Network (NHIN) Architecture* – To evolve and evaluate prototypical nationwide health information network (NHIN) architectures and advance capabilities for widespread health information exchange.
- *Adoption of Electronic Health Records* – To develop a standardized methodology to assess EHR adoption through surveys and studies.
- *Hurricane Katrina Information Network and Digital Health Information Recovery Project* – To plan and promote the widespread use of interoperable health information exchange in the Gulf Coast regions affected by recent hurricanes.
- *Federal Health Architecture (FHA)* – An e-Gov Line of Business established in response to the President's Management Agenda. ONC provides leadership for FHA activities collaborating with more than 20 Federal agencies that have a health care line of business.
- *Interagency Health Information Technology Policy Council (the Policy Council)* – To coordinate Federal health IT policy decisions across Federal agencies

In 2005, Secretary Leavitt announced the formation of the American Health Information Community (AHIC), a national, public-private collaboration formed pursuant to the Federal Advisory Committee Act. The AHIC was established to facilitate the transition to interoperable electronic health systems in a smooth, market-led way and provides input and recommendations to the Secretary. Membership consists of a combination of key leaders in the public and private sectors who represent stakeholder interests in advancing health IT. Approximately 10 meetings are held per year; members of the public have the opportunity to listen on the Web and

participate during the public comment portion of each meeting. Additional information can be found at: http://www.hhs.gov/healthit/ahic.html .

The AHIC initially established four workgroups that were charged to make recommendations for specific, achievable near-term results in the following areas:

- *Biosurveillance* –Transfer of standardized and anonymized health data from the point of health care delivery to authorized public health agencies within 24 hours of its collection.

- *Chronic Care* –Secure messaging, as appropriate to health and care, as a means of communication between patients and the clinicians who care for them.

- *Consumer Empowerment* – Consumer-directed and secure electronic health care registration information and a medication history for patients.

- *Electronic Health Records* –Access by health professionals to current and historical laboratory results and interpretations, that is standardized, widely available and secure.

Additional AHIC work groups have been recently formed to address confidentiality, privacy and security; quality assessment and improvement; and the incorporation of personalized genomic information in health care.

Numerous approaches have been proposed to accelerate the adoption of health IT applications and make them interoperable. In order for this to occur, multiple stakeholders must be engaged and multiple issues and concerns must be resolved. Such a confluence, coupled with the development of the necessary technological infrastructure, can lead to a true break through of barriers that have precluded widespread implementation to date. These "breakthroughs" in specific areas will produce tangible and demonstrable value to the health care consumer within a two to three-year period.

The Secretary, ONC, and Federal and private partners and contractors have made, and continue to make, significant strides laying the foundation for interoperable health care. The requested funding will be used to achieve ongoing success toward both short and long-term goals.

Working closely with the Secretary and ONC, the AHIC moved quickly to formulate recommendations for four unique breakthrough opportunities in health IT that will begin laying the groundwork for progress. These recommendations generated significant work for ONC as the organization responsible for translating the recommendations into an actionable path forward. To sustain and build on this momentum and bring to maturity the AHIC workgroup recommendations, ONC will implement these actions through multiyear contracts necessary to carry out the agenda for health IT. Specifically, in addition to the ongoing work from FY 2006 and FY 2007, the implementation of four breakthrough opportunities will be evaluated through a series of projects in multiple sites.

ONC is managing multiple contracts that are defining the requirements for and producing several prototype network architectures that will demonstrate potential methods and standards necessary to support safe and secure nationwide health information exchange.

In August 2006, the President issued an Executive Order (13410) that addresses Four Pillars necessary to transform the U.S. health care system to one that provides greater value:

- Widespread adoption of Health IT Standards Panel (HITSP) standards for interoperability of health information;
- Use of consensus-based, standardized, quality metrics that can compare care rendered by different providers;
- Transparency in health care pricing; and
- Incentives for providers to demonstrate improved outcomes of care and for consumers to access high value health care.

The Executive Order directs Federal agencies that contract for the implementation of, or upgrade of systems -- used for the direct exchange of health information between agencies and with non-Federal entities -- to incorporate into their contracts and agreements standard language that will require the utilization of health information technology systems and products that meet recognized interoperability standards. ONC will lead a cross-agency task force that will develop contractual language and an implementation plan and timeline for inclusion in the various agency contracts and agreements.

To that end, ONC is working with relevant agencies and departments, to assure that milestones are in place and meet the timeframe necessary to achieve the requirements relative to HITSP interoperability standards.

Rationale for the Budget Request

The FY 2008 budget includes a number of new initiatives as well as support for ongoing programs.

**New Initiatives**

*Priority Projects for Health Information Technology (FY 2008 Budget $22,000,000; +$19,500,000 increase over the FY 2007 CR level):* The FY 2008 request of $22,000,000 will build upon work started in FY 2007 to demonstrate the value of widespread availability and access of interoperable health information, and support the initial efforts to transition the work of the AHIC to the private sector.

In FY 2007, work will begin on early breakthrough planning and development of a methodology that will demonstrate and measure the value of interoperable health IT availability to consumers, providers, and payers in each of four breakthrough areas. Each breakthrough will require pilot implementations in multiple settings.

In FY 2008, breakthroughs will be funded to demonstrate the value of interoperable health IT availability in varying environments. Funds will be used to contract with non-Federal partners (i.e., states, regional communities, health care organizations, etc.) to provide necessary support for implementations and measure the value of these breakthroughs to stakeholders as adoption progresses. Areas to be demonstrated and evaluated include:

- *Biosurveillance* - Transmission within 24 hours of information critical to bio-surveillance;
- *Chronic Care* - Widespread availability of secure communications between patients and their clinicians to foster better management of chronic conditions;
- *Consumer Empowerment* - Widespread availability of electronic registration information and medication histories to generate interest and use of empowering personal health

records by consumers; and
- *Electronic Health Records* - Widespread availability of current and historic laboratory results to enhance the value of electronic health records.

Concurrent with these ongoing implementation activities, in preparation for the AHIC charter expiring in the next three years, plans developed in 2007 will begin a transition of this work to the private sector. The next step will be to transition the activities of the AHIC to a neutral non-governmental, public-private entity as a Partnership for Health and Care Improvement (Partnership). Beginning in FY 2008, the AHIC will move the activity of guiding the national health IT policy from a government-managed activity to one that is driven by the private sector. It will sustain the vision to accelerate the adoption of health IT nationwide and provide a foundation for the long-term success of the quality and transparency initiatives. The Partnership will prioritize and oversee the efforts outlined below, including attention to patient engagement with electronic health information. The Partnership will also be the coordinating governance body for work related to the development and reporting of information about the quality and value of health care.

Given the competitive nature of the health care industry, the sharing of these types of information requires a governance body comprised of its multiple stakeholders. Such a body is unlikely to form without initial governmental support.

Specific Activities of the Partnership will include:

- Create a governance structure that includes membership from multiple stakeholder groups as well as the ability to form workgroups as necessary to inform the governance structure; develop bylaws and processes for sustainable operations; develop a self-sustaining business model; and develop a business process for oversight of standards development -- both for interoperability specifications and for quality/value reporting.
- Prioritize and oversee other processes and programs related to support for national adoption of interoperable health IT, such as: certification processes, development of a nationwide health information network, privacy and security policies, measurement of adoption of health IT, assessment of policies and interventions to support health IT adoption, and use of local, regional, state-based information exchange models for transmission of clinical information. These will encompass technologies used by patients and consumers as well as providers of care.
- Prioritize the use of health IT to develop a person-focused system for health, rather than further entrench the provider-focused care model.
- Develop process to maintain and update existing standards and measures.
- Link with international efforts for health care assessment and information exchange.
- Investigate financial models for generating, exchanging, and using interoperable health information.
- Develop recommendations on workforce-related issues with respect to health IT.

The contract for the Partnership will be awarded competitively. The funding will be for expenses associated with the Partnership and not for any internal ONC costs associated with this effort and will support the priority setting process based on the development of a broad base of consensus.

<u>Data Standards Initiative</u> *($5,000,000, +$5,000,000 increase over the FY 2007 CR level)* This initiative would establish a fund within ONC for health data and health IT standards

development and related activities (such as mapping and evaluation) to support HHS implementation of public-private consensus health IT standards. Further, this fund would support Department-wide, interagency efforts in the convergence and adoption and use of public-private voluntary consensus standards.

Standards are the foundation of the current strategy. Previous and current HHS activities, are built on a market-based approach and a reliance on industry consensus-based data, including consideration of those health IT standards that are harmonized to an appropriate level of specificity through the Health Information Technology Standards Panel (HITSP) for message formats, data exchange, content, etc. Without a focus on data standards with detailed interoperability specifications, little progress in interoperability is likely. While reliance on data and technical standards is the central element of the HHS health IT strategy, the funding for HHS Federal data standards responsibilities is actually small, fragmented and ad hoc. A dedicated source of funding for HHS data standards work is needed. ONC plays an important role in supporting standards and making them available for use nationally.

*Personal Health Record (PHR) Architecture (FY 2008 Request $6,000,000; +$6,000,000 increase over the FY 2007 CR level):* As technical standards for the secure transmission of data in electronic health records (EHRs) are now moving toward implementation, the focus toward personalizing health care is gaining momentum. Personal Health Records will play an important role in some consumer's interactions with their health data, and may play an even larger role in the ability of consumers to manage access to their personal health information. Currently, the marketplace is generating a broad number of PHR solutions that are not standards-based, do not exchange the data necessary to improve care, are not linked to consumers' health care providers' EHRs, and are lacking privacy and security protections. The proliferation of systems that lack necessary interoperability standards will make it much more difficult to change the marketplace in the future. This FY 2008 investment will help facilitate the development and enhancement of viable PHR architectures that will incorporate the recognized interoperability standards and leverage the nationwide health information network (NHIN) architecture work. Several prototype models will be funded.

**Ongoing Programs**

*The American Health Information Community (AHIC) (FY 2008 Request $2,891,000; -$109,000 decrease from the FY 2007 CR level):* In FY 2008, the AHIC will continue as a consensus and advisory body, and these funds will cover the operational costs of this continuation. The AHIC will continue to focus on removing barriers to EHR and PHR adoption; connecting public health and health care, enabling automated quality measurement and reporting; integrating medical genomic test data and decision support into EHRs; and ensuring confidentiality, privacy and security of electronic health data.

Activities to support and coordinate across these workgroups, which have been extremely active and committed to supporting the aggressive health IT agenda timeline, should level off in FY 2008 and decrease as the Partnership for Health and Care Improvement assumes the governance process for health IT in the Nation.

*Nationwide Health Information Network Architecture (FY 2008 Request $38,000,000; $15,000,000 increase over the FY 2007 CR level):* In FY 2007, $23,000,000 in contracts will be awarded to build upon the work of the initial nationwide health information network (NHIN) architecture prototypes and begin trial implementations in 7 to 10 state and regional health

information exchanges. In FY 2008, $38,000,000 will expand the number of sites and help support necessary capabilities to advance some trial implementations into production-level systems.

The NHIN is the critical element to provide "health information that follows the consumer" and "is available to support clinical decision-making." Since the NHIN is envisioned to be a 'network of networks,' it is critical that this combined effort be advanced for widespread, standards-based, secure health information exchange adoption. There are many developing information exchange efforts, but little consistency or standard architecture elements. The NHIN initiative represents the architectural standardization that will enable exchanges to work together and achieve interoperability.

The NHIN is progressing from prototype architectures to trial implementations and then to production capabilities. To achieve reliable and clinical dependable production, new levels of security and redundancy will be required. This investment will enable the prototype architectures to incorporate requirements of additional priority breakthroughs identified through AHIC deliberations, supporting of core and specialized network functions, ensuring security protections and demonstrating approaches for inter-network operations and data exchange. To have a 'network of networks,' it will be necessary to reach a critical mass of sites that will be ready for production implementation in order for these efforts to succeed.

*Standards Harmonization (FY 2008 Request $4,463,000; +$472,000 increase over the FY 2007 CR level):* In FY 2008, the Health Information Technology Standards Panel (HITSP), will expand standards harmonization to add other areas prioritized by the AHIC. Additionally, HITSP will continue work on standards for security and confidentiality infrastructure and update the existing HITSP interoperability specifications. Work will continue to solidify and refine the processes required to transfer the standards-setting process to the private sector. The harmonization of standards is critical to having the right standards to support the national health IT agenda, to identifying gaps in standards that need to be filled, and to develop the specificity in standards use that can achieve interoperability.

*Technology Certification (FY 2008 Request $4,959,000; +$2,487,000 increase over the FY 2007 CR level)*: The next phase of technology certification will build upon FY 2007 efforts and advance these efforts in several critical areas. Areas to be advanced include: compliance testing, inspection testing, ambulatory EHR specialty system certification, expansion of covered inpatient functionality, and a variety of different network certification needs. The Certification Commission for Health Information Technology (CCHIT) has made substantial progress in advancing a business model that will eventually achieve self-sustainment. ONC will continue to fund refinements to existing criteria for ambulatory EHRs, inpatient EHRs, and health IT networks. With the availability of standards recognized by the Secretary of HHS (the Health Information Technology Standards Panel "Interoperability Specifications"), certification will need to use substantial technical support for the purpose of testing electronic data exchange (conformance testing) with enough reliability that errors in transmissions can be detected and risks to patient information exchange can be minimized.

*Interoperable Security and Privacy (FY 2008 Request $19,568,000; +$9,000,000 increase over the FY 2007 CR level):* Security and privacy continue to be in the forefront as a concern for all consumers and health care providers. Beginning with FY 2005, ONC has funded an initiative that coordinates with public and private partners in 33 States and 1 Territory to identify the potential impact that variations in organization-level business policies and state laws have on

privacy and security practices – including those related to HIPAA – and to propose solutions to any identified challenges. This work is to be completed in 2007 and will provide a basic platform of consensus-driven solutions that will enable interoperable health information exchange.

The FY 2008 request will fund Interoperable Security and Privacy coordination efforts needed to develop solutions related to variations in State laws and organization level business policies for privacy and security requirements that pose challenges to automated health information exchange. This funding level will allow for engagement of additional states and territories that were not involved in the initial project and is critical for the next phase of addressing implementation of multi-state solutions to address those challenges to sharing information across state lines.

Additionally, beginning in FY 2006, ONC funded an initiative that formed a forum, now called the State Alliance for e-Health. This consensus-based, executive-level advisory body and task force comprised of representatives from states and territories will identify and assess approaches to resolve state-level health IT issues that affect multiple states and pose challenges to interoperable electronic health information exchange. In FY 2008, states and territories will be able to frame solutions within and across states in a collaborative manner that will increase the efficiency and effectiveness of the health IT initiatives that they develop.

Program Support across Initiatives *(FY 2008 Request $6,441,000; +$1,476,000 increase over the FY 2007 CR level)* In FY 2008, a Technical Infrastructure Program Support Office ($3,465,000) will carefully coordinate contracts related to the NHIN, standards harmonization and technology certification; and the National Institute of Standards and Technology ($2,976,000) will provide program support and expertise to support the various industry infrastructure work ranging from standards harmonization to NHIN architecture to health IT certification. These activities include not only the national health IT standards, systems certification and information networking activities, but also policy analysis regarding the effects of engaging these technologies and governance structures to support the secure exchange of interoperable information between regional, state, and Federal entities.

Office Operations *(FY 2008 Request $8,550,000; no change from the 2007 CR level)* The request for office operations will support the ongoing ONC operations as a functioning office within the Office of the Secretary, and allow ONC to provide continuing leadership for the development and nationwide implementation of an interoperable health IT infrastructure to improve the quality and efficiency of health care. This funding primarily supports the salaries and benefits of the 38 Federal FTEs. In addition, it will provide the resources necessary to reimburse the costs of our facilities, communications, computing assets, and a small number of Memoranda of Understanding, Inter-Agency Agreements and contracts supporting ONC administrative, financial, logistical and planning activities.

**Public Health Service Evaluation Funds**

PHS Evaluation Funds *(FY 2008 $28,000,000; +$9,100,000 increase over the FY 2007 CR level)* will be used to support initiatives that are continuations from FY 2006 and FY 2007. These programs (described above) include: standards harmonization, technology certification, interoperable security and privacy assessment and solutions, NHIN architecture development, and PHR architecture.

Performance Analysis/ Detail Overview

ONC has taken the first steps in leading the Nation toward the goal of most Americans having access to their electronic health information by 2014. A better understanding of what the incentives and barriers are to adoption of health IT will allow ONC to better focus activities and resources. To that end, performance measures related to the rate of physician adoption of electronic health records were developed along with the mechanisms to be able to annually report on progress.

During the development of the FY 2008 budget, ONC participated in a Program Assessment Rating Tool (PART) review. The overall PART assessment was 'results not demonstrated;' this was not unexpected with the office having been established in August 2005. ONC worked during this review process to establish performance measures that reflect ONC's influence in reaching the goals established in Executive Order 13335 and begins reporting on results with this budget. Additional information about the ONC PART may be found on the website www.ExpectMore.gov.

**Effects of Continuing Resolution on Performance Targets**
Given the uncertainty of final FY 2007 appropriation levels at the time ONC developed the performance targets for the FY 2008 Congressional Justification, the FY 2007 targets were not modified to reflect differences between the President's Budget and the Continuing Resolution funding levels. Enacted funding may require modifications of the FY 2007 performance targets or extend the reporting time of results. Performance measures that may be affected significantly are footnoted throughout the Performance Detail section.

**Summary of Performance Targets and Results**

| FY | Total Measures | Results Reported | | Targets | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Not Met | | |
| | | Number | % | Met | Total | Improved | % Met |
| 2005 | 2 | 2 | 100 | 2* | | | 100 |
| 2006 | 5 | 3 | 60 | 3** | 2 | | 60 |
| 2007 | 5 | | | | | | |
| 2008 | 5 | | | | | | |

* Both Measures set baselines in 2005.
** The measures 'not met' have yet to report data. Data will be available in May 2007.

| Long Term Goal: Increase adoption of Electronic Health Records (EHR) | | | |
|---|---|---|---|
| **Annual Measure** | **FY** | **Target** | **Results** |
| Increase physician adoption of EHRs *outcome* | 2014 | 51% | May-15 |
| | 2009 | 30% | May-10 |
| | 2008 | 24% | May-09 |
| | 2007 | 18% | May-08 |
| | 2006 | 14% | May-07 |
| | 2005 | Baseline | 10% |
| Increase the percentage of small practices with EHRs *outcome* | 2014 | 16% | May-15 |
| | 2009 | 11% | May-10 |
| | 2008 | 8% | May-09 |
| | 2007 | 5% | May-08 |
| | 2006 | 4% | May-07 |
| | 2005 | Baseline | 3% |

| Long Term Goal: Increase adoption of Electronic Health Records (EHR) | | | |
|---|---|---|---|
| **Annual Measure** | **FY** | **Target** | **Results** |
| Percent of physician offices adopting ambulatory EHRs in the past 12 months that meet certification criteria *outcome* | 2009 | 50% | Sep-09 |
| | 2008 | 25% | Sep-08 |
| | 2007 | 10% | Sep-07 |
| | 2006 | Baseline | 0% |
| Develop a unified set of standards to support requirements for broad health information exchange. *outcome* | | Targets under development | |
| Develop a mature Nationwide Health Information Network (NHIN) architecture that will support broad health information exchange. *outcome* | | Targets under development | |
| **Data Sources:** Annual health IT adoption survey published by George Washington University; | | | |
| **Data Validation:** Survey publication utilizes standardized methodology for defining and measuring health IT adoption. | | | |
| **Cross Reference:** HHS Strategic Goal 5: Improve the Quality of Health Care Services | | | |

[1], [2]

## Performance Detail

The Nation's leaders are focused on the importance of safe and effective health care while being well aware that the cost of providing that care is continuing to rise in both the public and private sectors. ONC, together with Federal and private-sector entities, have made great strides in moving the health IT agenda forward, as evidenced by the emphasis placed on these initiatives by all health care stakeholders across the United States. The long-term goal for ONC is that by 2014, most Americans will have access to safe, secure, and interoperable electronic health records through their physicians' offices. There are four areas of emphasis that are represented by performance measures to guide the Office and ensure that progress is made to reach this long-term goal. These areas are: physician adoption of EHRs, certification of EHR systems, development of unified standards, and development of a mature nationwide health information network architecture.

### *Measuring Physician Adoption of Electronic Health Records*

By 2014, at least 50 percent of physicians will have electronic health records (EHRs) for their patients as measured by a standardized methodology. The measure, 'Increase physician adoption of EHRs,' will lead ONC to a better understanding of the challenges to adoption of EHRs in health care settings. This is a critical step to successfully facilitate implementation. In FY 2006, ONC developed a methodology to better characterize and measure the state of EHR adoption and monitor the effectiveness of policies aimed at accelerating adoption of EHRs and interoperability.

[1] Continuing Resolution level of funding may delay completion of the annual survey.

[2] Continuing Resolution level of funding may limit progress toward addressing identified issues related to the adoption gap between large organizational practices and small independent practices.

An expert consensus panel was created to conduct an environmental scan of the current state of EHR adoption measurement. The resulting information was used to create a standard methodology for incorporation into existing surveys that will be utilized for measuring adoption in a consistent fashion. The baseline for this measure was established at 10 percent by the 2005 survey results. Based on the momentum gained in the health care community with the establishment of ONC in 2004, expectations are that the rate of adoption will increase moderately every year with the ultimate goal of 51 percent of physicians having adopted EHRs by 2014.

There is a subset of ambulatory physician practices that have other issues to overcome when considering adoption of EHRs. The measure, "Increase the percentage of small practices with EHRs" will guide ONC to determine what these challenges are and the solutions needed to overcome them. The long-term goal of this measure is to achieve, by 2014, an adoption rate for small physician practices that is representative of the physician community at large.

This measure will help focus on addressing the gap in adoption between large physician practices (20 or more physicians) and small physician practices (those with 5 or less physicians). Currently, the adoption rate for small physician practices is significantly lower than the national average. The targets for adoption among small practices reflect a lower starting point and the expected adoption rates associated with that baseline. Small physician offices are also more likely to have practices in underserved settings. The 2005 survey results indicate a 3 percent adoption rate of EHRs in small physician practices with the rate of adoption increasing each year thereafter.

In addition, an annual report will be published that will provide an update on the state of EHR adoption and discuss the effectiveness of policies aimed at accelerating adoption of EHRs and interoperability.

Other ongoing initiatives that support efforts of EHR adoption are:

*Easy and Immediate Access to Laboratory Data Through Electronic Health Records:*
To simplify health information access and communication among clinicians, the AHIC established the EHR Workgroup to focus on barriers and enablers of EHR adoption. One of the clear enablers is improved access to needed clinical information. Working as a public/private partnership with representation from all stakeholders, the EHR Workgroup initially focused on the AHIC's recommendation of *providing easy and immediate access to laboratory data through the EHR*. The workgroup developed recommendations for the Health Information Technology Standards Panel (HITSP), described below, to review and evaluate the core set of standards necessary to achieve laboratory EHR interoperability.

In addition, ONC responded to recommendations to review possible models for exchange of both current and historical laboratory information to determine which would require Clinical Laboratory Improvement Amendments (CLIA) or Health Insurance Portability and Accountability Act (HIPAA) guidance, regulatory change, and/or statute change. Recommendations with respect to privacy and security (similar to those of other workgroups) led to the formation of a Confidentiality, Privacy and Security Workgroup. Other recommendations regarding the need for the Federal government to lead the Nation in adoption of interoperability standards led to Executive Order 13410, which requires Federal adoption of these standards in its delivery systems (as they are upgraded), as well as including provisions for adoption in relevant Federal contracts. Metrics and milestones are being established to document progress toward

implementation, and pilot sites are being identified to demonstrate the value of this initiative to consumers and clinicians and laboratory providers and payers.

*Hurricane Katrina Information Network and Digital Health Information Recovery Project for the State of Louisiana:*
ONC initiated a project in 2005 that established a task force of local and national experts to help area providers turn to electronic medical records as they rebuild. The tremendous impact that Hurricane Katrina had on Gulf Coast residents was compounded by the loss of vital health information such as medical records, prescription information and laboratory results. The hurricane destroyed a large number of paper records maintained by physicians, hospitals nursing homes and other health care facilities. Despite the devastation, providers and payers using electronic medical records were largely able to preserve their systems and patient information. As physicians, hospitals and other facilities return to operation, they will need to rebuild medical records for their patients.

Local and national resources have combined to coordinate the planning for a digital health information recovery, as well as to develop a prototype of health information sharing that can be replicated throughout the region. This task force is helping to implement, support and disseminate state-of-the-art information technology that will contribute to an infrastructure that supports interoperable health care data exchange.

The partnership required to bring about this effort includes the Department of Health and Human Services, the Department of Veterans Affairs, the Department of Defense, the Department of Homeland Security, the Environmental Protection Agency, the National Science Foundation, the General Services Administration, and private sector resources.

*Clinical Decision Support:*
Clinical Decision Support (CDS), another potential incentive for adoption of EHRs, provides objective information and alerts to clinicians at the point of care, based on well-researched scientific knowledge and patient characteristics to guide the appropriate care for individual patients. The current challenge is to provide clinicians or patients with clinical knowledge tailored to each patient in a timely manner in order to improve the delivery of patient-centric, high quality care on a systematic basis.

In FY 2006, a roadmap was developed for clinical decision support and presented to the AHIC. More recently, the AHIC recommended the establishment of the Quality Workgroup that will, among other objectives, develop recommendations in FY 2007 to accelerate the use of clinical decision support that can enhance clinician performance and the overall system as measured by a uniform set of quality metrics. ONC will begin work to integrate CDS into both the quality aspects associated with EHRs and into the health information exchanges for consumer use.

*Promote adoption of remote monitoring technology for communication between providers and patients:*
Chronic disease can be difficult to manage and could be improved with better communication between the health care provider and the patient. The AHIC established the Chronic Care workgroup to make recommendations so that within one year, widespread use of secure messaging is fostered as a means of communication between patients and their clinicians about care delivery. ONC will initiate a demonstration pilot project will be completed in 2007 to prove the value of secure electronic communications.

*Anti-fraud for Electronic Health Records*:
In FY 2006, ONC received funds from the Health Care Fraud and Abuse Control Account of the U.S. Treasury for a project to explore and describe how the use of health IT can enhance and expand health care anti-fraud activities. The project involved collecting health care anti-fraud techniques from experts in Federal agencies, information technology vendors, health care providers, and private health insurance companies and developing a model that would help detect and deter fraud in EHR environments. This work is being coordinated with the Health Information Technology Standards Panel (HITSP) and the Certification Commission for Health Information Technology (CCHIT) to translate the model functionalities and requirements for health care anti-fraud data collection and management into EHR certification and standards criteria. The present work will be completed in 2007 and ONC anticipates continuing these efforts.

***Increase adoption of certified electronic health record systems***

One of the criteria for adoption is to ensure that the systems being adopted will be able to communicate with each other in a safe, secure and interoperable way. To that end, development of an interoperable infrastructure will accelerate the adoption of EHRs, as well as their use in a way that benefits consumers, purchasers, and society as a whole. The foundational infrastructure will continue to evolve over time so that by 2009, it will be better positioned to meet the needs of the health care system.

For many clinicians, incorporating an EHR into their practice is a daunting task; there are over 300 EHR products from which to choose; most are costly alternatives to their current business practice, and all will disrupt their current workflows. Further, EHRs pose special risks to small and rural providers, for whom resources are particularly scarce or not shared with other institutions.

In 2006, ONC funded an initiative, as a key part of the HHS health IT plan, for the development and evaluation of a certification process that would require that certified EHR products meet a set of criteria for functionality, security, and interoperability recognized by the Secretary of HHS. The Certification Commission for Healthcare Information Technology (CCHIT) is a non-profit, voluntary organization with public and private-sector representation established to certify health IT products, evaluate the feasibility and effectiveness of a compliance certification, and create an inspection process for EHRs as a means to mitigate the risks of EHR adoption and assure the interoperability of these products. The goals of the CCHIT are to: reduce the risk of health IT investment by physicians and other providers; ensure a minimum level of interoperability or compatibility of health IT products; assure payers and purchasers can provide incentives for EHRs where the investment will address systems needs that can improve quality; and protect the privacy of patients' personal health information.

CCHIT focused its first efforts on ambulatory EHR products for the office-based physician and provider. As of the start of 2007, CCHIT certified 39 ambulatory care EHR products. These certified products were inspected against published, accepted, criteria, using a fair and impartial jury process. CCHIT closely coordinates its work with the Health Information Technology Standards Panel (HITSP) and the National Health Information Network (NHIN) architecture efforts to ensure that all aspects of development are integrated.

CCHIT began the process of certification for inpatient EHR products and certified the first products in 2007. CCHIT criteria will continue to evolve and mature along with the HITSP interoperability standards from year-to-year. CCHIT has developed a forward-looking roadmap, to offer standards-development organizations a timeline to work against, and provide vendors with a guide for their development plans. As the CCHIT matures, it will move to be an independent organization with a self-sustainable business model.

***Develop a unified set of standards to support requirements for broad health information exchange***

This measure will guide ONC as a unified set of standards are developed through an established process that engages both the public and private sectors. The targets for this measure are under development. The proposed targets will establish achievement of milestones required to successfully develop harmonized standards and evolving these standards over time resulting in the ability to exchange health information. These are:

| Year | Target |
|---|---|
| 2009 | Harmonize a third set of standards and perform additional review of previously established standards for any necessary updates |
| 2008 | Harmonize a second set of standards for a second 'use case' |
| 2007 | Harmonize an initial set of standards around defined business needs as described in a 'use case' |

In 2006, progress toward this goal was made with the development of a process and roadmap for harmonizing standards and is discussed in greater detail below.

*Standards Harmonization Process for Health Information Technology:*
Data and technical standards are foundational to interoperability between systems, for supporting breakthrough activities and the vision of the nationwide health information network. Interoperability, in this instance, means the ability of different information systems, software applications and networks to communicate and exchange information in an accurate, effective, useful, and consistent manner. Competing standards, gaps in standards, lack of standards adoption and a lack of specificity in the use of standards has made systems implementation difficult and information flow problematic and has helped to create an unstable environment for investment in clinical systems.

Harmonization means the function of developing, reconciling, setting and maintaining of standards required to achieve interoperability of the structure and content of health care data, information, or concepts that are usefully exchanged or provided between and among care providers and public health authorities, and the interchange methods used to facilitate these exchanges.

ONC has made much progress in this area. In FY 2006, the Health Information Technology Standards Panel (HITSP) was established to be a multi-stakeholder coordinating body designed to provide the process within which affected parties can identify, select, and harmonize standards for communicating health care information throughout the health care spectrum. This panel is functioning as a partnership of the public and private sectors, with more than 260 organizations represented, and operates with a neutral and inclusive governance model. The initial set of HITSP Interoperability Specifications, that represented over 12,000 hours of expert work and the harmonization of over 700 standards for three breakthrough areas defined by the AHIC, was

submitted to HHS in October 2006 and was recommended by the AHIC to the Secretary of HHS for recognition and incorporation into business processes. The Secretary accepted the three HITSP Interoperability Specifications (Version 1.2) on December 28, 2006 and they will be recognized in their Version 2.0 form in December of 2007.

Pursuant to Executive Order 13410 on August 22, 2006, recognition of interoperability standards requires that each Federal health agency -- as it implements, acquires, or upgrades health IT systems used for the direct exchange of health information between agencies and with non-Federal entities -- to "utilize, where available, health IT systems and products that meet recognized interoperability standards." Therefore, Federal agencies would need to properly consider health IT systems and products that comply with these Interoperability Specifications when purchasing, implementing or upgrading such items. Similarly, the Executive Order directs Federal agencies to contractually require, to the extent permitted by law, certain entities with whom they do business, to use, where available, health IT systems and products that meet recognized interoperability standards. To that end, the Federal Health Architecture program is working across agency lines to incorporate approved standards into the Federal health IT system, in support of the Executive Order.

All efforts must support the development and implementation of appropriate privacy and security policies, practices, and standards for electronic health information exchange. The Privacy and Security Solutions contract, the Confidentiality, Privacy, and Security Workgroup and the HHS Health Information Technology Policy Council all coordinate efforts across various sectors to harmonize these policies, practices, and standards.

Other ONC efforts supporting the standardization of information exchange:

*Best practices for State-Level Health Information Exchange Organizations:*
Another aspect of accomplishing interoperability is the standardization of health information exchange across state lines. In FY2006, ONC funded a project to gather information from existing state-level health information exchanges and define, through a consensus-based process, best practices that can be disseminated across a broad spectrum of health care and governmental organizations. Information was gathered from nine mature state initiatives related to governance, legal, financial and operational characteristics, and health information exchange policies. A State Steering Committee and technical advisors analyzed the findings and obtained public input during a consensus conference on guiding principles for state-level health information exchanges. These principles and practical guidance for state-level health information exchange initiatives are now available to guide leaders of state-level public-private partnerships across the country.

*Biosurveillance Data Steering Group:*
The Biosurveillance Data Steering Group (BDSG), building on the work of the Biosurveillance Workgroup and the Health Information Technology Standards Panel (HITSP), made recommendations to the AHIC that were accepted that identify requirements for data needed from ambulatory care settings, emergency departments and laboratories, and hospitals for critical, multi-jurisdictional biosurveillance programs.

*Adoption of personal health records:*
ONC is committed to expanding access to personal health information and management tools. Consumers can take responsibility for their part in managing their care through personal health records (PHRs). There are a multitude of issues related to creating a standardized, secure and

interoperable PHR being addressed by the AHIC's Consumer Empowerment Workgroup. This workgroup is charged to make recommendations to the AHIC to gain wide-spread adoption of a PHR that is easy-to-use, portable, longitudinal, affordable, and consumer-centered. Preliminary recommendations related to this charge will be made to the AHIC in January 2007.

In 2006 and 2007, HITSP will identify the technical and data standards that can enable the availability of a core registration dataset and medication history including vocabularies, messaging, authentication, security standards, and appropriate documentation. Planned pilots for the electronic registration summary and medication history will be coordinated with HHS agencies and private sector health organizations to promote provider and consumer participation in a breakthrough priority project. The workgroup will analyze the challenges and make recommendations in 2007.

***Development of a mature Nationwide Health Information Network (NHIN) architecture***

ONC measures progress against the goal of developing a mature nationwide health information network architecture by monitoring achievement of major milestones required to successfully interconnect clinicians by developing an interoperable infrastructure to allow secure movement of health information that follows patients as they move across care settings. These milestones are under development and the proposed targets are:

| Year | Target |
|---|---|
| 2008 | Define NHIN architectures that are scalable and replicable |
| 2007 | Develop functional requirements for future operational NHIN prototypes |

In 2006, progress was made toward this goal with the development of prototypes for secure information exchange. These efforts are described in detail below.

*National Health Information Network (NHIN) Architecture*
An important step toward ensuring secure information exchange across the United States requires the development of a health IT architecture. Since the NHIN will be a "network of networks," this architecture is a critical component of making exchange possible. This work must be done collaboratively with other ONC efforts that are concurrently developing and evaluating a compliance certification process for networks, a standards harmonization process for the standards necessary for health information exchange, and privacy and security solutions, as well as Federal-specific activities being completed through the Federal Health Architecture program. This collaboration is essential because tasks within each initiative are interdependent and require a coordinated and systematic approach. For example, this effort requires laying the ground work that coordinates harmonized standards, policy and regulations, and architectures that can exchange interoperable information.

ONC's NHIN architecture initiative has developed and is evaluating prototype architectures for a nationwide health information network that maximize the use of existing resources, such as the Internet, to achieve widespread interoperability among software applications, particularly EHRs. These efforts are also intended to spur technical innovation for nationwide electronic sharing of health information in patient care and public health settings. The results will move the Nation toward the goals of having access to information that follows the consumer and support clinical decision-making by creating a usable architecture and environment for secure health information exchange. The NHIN initiative will be coordinated with the work of the Federal Health

Architecture Program and other interrelated infrastructure projects. The goal is to develop real solutions for nationwide health information exchange by stimulating the market through a collaborative public/private process and the development of network services.

In June 2006, proposed functional requirements for four NHIN architectures were submitted to ONC and a forum with over 400 participants was held to gain input and inform the community about them. This forum was open to the public and included participants in key processes supported by ONC and key representatives from other public, private, and non-profit health information technology stakeholders. The forum illuminated the service needs of a NHIN focusing on categories of "functional requirements" (i.e., security, data transmission and transformation, information location) and on the core system components and the requirements of applications that will be participating in the exchange of health information technology.

ONC is continuing to build upon the initial NHIN architecture prototypes by moving to trial implementations. These trial implementations will directly engage state and regional health exchanges to implement core NHIN functionality as well as implementing the breakthroughs of the AHIC. Additional enhancements will also be required to advance to production-level implementations. This combined effort is required to move toward the vision of a nationwide health information network. By the end of 2007, the trial implementations will be demonstrating inter-network health information exchange as well as breakthrough functionality in numerous health care markets nationally.

*Privacy and Security Solutions for Interoperable Health Information Exchange:*
An important activity that will support adoption, as well as facilitate interoperability, is the Privacy and Security initiative. The Department funded an initiative to coordinate public and private partners to identify challenges and advance plans to address variations in organization-level privacy and security practices, policies, and state laws that may pose challenges to interoperable health information exchange. Participating states are identifying potential challenges that these privacy and security practices and underlying state laws pose to health information exchange within and across states and developing plans to address problematic barriers. The variations in practices, policies, and state law will provide an environmental scan and provide solutions from a grassroots perspective on how to address state-level challenges in this area. It is anticipated that the results of this work, which is planned to be completed in 2007, will provide a basic platform of consensus-driven to privacy and security issues solutions that will enable interoperable health information exchange.

Other ongoing initiatives in support of development of broad health information exchange:

*State Alliance for e-Health:*
In 2006, ONC funded an initiative, formerly called the State Healthcare Alliance for Data Exchange Solutions (SHADES), that formed a forum – a consensus-based executive-level advisory body and task force comprised of representatives from states and territories that will: identify, assess, and through the formation of consensus solutions, identify approaches to resolve state-level health IT issues that affect multiple states and pose challenges to interoperable electronic health information exchange. Through this forum, states and territories will be able to frame solutions within and across states in a collaborative manner that will increase the efficiency and effectiveness of the health IT initiatives that they develop.

*Enable simultaneous flow of clinical care data to and among local, state, and Federal bio-surveillance programs:*

In the case of national crisis or attack, the flow of clinical care data to and among local, state, and Federal biosurveillance programs will be crucial. At its November 2005 meeting, the AHIC recommended the formation of a workgroup on biosurveillance. This workgroup was charged to develop a plan to enable the transmitting of certain data from health care providers to public health systems and work towards the implementation of a public health monitoring/response system. In May 2006, the workgroup made recommendations to the AHIC on this charge and will continue to make recommendations to implement the informational tools and business operation to support real-time nationwide public health event monitoring and rapid response management across public health and care delivery communities and other authorized government agencies.

## Major Management Challenges

*Government Accountability Office*:
In 2005, the Government Accountability Office (GAO) conducted an audit that provided an overview of the HHS efforts to develop and implement a national health IT strategy, identified lessons learned from the Department of Defense (DoD) and the Department of Veterans Affairs (VA) experiences with implementing electronic health records, and identified lessons from other countries' efforts to modernize health IT infrastructures. The Recommendation for Executive Action read as follows: "As a result of our work, we recommend that the Secretary of Health and Human Services establish detailed plans and milestones for each phase of the framework for strategic action and take steps to ensure that those plans are followed and milestones are met." In response, HHS agreed with the GAO recommendation and the Secretary established health IT as one of his Ten Top Priorities through 2008. The testimony related to this audit can be found at: http://www.gao.gov/new.items/d05628.pdf.

*Permanent Staff*:
ONC receives strong support from other Federal agencies, especially from those who provided temporary staffing during the initial formation of the office. These included staff from the Department of Health and Human Services: the Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Food and Drug Administration, Health Resources and Services Administration, Office of the General Counsel, and Office of the Secretary; National Institute of Standards and Technology; Department of Defense, Department of Homeland Security; and Department of Veterans Affairs. In addition to providing needed support during the very busy start-up period, these and many other Federal organizations have continued to work across agency lines to support this work. By the end of FY 2006, most positions had been announced and closed with permanent staff coming on board. However, with the vacancy of the National Coordinator, some positions have been difficult to fill. With the increasing workload generated by the AHIC recommendations and enthusiasm in the health care community, concerted efforts will be made to ensure adequate staffing is available to meet the challenges this fast-paced office faces.

## President's Management Agenda

*Budget and Performance Integration:*
ONC established long-term and annual goals in 2006 and has worked to achieve integration of performance and budget documents. As discussed above, during development of the FY 2008 budget, ONC participated in a program assessment. ONC will work to address the identified recommendations.

*Expanding Electronic Government:*
ONC is the designated Program Manager for the Federal Health Architecture (FHA). FHA is an eGov Line of Business established in response to the President's Management Agenda. FHA also aligns with the President's health IT plan, which is driven by Executive Order 13335. The Executive Order outlined the President's commitment to promoting health information technology to improve efficiency, reduce medical errors, improve quality of care, and provide better information for patients and physicians.

ONC works closely with the FHA Lead Partners (the Department of Health and Human Services as the Managing Partner, the Department of Veterans Affairs, and the Department of Defense) to provide leadership for health IT activities within the Federal government, and collaborates with more than 20 Federal agencies that have a health care line of business to support Federal sector health IT activities and support their participation in the Nation health IT agenda.

FHA plays a significant role through three goals:

- **Input:** A coordinated Federal voice and collaboration in the national health IT agenda including standards harmonization, the Nationwide Health Information Network, systems certification and other activities.
- **Implementation:** Support the implementation and adoption of recognized standards in the Federal health sector.
- **Accountability**: Ensure accountability for health IT activities in the Federal sector to advance interoperability; analyze compliance of the Federal health IT environment; and develop guidance to ensure Federal health IT investments align to the national agenda.

FHA provides a collaborative forum for Federal agencies involved in health IT activities. The need for interoperability of Federal health IT systems is amplified as the Nation moves toward general adoption of EHRs and faces threats such as emerging epidemics and acts of bioterrorism. The Federal voice in national issues is strengthened through the collaboration of agency subject matter experts who share their unique perspectives, which enables agencies to engage efficiently with Standards Development Organizations and other external entities.

FHA's progress to date:

- Defined better business processes to protect the nation's food supplies while saving money through inter-departmental cooperation.

- Leading the development of the Federal perspective on proposed health IT standards, and the functional requirements for the Nationwide Health Information Network.

- Coordinating agency adoption of national health IT standards, including the development of implementation plans.

- Developing requirements for an emergency response EHR that can be used to support emergency and routine health care activities; describing the role that an emergency responder EHR will provide, comprising, at a minimum, demographic, medication, allergy and problem list information; leveraging the work in related activities from the AHIC's Electronic Health Record Workgroup and elsewhere.

The FHA will continue to identify and implement high-value, high-priority opportunities to

advance Federal health IT. FHA's activities will align with recommendations identified by the AHIC and other Federal priorities such as: improving emergency care for citizens, accelerating Federal health IT standardization, improving Federal health IT cost-effectiveness, supporting the Nationwide Health Information Network, and reducing the reporting burden for businesses.

## DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Health Information Technology . . . . | 6 | 28 | 38 |

| Average GS Grade | |
|---|---|
| 2006 | GS-13/3 |
| 2007 | GS-13/7 |
| 2008 | GS-15/6 |

# DETAIL OF POSITIONS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Executive Level I | – | – | – |
| Executive Level II | – | – | – |
| Executive Level III | – | – | – |
| Executive Level IV | – | – | – |
| Executive Level V | – | – | – |
| Subtotal | – | – | – |
| Total – Executive Level Salaries | $– | $– | $– |
| ES-6 | – | – | – |
| ES-5 | 1 | 1 | 2 |
| ES-4 | – | – | – |
| ES-3 | 1 | 1 | 2 |
| ES-2 | – | 1 | 1 |
| ES-1 | – | – | – |
| Subtotal | 2 | 3 | 5 |
| SES Subtotal | 2 | 3 | 5 |
| GS-15 | 2 | 8 | 11 |
| GS-14 | 2 | 6 | 9 |
| GS-13 | 4 | 4 | 4 |
| GS-12 | 1 | 1 | 2 |
| GS-11 | 1 | 1 | 1 |
| GS-10 | – | – | – |
| GS-09 | 4 | 4 | 4 |
| GS-08 | 1 | 1 | 2 |
| GS-07 | – | – | – |
| GS-06 | – | – | – |
| GS-05 | – | – | – |
| GS-04 | – | – | – |
| GS-03 | – | – | – |
| GS-02 | – | – | – |
| GS-01 | – | – | – |
| Subtotal | 15 | 25 | 33 |
| Ungraded Positions | – | – | – |

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Total Positions | 17 | 28 | 38 |
| Total FTE usage, end of year | 6 | 28 | 38 |
| Average ES level | 1 | 3 | 3 |
| Average ES salary | $164,560 | $163,530 | $167,519 |
| Average GS grade | GS-13/3 | GS-13/7 | GS-15/6 |
| Average GS salary | $82,467 | $96,010 | $130,694 |

## NEW POSITIONS REQUESTED

| | FY 2008 | | |
|---|---|---|---|
| Position Title | Grade | Number | Annual Salary |
| Program Director | ES-2 | 2 | $159,238 |
| Senior Program Analyst . . . . . . . . . . . . . | GS-15/5 | 2 | $129,553 |
| Senior IT Specialist . . . . . . . . . . . . . . . . | GS-15/5 | 1 | $121,856 |
| Program Analyst . . . . . . . . . . . . . . . . . . | GS-14/5 | 3 | $103,594 |
| Program Analyst . . . . . . . . . . . . . . . . . . | GS-12/5 | 1 | $73,720 |
| Staff Assistant . . . . . . . . . . . . . . . . . . . . | GS-8/5 | 1 | $50,839 |
| TOTAL . . . . . . . . . . . . . . . . . . . . . . . . . . | | 10 | |

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

# PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

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# FY 2008 PROPOSED APPROPRIATION LANGUAGE

*For expenses necessary to support activities related to countering potential biological, disease, nuclear, radiological and chemical threats to civilian populations, and for other public health emergencies, $780,646,000, of which not to exceed $22,338,000, to remain available until September 30, 2009, is to pay the costs described in section 319F–2(c)(7)(B) of the Public Health Service Act.*

*For expenses necessary to prepare for and respond to an influenza pandemic, $948,091,000, of which $870,000,000 shall be available until expended, for activities including the development and purchase of vaccine, antivirals, necessary medical supplies, diagnostics, and other surveillance tools: Provided, That products purchased with these funds may, at the discretion of the Secretary, be deposited in the Strategic National Stockpile: Provided further, That notwithstanding section 496(b) of the Public Health Service Act, funds may be used for the construction or renovation of privately owned facilities for the production of pandemic vaccine and other biologicals, where the Secretary finds such a contract necessary to secure sufficient supplies of such vaccines or biologicals: Provided further, That funds appropriated herein may be transferred to other appropriation accounts of the Department of Health and Human Services, as determined by the Secretary to be appropriate, to be used for the purposes specified in this sentence.*

*For expenses to provide screening and treatment for first response emergency services personnel related to the September 11, 2001, terrorist attacks on the World Trade Center, $25,000,000 shall be available until expended.*

## LANGUAGE ANALYSIS

| Language Provision | Explanation |
|---|---|
| "of which not to exceed $22,338,000, to remain available until September 30, 2009, is to pay the costs described in section 319F–2(c)(7)(B) of the Public Health Service Act." | This language provides funding for Project Bioshield. Funding will support oversight and implementation infrastructure for medical countermeasure procurement. |
| "For expenses necessary to prepare for and respond to an influenza pandemic, $948,091,000, of which $870,000,000 shall be available until expended, for activities including the development and purchase of vaccine, antivirals, necessary medical supplies, diagnostics, and other surveillance tools: Provided, That products purchased with these funds may, at the discretion of the Secretary, be deposited in the Strategic National Stockpile: Provided further, That notwithstanding section 496(b) of the Public Health Service Act, funds may be used for the construction or renovation of privately owned facilities for the production of pandemic vaccine and other biologicals, where the Secretary finds such a contract necessary to secure sufficient supplies of such vaccines or biologicals: Provided further, That funds appropriated herein may be transferred to other appropriation accounts of the Department of Health and Human Services, as determined by the Secretary to be appropriate, to be used for the purposes specified in this sentence." | This language provides funding for pandemic influenza activities, of which $870,000,000 is requested as no-year funds. |
| "For expenses to provide screening and treatment for first response emergency services personnel related to the September 11, 2001, terrorist attacks on the World Trade Center, $25,000,000 shall be available until expended." | This language provides no-year funding to support screening and treatment for World Trade Center first responders. |

# AMOUNTS AVAILABLE FOR OBLIGATION[1]

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| **Annual Appropriation** | $63,589,000 | $729,527,000 | $836,399,000 |
| Rescission pursuant to PL 109-77 | -635,890 | | |
| Section 202 transfer to CMS | -43,245 | | |
| Enacted Supplementals: | | | |
| Pandemic Influenza Act, PL 109-148 | 96,000,000 | | |
| Subtotal, Annual Appropriation | $158,909,865 | $729,527,000 | $836,399,000 |
| **Multi-Year Appropriation** | | | $22,338,000 |
| **No-Year Appropriation** | $– | | $895,000,000 |
| Rescission pursuant to PL 109-148 | -10,000,000 | | |
| Unobligated Balance (Smallpox Claims) | 14,628,912 | | |
| Recovery of Prior Year Obligations | | | |
| Enacted Supplementals | 5,504,000,000 | | |
| Pandemic Influenza Act, PLs 109-148 & 149 | -30,000,000 | | |
| Real Transfer to State Dept, PL 109-234 | $5,478,628,912 | | $895,000,000 |
| Subtotal, No Year Appropriation | | | |
| Total, adjusted budget authority | $5,637,538,777 | $729,527,000 | $1,753,737,000 |
| Unobligated balance, start of year | $52,017,405 | $3,278,788,048 | $15,000,000 |
| Unobligated balance, end of year | $3,278,788,048 | $15,000,000 | $15,000,000 |
| Unobligated balance lapsing | $841,189 | | |
| Total obligations | $2,409,926,945 | $4,008,315,048 | $1,753,737,000 |

[1] Excludes reimbursable activities carried out by this account and evaluation fund transfers.

## SUMMARY OF CHANGES

| | | |
|---|---|---|
| 2007 | Comparable CR Level | $729,527,000 |
| | Total estimated budget authority | $729,527,000 |
| 2008 | Budget | $1,753,737,000 |
| | Total estimated budget authority | $1,753,737,000 |
| | Net change | +$1,024,210,000 |

| | 2007 CR Budget Base | | Change from Base | |
|---|---|---|---|---|
| | (FTE) | Budget Authority | (FTE) | Budget Authority |
| **Increases:** | | | | |
| Assistant Secretary for Preparedness and Response | | $632,297,000 | | +$118,454,000 |
| Cyber-Security | | 9,482,000 | | +$500,000 |
| Medical Reserve Corps | | 9,748,000 | | +$5,365,000 |
| Pandemic Influenza | | 78,000,000 | | +$870,091,000 |
| World Trade Center | | – | | +$25,000,000 |
| Healthcare Provider Credentialing | | – | | +$3,300,000 |
| Security Coordination and Improvement | | – | | +$1,500,000 |
| Total Increases | (308) | $729,527,000 | (+167) | +$1,024,210,000 |
| **Decreases:** | | | | |
| Total Decreases | | | | $0 |
| Net Change | | | (+167) | +$1,024,210,000 |

# BUDGET AUTHORITY BY ACTIVITY
(Dollars in thousands)

| | FY 2006 Actual | | FY 2007 CR | | FY 2008 Budget | |
|---|---|---|---|---|---|---|
| | FTE | Amount | FTE | Amount | FTE | Amount |
| Bioterrorism . . . . . . . . . . | 240 | $651,142 | 284 | $651,527 | 451 | $780,646 |
| Pandemic Influenza . . . . | 11 | 5,152,000 | 24 | 78,000 | 24 | 948,091 |
| World Trade Center . . . . | – | – | – | – | – | 25,000 |
| TOTAL . . . . . . . . . . . . . . | 251 | $5,803,142 | 308 | $729,527 | 475 | $1,753,737 |

## BUDGET AUTHORITY BY OBJECT

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Full-time equivalent employment .... | 308 | 475 | 167 |
| Average SES salary ............... | $164,730 | $159,879 | -$4,851 |
| Average GS grade ................ | 13.6 | 13.4 | – |
| Average GS salary ................ | $91,118 | $89,721 | -$1,397 |
| Personnel compensation: | | | |
| Full-time permanent .............. | $23,134,000 | $42,460,000 | +$19,326,000 |
| Other than full-time permanent ..... | 379,000 | 396,000 | +17,000 |
| Other personnel compensation ...... | 423,000 | 809,000 | +386,000 |
| Military Personnel ............... | 3,694,000 | 3,841,000 | +147,000 |
| Special Personnel Services | – | – | – |
| Subtotal, personnel compensation .... | 27,630,000 | 47,506,000 | +19,876,000 |
| Civilian personnel benefits ......... | 6,100,000 | 10,715,000 | +4,615,000 |
| Military Benefits ................ | 871,000 | 906,000 | +35,000 |
| Benefits to former personnel ........ | – | – | – |
| Subtotal, pay costs .............. | 34,601,000 | 59,127,000 | +24,526,000 |
| Travel .......................... | 2,038,000 | 3,470,000 | +1,432,000 |
| Transportation of things ............ | 52,000 | 89,000 | +37,000 |
| Rental payments to GSA ........... | 3,207,000 | 5,635,000 | +2,428,000 |
| Rental payments to others .......... | 784,000 | 1,383,000 | +599,000 |
| Communications, misc charges ...... | 769,000 | 1,356,000 | +587,000 |
| Printing and reproduction .......... | 4,000 | 4,000 | – |
| Other contractual services: | | | |
| Advisory and assistance services .... | – | – | – |
| Other services .................. | 5,971,000 | 19,902,000 | +13,931,000 |
| Purchases of goods and services from Govt accounts ................. | 205,948,000 | 1,214,451,000 | +1,008,503,000 |
| Operation and maintenance of facilities ..................... | – | – | – |
| Research and development contracts | – | – | – |
| Medical care .................... | – | – | – |
| Operation and maintenance of equipment .................... | 922,000 | 1,626,000 | +704,000 |

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Subsistence and support of persons . . | – | – | – |
| Subtotal, other contractual services | 211,919,000 | 1,234,353,000 | +1,022,434,000 |
| Supplies and materials . . . . . . . . . . . . . | 3,339,000 | 5,722,000 | +2,383,000 |
| Equipment . . . . . . . . . . . . . . . . . . . . . . | 3,566,000 | 6,062,000 | +2,496,000 |
| Grants, subsidies and contributions . . . | 468,326,000 | 434,910,000 | -33,416,000 |
| Subtotal, non-pay costs . . . . . . . . . . | 694,926,000 | 1,694,610,000 | +999,684,000 |
| Total budget authority . . . . . . . . . . . . . | $729,527,000 | $1,753,737,000 | +$1,024,210,000 |

## SALARIES AND EXPENSES
(Budget Authority)

| | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|
| Personnel compensation: | | | |
| Full-time permanent | $23,134,000 | $42,460,000 | +$19,326,000 |
| Other than full-time permanent | 379,000 | 396,000 | +17,000 |
| Other personnel compensation | 423,000 | 809,000 | +386,000 |
| Military Personnel | 3,694,000 | 3,841,000 | +147,000 |
| Special Personnel Services | – | – | – |
| Subtotal, personnel compensation | 27,630,000 | 47,506,000 | +19,876,000 |
| Civilian personnel benefits | 6,100,000 | 10,715,000 | +4,615,000 |
| Military Benefits | 871,000 | 906,000 | +35,000 |
| Benefits to former personnel | – | – | – |
| Subtotal, pay costs | 34,601,000 | 59,127,000 | +24,526,000 |
| Travel | 2,038,000 | 3,470,000 | +1,432,000 |
| Transportation of things | 52,000 | 89,000 | +37,000 |
| Rental payments to others | 784,000 | 1,383,000 | +599,000 |
| Communications, misc charges | 769,000 | 1,356,000 | +587,000 |
| Printing and reproduction | 4,000 | 4,000 | – |
| Other contractual services: | | | |
| Advisory and assistance services | – | – | – |
| Other services | 5,971,000 | 19,902,000 | +13,931,000 |
| Purchases of goods and services from Govrn't accounts | 205,948,000 | 1,214,451,000 | +1,008,503,000 |
| Operation and maintenance of facilities | – | – | – |
| Medical care | – | – | – |
| Operation and maintenance of equipment | 922,000 | 1,626,000 | +704,000 |
| Subsistence and support of persons | – | – | – |
| Subtotal, other contractual services | 211,919,000 | 1,234,353,000 | +1,022,434,000 |
| Supplies and materials | 3,339,000 | 5,722,000 | +2,383,000 |
| Total, Salaries and Expenses | $254,428,000 | $1,307,130,000 | +$1,052,702,000 |

## SIGNIFICANT ITEMS IN APPROPRIATIONS COMMITTEE REPORTS

### FY 2007 Senate Appropriations Committee Report Language (H. Rpt 109-287)

Item

***Operating plan - access to supplies and equipment*** - In light of the imminent hurricane season and potential pandemic flu considerations, the Committee is concerned that responses to recent hurricanes revealed problems in assuring availability of an adequate blood supply through implementation of the National Response Plan. In particular, the local non-profit community-based blood centers experienced shortages of: fuel for generators to collect and maintain as well as vehicles to distribute a viable blood stock; reliable access to emergency communications; and availability of emergency transportation for distribution of blood and supplies. The Committee expects the Secretary of Health and Human Services, by August 1, 2006, to submit an operating plan with policies and procedures that ensure FDA-licensed or registered blood centers received priority access to fuel, communications equipment and frequencies, and transportation, consistent with their role as providers of emergency medical services. Further, this plan shall identify an impediments related to State responsibilities in providing priority access to those resources. In preparing the plan, the Secretary shall consult with the Secretary of Homeland Security and the Secretary of Transportation regarding coordination with their responsibilities under the Response Plan. (p. 169)

Action Taken or To Be Taken:

We at the Department of Health and Human Services (HHS) appreciate the opportunity to investigate the systematic assurance of an adequate blood supply and the required resources to maintain and distribute blood in the affected zone of a disaster. While a shortage of blood was not experienced during the 2005 hurricane season, there were requests for federal assistance to supply fuel to blood center vehicles which were not supported by the state Emergency Management Agency (EMA).

As a matter of routine, Federal agencies do not work directly with individual blood centers. Assistance is provided when requested through the state in order to ensure adherence to the local simple resource support options and plans that affect the interagency. The state or local EMA control or request scarce resources that exist in theater or that are moved in during, or immediately following, the event. Planning for the continuity of operations is essential in preparing for emergencies and disasters and would include the following activities: the assurance of fuel for emergency generators and business operations, access to communications, back-up electric power, and special requirements for transportation. It is incumbent upon individual local institutions to perform this type of planning and identify their requirements in concert with the local EMA. This will ensure that scarce resources that are required to maintain continuous operations during a disaster are properly accounted for thus permitting unfettered access by the blood bank community. This has been communicated to the AABB (formerly the American Association of Blood Banks). HHS has also appointed a Senior Health Official (SHO) to coordinate health and medical activities at the site of a disaster. This SHO can work with blood banks to ensure their functionality during disasters.

As requested, we will poll the blood bank community for any specific issues that can identify local barriers to their continuity of operations during the critical times of a disaster. We also pledge to work diligently with our partners at FEMA and the AABB Task Force, which represents the blood bank community's professional organizations, to identify policy, procedures, and tactics that ensure the priority delivery of this essential service. The blood banking system is considered as "critical infrastructure," and we will see that any issues discovered are shared with the appropriate Critical Infrastructure Working Group at the Department of Homeland Security.

## AUTHORIZING LEGISLATION

| | 2007 Amount Authorized | 2007 CR | 2008 Amount Authorized | 2008 Budget |
|---|---|---|---|---|
| Public Health Security and Bioterrorism Preparedness and Response Act, 2002 . . | | $651,527,000 | | $805,646,000 |
| Emergency Supplemental Appropriations Act to Address Hurricanes in the Gulf of Mexico and Pandemic Influenza, 2006 | | $78,000,000 | | $948,091,000 |

## APPROPRIATIONS HISTORY TABLE
(Non-Comparable)

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| FY 1998 | | | | |
| Appropriation | – | – | – | – |
| FY 1999 | | | | |
| Appropriation | – | – | – | $216,922,000 |
| Y2K Appropriation | – | – | – | 189,053,000 |
| FY 2000 | | | | |
| Appropriation | 386,022,000 | 391,800,000 | 475,000,000 | 583,600,000 |
| Rescission | | | | -437,000 |
| FY 2001 | 264,600,000 | 286,600,000 | 264,600,000 | 241,231,000 |
| Appropriation | | | | -282,000 |
| Rescission | | | | |
| Supplemental Appropriation | – | – | – | 126,150,000 |
| FY 2002 | | | | |
| Appropriation | 250,619,000 | 300,619,000 | 250,619,000 | 2,429,490,000 |
| Defense Approp | | | | 2,644,315,500 |
| Rescission | | | | -1,396,000 |
| FY 2003 | | | | |
| Appropriation | 1,806,180,000 | 2,507,184,000 | 2,306,580,000 | 2,246,680,000 |
| Rescission | | | | -14,604,000 |
| Transfer to Dept of Homeland Security (DHS) | | | | -427,638,000 |
| Supplemental Appropriation | | | | 142,000,000 |
| FY 2004 | | | | |
| Appropriation | 1,896,149,000 | 1,776,846,000 | 1,856,040,000 | 1,776,846,000 |
| Rescission | | | | -1,0483,000 |
| Transfer from DHS | | | | 397,640,000 |

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| FY 2005 | | | | |
| Appropriation | $61,456,000 | $61,456,000 | $61,456,000 | $161,456,000 |
| Rescissions | | | | -1,389,984 |
| Supplemental Appropriation | | | | 60,000,000 |
| FY 2006 | | | | |
| Appropriation | 203,589,000 | 60,633,000 | 60,633,000 | 63,589,000 |
| Rescissions | | | | -635,890 |
| Transfer to CMS | | | | -43,245 |
| Supplemental Appropriation | | | | 5,570,000,000 |
| FY 2007 | | | | |
| Appropriation | 218,413,000 | $160,475,000 | $166,907,000 | 15,895,311,047, |
| Transfer from DHS | | | | 000,000[1] |
| FY 2008 | | | | |
| Budget | 1,753,737,000 | | | |

[1] Reflects FY 2007 Continuing Resolution.

# PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND
(Office of the Secretary )

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $5,803,142,000 | $729,527,000 | $1,753,737,000 | +$1,024,210,000 |
| FTE | 251 | 308 | 475 | 167 |

*NOTE: Funding and FTE have been comparably adjusted to reflect the National Disaster Medical System (NDMS), the Advanced Development program, the Hospital Preparedness program, and Training and Curriculum Development.*[1]

## OVERVIEW

The FY 2008 request for the Public Health and Social Services Emergency (PHSSEF) is $1,753,757,000, and increase of $1,024,210,000 and 167 FTE above the FY 2007 comparable Continuing Resolution (CR) level. These funds will provide the necessary resources to:

- support a more comprehensive program to prepare for the health and medical consequences of bioterrorism and other public health emergencies;
- continue the Department's cyber-security efforts; and
- support the Department's pandemic influenza activities.

The budget justification which follows represents funds requested within the Office of the Secretary (OS) for the Office of the Assistant Secretary for Preparedness and Response (ASPR), the Office of the Assistant Secretary for Resources and Technology (ASRT), the Office of Public Health and Science (OPHS). This justification also requests funding for the Department's Pandemic Influenza Initiative, treatment for World Trade Center responders, healthcare provider credentialing, and security coordination and improvement.

[1] The *President's Budget Appendix* reflects the NDMS transfer in FY 2007 and the transfer of previously HRSA activities (hospital preparedness and training curriculum and development) in FY 2008.

# PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

## OFFICE OF THE SECRETARY – FUNDING SUMMARY
(Dollars in thousands)

| | FY 2006 Actual | FY 2007 Pres Budg | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|---|
| **Assistant Secretary for Preparedness and Response** | | | | |
| Operations | $9,147 | $13,031 | $9,190 | $13,031 |
| Preparedness & Emergency Operations | 14,942 | 48,090 | 14,942 | 48,090 |
| National Disaster Medical System | 47,000 | 47,000 | 47,000 | 53,000 |
| Hospital Preparedness | 473,882 | 451,507 | 473,994 | 413,843 |
| Training and Curriculum Development | 20,776 | 12,396 | 21,006 | – |
| Advanced Research and Development | 54,421 | 165,391 | 54,421 | 189,000 |
| Bioshield Management [1] | – | 22,363 | – | 22,363 |
| Intl Early Warning Surveillance | 8,988 | 9,028 | 8,988 | 9,028 |
| Media/Public Information Campaign | 2,756 | 2,396 | 2,756 | 2,396 |
| *Subtotal, ASPR* | 631,912 | 771,202 | 632,297 | 750,751 |
| **Assistant Secretary for Resources and Technology** | | | | |
| Cyber-Security | 9,482 | 9,342 | 9,482 | 9,982 |
| **Office of Public Health and Science** | | | | |
| Medical Reserve Corps | 9,748 | 22,121 | 9,748 | 15,113 |
| **Office of the Secretary** | | | | |
| Pandemic Influenza | 5,152,000 | 78,880 | 78,000 | 948,091 |
| World Trade Center | – | – | – | 25,000 |
| Healthcare Provider Credentialing | – | 7,271 | – | 3,300 |
| Security Coordination and Improvement | – | – | – | 1,500 |
| **Total, OS** | **$5,803,142** | **$888,816** | **$729,527** | **$1,753,737** |

[1] In FY 2006, funding for Bioshield management ($11M) was budgeted within the Strategic National Stockpile at CDC.

# ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $631,912,000 | $632,297,000 | $750,751,000 | +$118,454,000 |
| FTE | 234 | 279 | 446 | 167 |

*NOTE: Funding has been comparably adjusted to reflect the National Disaster Medical System (NDMS), the Advanced Development program, the Hospital Preparedness program, and the Training and Curriculum Development where appropriate. The request assumes Project BioShield program management is funded through direct appropriations in FY 2008. In addition, the request assumes funding for Pandemic Influenza program management is included within the consolidated request for the Office of the Secretary.*

## Statement of the Budget

The FY 2008 request for the Office of the Assistant Secretary for Preparedness and Response (ASPR) to direct the Department's efforts to prepare for, protect against, respond to, and recover from all public health emergencies, including acts of bioterrorism that affect the civilian population, is $750,751,000, an increase of $118,454,000 above the comparable FY 2007 Continuing Resolution (CR) level. The total staff to support the programmatic responsibilities of ASPR in FY 2008 will be 528.

## Program Description

Carrying out HHS' responsibility as the primary agency for medical and public health preparedness requires the diverse and unique skills of scientists, public health experts and health care providers at the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Agency for Healthcare Research and Quality (AHRQ), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Through its program offices, ASPR focuses the activities of these agencies, develops and coordinates national policies and plans, provides program oversight, and is the Secretary's public health emergency representative to other federal, state and local organizations.

The Pandemic Preparedness and All-Hazards Preparedness Act, enacted December 19, 2006, created both the position and the Office of the Assistant Secretary for Preparedness and Response. The Act provides ASPR with "authority over and responsibility for" NDMS (as of January 1, 2007) and the Hospital Preparedness Cooperative Agreement Program. Additionally, the Act states that ASPR shall "exercise the responsibilities and authorities of the Secretary with respect to the coordination of" the Medical Reserve Corps, the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP), the Strategic National Stockpile (SNS), the Cities Readiness Initiative (CRI) and other duties as the Secretary determines appropriate. The Act also establishes the Biomedical Advanced Research and Development Authority (BARDA).

In addition to providing the authorities outlined above, the Act requires HHS to establish a near real-time electronic nationwide public health surveillance system through a network of interoperable systems; requires the joint review of NDMS (including an evaluation of medical

surge capacity and mobile medical units) with the Department of Homeland Security (DHS), Department of Defense (DOD), and Department of Veterans Affairs (VA); and enhances VA's support of the Secretary of HHS during incidents (including directive to train and equip staff and centers and provide supplies and logistical support).

***Preparedness and Emergency Operations:*** HHS serves as the primary agency for Emergency Support Function (ESF) #8 - preparedness for and response to the health consequences of disasters, including terrorist incidents involving weapons of mass destruction - under the National Response Plan (NRP). ASPR is the action agent for all activations of ESF #8 and independent authorities under which HHS is responsible such as the Public Health Service Act, Sections 311 and 319. Through the Secretary's Operations Center (SOC), the Incident Response Coordination Team (IRCT, previously titled the Secretary's Emergency Response Team, SERT), NDMS, and the office's Regional Emergency Coordinators (RECs), ASPR directs and coordinates all public health and medical assets associated with ESF #8 response. In addition, ASPR has lead responsibility for ensuring that HHS complies with all Continuity of Operations (COOP) and Continuity of Government (COG) requirements. This includes planning and implementing the Department's essential functions during emergencies. ASPR has the lead representing HHS for the Critical Infrastructure Program for the Healthcare and Public Health Sector as outlined in HSPD-7. ASPR also has responsibilities in the areas of counterintelligence, counterterrorism and physical security.

ASPR leads planning activities required to fulfill HHS mass casualty care responsibilities under ESF #8 of the NRP and Homeland Security Presidential Directive (HSPD) 10. This includes the continuing development of Federal Medical Stations (FMS, formerly named Federal Medical Contingency Stations, FMCS). The FMS project is assisting HHS to fulfill the responsibility under mandates as set forward above to develop a federal asset to provide over 30,000 patient beds. The HHS mass casualty care initiative also works to mobilize emergency medical personnel by planning the development of an internet-based credentialing system to identify and aggregate health provider volunteers from relevant federal, state, local and non-government sources. Other mass casualty preparedness planning activities include initiatives to promote development of subject matter expertise and decision support tools for chemical, biological, radiological and nuclear incidents.

Pursuant to the Department of Homeland Security Appropriations Act, 2007 (P.L. 109-295) and the Pandemic and All-Hazards Preparedness Act (P.L. 109-417), NDMS was transferred to HHS/ASPR from DHS in January 2007. NDMS is a cooperative, asset-sharing partnership that leverages federal and non-federal resources to care for large numbers of casualties generated in a domestic disaster or an overseas conventional war. The statutory mission of NDMS is to organize a coordinated effort by the NDMS federal partners (HHS, DHS, DOD and VA), working in collaboration with the states and other appropriate public or private entities, to provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency, and to be present at locations, for limited periods of time, when such locations are at risk of a public health emergency.

NDMS consists of three key functions: medical response, patient evacuation, and definitive medical care. NDMS medical response includes assessments of health/medical needs, primary and emergency medical care, health/medical equipment and supplies, victim identification/mortuary services, veterinary services, and other auxiliary services at the site of an emergency through NDMS response teams. Patient evacuation consists of establishing and

maintaining a communication, transportation, and medical regulating system to evacuate patients from a mobilization center near the disaster site to reception facilities where they may receive definitive medical care and communicating evacuation information to federal, state, and local authorities, as needed. Definitive medical care consists of medical treatment or services beyond emergency medical care, initiated upon inpatient admission to a NDMS partner hospital and provided for injuries or illnesses resulting directly from a specified public health emergency, or for injuries, illnesses and conditions requiring non-deferrable medical treatment or services to maintain health when such medical treatment and services are temporarily not available as a result of the public health emergency. Definitive care is rendered by a nationwide network of voluntarily participating, pre-identified, non-federal and federal hospital services. The network includes an ability to track available beds by medical specialty. In a public health emergency, these services provide definitive medical care for victims. In a military health emergency, NDMS non-federal hospitals provide backup to the available military and VA medical services for military beneficiaries.

Performance Objective: Develop effective and efficient responses to public health and medical threats and emergencies.

Performance Analysis: ASPR has successfully responded to hurricanes, national security special events, threats and exercises throughout the past year. During the response to multiple hurricanes including Hurricanes Katrina and Rita, ASPR deployed thousands of public health and medical personnel to affected areas. These responses have provided ASPR and HHS the opportunity to test many Departmental and national plans, including the NRP, the National Incident Management System (NIMS), the HHS Concept of Operations Plan for Public Health and Medical Emergencies (CONOPS), the HHS Emergency Management Group (EMG, previously titled the Incident Management Team) System Description, and the IRCT System Description; and make necessary revisions in order to expand the capabilities of the Department to respond. The lessons learned from these operations and exercises allow HHS and ASPR to continuously improve response capabilities. ASPR also successfully executed a COOP exercise in conjunction with "TOPOFF 4" as well as classified COG exercises, demonstrating the ability to carry out essential functions at remote locations.

Performance Objective: Develop a mass casualty care capability to enhance medical surge capacity in response to a variety of threat scenarios.

Performance Analysis: ASPR is building mass casualty care capability by developing threat-based operational plans, building surge bed capabilities, establishing processes for surging federal and civilian medical personnel and developing subject matter expertise both within HHS and in the community. ASPR has developed operational plans to guide emergency response to hurricanes, pandemic influenza, anthrax, smallpox, and detonation of improvised nuclear and conventional devices. The plans describe how HHS would allocate federal public health and medical assets and coordinate with its ESF #8 partners in response to these disasters. ASPR is researching and developing the requirements for a credentialing portal that will provide an internet-based system for verifying the credentials of health care professionals. ASPR is also building a cadre of surge personnel with specialized skills anticipated to be in short supply during disasters. For example, ASPR developed a Burn Nurse Training Program that has trained approximately 200 Public Health Service Registered Nurses who will be able to respond to a burn mass casualty event. In addition, surge staffing is being implemented through a program that will allow ASPR to hire specific types of health care professionals during disasters. Respiratory therapists are the first professional category that is being hired. Expertise for

specific types of terrorist or naturally occurring events is being developed by creating a cadre of subject matter experts within ASPR.

Performance Objective: Develop expanded and enhanced NDMS capability/capacity to respond to public health and medical threats and emergencies.

Performance Analysis: NDMS was transferred to HHS/ASPR from DHS in January 2007. ASPR will work to enhance NDMS to be fully functioning and to integrate it into HHS-wide response capabilities.

***Medical Countermeasures Research and Development:*** The Advanced Research and Development program will coordinate HHS research efforts throughout the Public Health Emergency Medical Countermeasure Enterprise, which consists of ASPR and its partner offices at NIH, FDA, and CDC. This effort is consistent with the Departmental objective #17, Enhance Emergency Response and Renew the Commissioned Corps. ASPR's efforts include expanding the knowledge base for medical countermeasures for responding to chemical, biological, radiological or nuclear events and outbreaks of emerging infectious diseases, including preparing for an influenza pandemic. Under its BARDA authorities, ASPR will foster the advanced development of promising chemical, biological, radiation and nuclear (CBRN) medical countermeasures. In addition, FY 2008 would mark the beginning of the fifth year of Project BioShield, the unprecedented effort to accelerate research, development, acquisition and utilization of medical countermeasures for the Strategic National Stockpile (SNS).

Performance Objective: Obtain sufficient evidence for the proof of principle, safety, efficacy and product characteristics of candidate medical countermeasures for priority chemical, biological, radiation and nuclear agents to accelerate their potential for procurement under Project BioShield.

Performance Analysis: ASPR has carried out a program to plan, coordinate and manage a program for identifying targets and pursuing acquisition of priority medical countermeasures for CBRN threat agents. By FY 2008, priorities for the advanced development and acquisition of medical countermeasures for CBRN threats will be established by the HHS Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) Strategy and PHEMCE Implementation Plan, which will be integral components of the Strategic Plan for Countermeasure Research, Development and Acquisition called for in Title IV of the Pandemic and All Hazards Preparedness Act of 2007. Historically, interagency requirements and acquisition targets have been established through the Weapons of Mass Destruction Medical Countermeasures Subcommittee (WMD MCM Subcommittee) for critical products such as anthrax and smallpox vaccines, and treatments for anthrax, botulism and radiation exposures. Additional assessments of medical countermeasure requirements for CBRN threat agents are in progress. Ongoing assessment of the medical countermeasures research, development and acquisition pipeline effort will be accomplished through the PHEMC Enterprise Governance Body and its subordinate Working Groups and is complimented by regularly scheduled (every 6 weeks) ASPR-sponsored risk management meetings of all interagency stakeholders. The advanced research and development program will be integrated into the entire life cycle of medical countermeasure product development, from the development of requirements to the manufacturing of product, so that synergies can be achieved across Enterprise components, including within the Project BioShield and pandemic influenza programs (as mandated by the Pandemic and All-Hazards Preparedness Act of 2007). Management of advanced research and development within ASPR will allow for improved coordination of all necessary requirements

and steps to address FDA regulatory issues, from the research phase of a product to its procurement for the Strategic National Stockpile. Integrated management of the advanced development phases of product development will streamline the technical, regulatory and manufacturing maturation of vaccine, therapeutic and diagnostic product candidates and accelerate the delivery of products to the Strategic National Stockpile, including under Project BioShield. In addition, late stage advanced development will include the modeling and simulation assessments that are critical to the identification of appropriate countermeasures that will provide the maximum benefit to the public in the event of an emergency. Factors such as the shelf life, concept of use, route of administration, and time of administration of a product relative to an event are all highly significant when selecting an appropriate public health medical countermeasure for a chemical, biological, radiological or nuclear event, or for outbreaks of emerging infectious diseases.

Performance Objective: Delivery to the Strategic National Stockpile of licensed, licensable and approvable medical countermeasures for priority chemical, biological, radiation and nuclear agents.

Performance Analysis: In FY 2005, the first major Project BioShield contract for a next generation anthrax vaccine (rPA) was awarded with an original delivery target in FY 2007, which had been modified to 2009 due to product manufacturing issues. This contract was terminated in December 2006 because a critical milestone could not be met by the company. Despite the decision to terminate the contract with VaxGen, HHS remains committed to developing a next-generation rPA anthrax vaccine for the SNS and will continue to vigorously pursue an anthrax vaccine acquisition strategy under the BioShield program. Contracts for the currently licensed anthrax vaccine (AVA) and pediatric potassium iodide (KI) were awarded and the products have been delivered to the SNS (5 million AVA doses and 1.7 million courses for pediatric KI). In FY 2006, a contract was awarded for calcium and zinc DTPA, a chelating agent that removes radioactive particulates from the body, and 474,739 doses have been delivered to the SNS. Existing contracts were modified in FY 2006 to purchase additional 5 million doses of AVA and 3.1 million courses of the pediatric formulation of KI. During FY 2006, awards were also made for anthrax therapeutic agents and botulinum antitoxin.

***Direction and Coordination of State and Local Preparedness Funding:*** Since FY 2002, the Department has awarded over $6 billion to 50 states, 4 major metropolitan areas (i.e., Los Angeles County, Washington, DC, Chicago, and New York City), the American territories and the Freely Associated States of the Pacific. A portion of these funds will be targeted to continue the Cities Readiness Initiative (CRI), which has the goal of preparing cities to provide medical countermeasures during a public health emergency to 100 percent of affected populations within 48 hours of a decision to do so. ASPR coordinated the development of the cooperative agreement guidance documents with HRSA and CDC to ensure coordination among the public health and medical communities. ASPR also assisted in the development of performance measures, which will help better identify and highlight successful preparedness efforts at the state and local levels, as well as hold all awardees accountable for achieving short and long-term goals. ASPR is an active participant in developing the National Preparedness Goal (NPG) as required by HSPD 8. ASPR has provided leadership in the development of all public health and medical capabilities, particularly mass prophylaxis and medical surge – the national public health and medical prorities as identified in the NPG. ASPR continues to develop and test new performance measures for mass prophylaxis capability. Progress has been made in developing evaluation instruments that more accurately assess implementation rather than planning at the community and state levels of government, and in developing and pilot testing drills to test and

improve plans. New efforts are focusing on incorporating continuous quality improvement concepts into mass prophylaxis preparedness, developing standards, further developing and testing performance measures, and identifying and capturing promising practices based on standards.

To promote synchronization across DHS and HHS preparedness grant programs, a steering committee that is co-chaired by the two departments is identifying and implementing various initiatives. Initiatives include the development of common metrics to measure performance and joint exercises that include all members of the jurisdiction emergency response. The primary result of these activities is the continuation of a consistent, coordinated, performance-based approach to funding activities to address public health emergencies among health departments, hospitals and the jurisdiction emergency management system.

Performance Objective: Establish a secure information technology and physical infrastructure for healthcare delivery.

Performance Analysis: To assure the protection of critical infrastructures and key resources in coordination with other government agencies and the private sector, HHS and the Government Coordinating Council organized a meeting on December 15, 2005 to bring both private and government stakeholders together and develop a charter to address relevant issues. As of November 2006, the private sector Healthcare and Public Health Sector Coordinating Council signed its charter and was recognized by DHS. The Healthcare and Public Health Sector Specific Plan was submitted to DHS in December 2006, and the joint government and private sector councils met January 11, 2007, to begin working in partnership on SSP implementation planning. Information technology objectives that were met include organizing sector experts that worked with HHS to develop the first version of a Critical Infrastructure Data System (CIDS) that will be integrated into a situational awareness system to provide the Secretary of HHS with up-to-date status reports on health care infrastructure status including operation status, resource needs, and high-level symptom surveillance data.

***Hospital Preparedness:*** The Hospital Preparedness Cooperative Agreement Program began at HRSA in FY 2002. The Pandemic and All-Hazards Preparedness Act transferred responsibility for the program to ASPR.

In earlier years, the program focused on building medical surge capacity – the ability to respond to a markedly increased number of patients – and made funding available to States for this purpose and for the purpose of targeted mass prophylaxis. As a result, hospitals and other healthcare entities were able to implement workforce safety initiatives such as procuring Personal Protective Equipment (PPE) and decontamination facilities; increasing hospital isolation capacity; and procuring caches of pharmaceuticals for hospital personnel and their family members. Funds were also allowed to improve training efforts and to upgrade communication systems which link hospitals, public health departments, and first responder agencies. In addition, the program moved to an all hazards approach, consistent with the NRP and State and local emergency management planning. In FY 2006, the program's focus shifted to building the capability of the healthcare system to effectively manage a mass casualty event that results in injured or ill being rapidly and appropriately cared for and ensuring that continuity of care is maintained for non-incident related illness or injury.

The Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program is a companion to the Hospital Preparedness program to support the use of

volunteers at all tiers of response (local, regional, State, inter-State, and federal). The ESAR-VHP program has been working to establish a national network of State-based programs that manage the information needed to effectively use health professional volunteers in an emergency. It provides States with standardized guidance for volunteer recruitment, registration, credential verification, classification according to verified professional credentials, legal and regulatory issues, and policies for the use of volunteers. The program also provides technical assistance to the States in all of these areas. In FY 2006 and FY 2007, the ESAR-VHP program supported the development of State programs for advance registration, credential verification, and management of volunteer health professionals. In FY 2007, the program will finalize its national compliance requirements and provide significant assistance to continue to increase the number of operational State systems and enhance the capability of those State systems already in place.

In FY 2007, consistent with the legislation, the program is working to develop stronger state and regional partnerships to improve overall surge capacity and capability and enhance hospital preparedness. The focus is on strengthening healthcare coalitions at the community and regional levels, developing ESAR-VHP systems, supporting the development or enhancements of bed and other asset tracking systems, enhancing medical mobile capabilities, and supporting training and exercises to promote seamless preparedness integration and response capabilities across the local, state, regional and federal tiers of health care asset management.

Performance Objective: Percent of awardees that have developed plans to address surge capacity.

Performance Analysis: By FY 2005, 100 percent of the program's awardees had developed surge capacity plans and, as awardees were the same, 100 percent had such plans in FY 2006. This performance goal is intended to enhance hospital preparedness for biological, chemical, radiological, explosive incidents, public health emergencies and other potential mass casualty incidents. One of the key aspects of facility preparedness is the development of surge capacity plans, which are designed to address incidents involving at least 500 casualties per million.

A Program Assessment Rating Tool (PART) review of the program was conducted for the FY 2005 budget. The program received a rating of "Results Not Demonstrated." The assessment indicated that the program had not yet demonstrated results due to its relative newness and the inherent difficulty in measuring preparedness for events that do not regularly occur. Performance measures focusing on the implementation of various aspects of awardees plans to address surge capacity were initially developed, but they no longer reflect the evolution of the program and the elements identified in the National Preparedness Goal that involve increasing medical surge capacity. The program is currently in the process of developing new measures to reflect the direction and focus of current and future proposed preparedness efforts.

***Bioterrorism Training and Curriculum Development:*** The purpose of this program has been to improve the capability of the Nation's healthcare workforce to respond to bioterrorism and other public health emergencies. The goal of this program is the development of a healthcare workforce capable of demonstrating the ability to: (1) recognize indications of a terrorist event and other public health emergencies; (2) treat patients and communities in a safe and appropriate manner; (3) participate in a coordinated response; and (4) rapidly and effectively alert the public health system of such an event at the community, State, and national level.

In response to concerns raised in the FY 2006 Senate Appropriations Report, the program

eliminated funding for the 13 curriculum development awards and initiated contracts with interested accreditation bodies. By working to change the accreditation standards, the program is much more rapidly able to affect the incorporation of preparedness elements into the curriculum of a larger number of academic institutions. The program focused FY 2006 and FY 2007 existing continuing education awardees on better aligning healthcare provider training with the NPG Target Capability Lists, professionally vetted competencies, and regional hazard vulnerability assessments. Emphasis was placed on simulations, drills, and exercises to measure the competency of those participating in training and as an evaluation of the training delivered. Also, the program developed a competitive supplemental opportunity for existing awardees to demonstrate the ability to disseminate existing training initiatives nationwide.

Performance Objective: Implementation of the health professional bioterrorism preparedness training for health professionals in practice.

Performance Analysis: In FY 2003, 92,908 providers were trained; in FY 2004, 129,971 providers were trained; and in FY 2005 239,078 providers were trained. Providers trained for each year exceeded targets by over 200 percent. This performance goal refers to the number of health professionals trained to address emergency preparedness and response issues.

***International Early Warning Surveillance:*** HHS's primary international responsibilities are those actions required to protect the health of all Americans, in cooperation with the Secretariat of the World Health Organization (WHO) and other technical partners, including leading U.S. Government efforts in the surveillance and detection of influenza outbreaks overseas. ASPR, in coordination with the Office of Global Health Affairs (OGHA), is working to enhance activities for pandemic influenza preparedness and response. This includes strengthening the pandemic influenza preparedness and response capacity of Cambodia, Laos, Viet Nam and other developing countries. ASPR supports a project to enhance the surveillance, epidemiological investigation, and laboratory diagnostic capabilities in Panama and selected countries in Latin America at risk for the H5N1 influenza strain. ASPR also will continue to build the capacity of public health systems of all 20 U.S. Border States (including Alaska), to provide cross-border early warning of infectious diseases by enhancing the infectious disease surveillance capabilities and prompt sharing of information among U.S. states, Mexican states, and Canadian provinces along the borders.

Performance Objective: In response to the National Strategy for Pandemic Influenza Implementation Plan, HHS will implement the tasks in collaboration with U.S. Government agencies and in concert with the International Partnership on Avian and Pandemic Influenza. HHS will establish programs with other nations in combating public health threats and emergencies, including a potential influenza pandemic.

Performance Analysis: Progress has been made toward the FY 2006 performance target by expanding worldwide surveillance through agreements with the WHO, with Ministries of Health and other international entities, and by leveraging global partnerships to increase preparedness and response capabilities around the world. ASPR's activities last year have been directed toward improving influenza surveillance and pandemic preparedness for H5N1 avian influenza in Asia, Africa and Latin America thereby strengthening global health security. ASPR also continued development and implementation of a collaborative program with states or provinces across the U.S. international border to provide rapid and effective laboratory confirmation of urgent infectious disease case reports in the border region and for the development and implementation of cross-border, interoperable disease tracking for all illnesses and conditions

possibly resulting from bioterrorism and other infectious diseases.

***Media/Public Information Campaign***: In coordination with the Assistant Secretary for Public Affairs (ASPA), ASPR will continue to enhance public health risk communication. Through paid and free media, and training and education of journalists and public spokespersons, HHS will develop and deliver messages and strategies that can be used to modulate the community's response to a public health emergency, including a pandemic influenza outbreak or a terrorist attack. HHS also is developing the capability of its broadcast studio to better communicate the risks inherent in public health emergencies. In addition, mental health factors including psychological, social and behavioral responses will be examined and applied to formulate effective approaches to combating the potential impact of such emergencies on the public's sense of well-being.

Performance Objective: Develop clear, balanced, and timely communication with the public regarding terrorism risks.

Performance Analysis: Work on implementing the Emergency Public Information Committee's (EPIC) recommendations is ongoing. Planning and development of emergency crisis risk communications necessary as part of the response to a pandemic influenza outbreak is well underway. Public health communications strategies and messages have been identified, used and shared during both major disasters such as Hurricanes Katrina and Rita and training sessions such as the series of pandemic influenza outbreak response tabletop exercises. Ongoing collaboration on crisis and emergency risk communications related to public health emergencies, including a pandemic influenza outbreak or terrorism, has expanded to include not only federal partners via the Incident Communications Public Affairs Coordination Committee but also the National Public Health Information Coalition of state and local public health communicators, our North American partners Canada and Mexico, and the entire international health community via the World Health Organization. Renovation of the HHS-TV studio is nearing completion and production activities to provide emergency preparedness information via satellite are underway.

Rationale for the Budget Request:

The FY 2008 request for ASPR is $750,751,000 an increase of +$118,454,000 over the FY 2007 CR level.

The budget request will support the following activities:

- Operations: $13,031,000, an increase of +$3,841,000, is requested to support ASPR's leadership for all HHS bioterrorism and emergency preparedness activities. Funding will be used for staff salaries, equipment costs, travel, logistic support, telecommunications, training and continued implementation of revised OMB Circular A-123. Funding will support ten additional administration and finance staff to manage emergency funding, financial reporting, personnel accountability and internal controls.

- Preparedness and Emergency Operations: $48,090,000, an increase of +$33,148,000 above the FY 2007 CR level. Additional funds will be used to strengthen preparedness and response based on the findings of the White House report, *Federal Response to Hurricane Katrina: Lessons Learned*. The requested increase will support improved regional response coordination, including through the development of scenario-based response plans tailored to individual geographic regions; the development of emergency

response capabilities, including through training and table top exercises; and additional personnel to support emergency management and deployable teams. The request also includes funding for human services emergency coordination staff at headquarters and in the regions. Funds will also support ASPR's Critical Infrastructure Protection (CIP) program, (which will continue integrating a public health information sharing mechanism with the Secretary's Operations Center).

- National Disaster Medical System (NDMS): $53,000,000, an increase of +$6,000,000 over a comparable FY 2007 level. In FY 2008, funds will be used to increase by 15 the number of Disaster Medical Assistance Teams (DMATs) and upgrade 15 existing teams from level 2 to level 1, making them fully operational. ASPR will develop an electronic casualty tracking system that would be used by the Federal Medical Stations and NDMS facilities. Funding will also support operational needs to support teams and ensure they are ready to deploy.

- Hospital Preparedness: $413,843,000, a decrease of -$60,151,000 below the FY 2007 estimate. Consistent with directions identified in the Pandemic and All-Hazards Preparedness Act, the program will focus on exercises, drills, after action reports and corrective action plans to test the functionality of the regional health care coalitions that are established. Exercises will be integrated with the other preparedness grant programs (e.g. CDC and DHS) and will test the target capabilities that are identified as part of the National Preparedness Goal. Best practices for coalitions in support of surge capacity will be shared to inform the creation of additional coalitions throughout the country. An increasing portion of the funding will be awarded competitively to encourage innovation in disaster preparedness. There will be ongoing requirements for the states and health care facilities to report available assets in support of seamless preparedness and response across the tiers of health care asset management. The ESAR-VHP program will work to create operational and compliant systems in the remaining States and Territories. The states with functional systems will test them regularly.

- Bioterrorism Training and Curriculum Development Program: No funding is requested for this program. There has been a proliferation of training opportunities, courses, and materials at the federal, state and local levels since 2001. Recent expenditures on the federal level from both HHS and DHS are a small piece of the total funds being expended. Preparedness training is a growing element in the $2 billion continuing medical education, attracting public and private entities.

- Advanced Research and Development: $189,000,000, an increase of +$134,579,000, supports efforts to evaluate, assess and develop candidate medical countermeasures with the long-term potential to qualify for acquisition as medical countermeasures for the Strategic National Stockpile. Included in this total are funds to support the advanced research and late stage advanced development to the point of acquisition readiness that could be responsive to a procurement solicitation utilizing the Special Reserve Fund authorized for acquisitions under Project BioShield and to address potential impediments in the regulatory late stage critical pathway, as described under the Pandemic All-Hazards Preparedness Act. Funds will be used to support 15 to 20 expanded technology assessment and targeted late stage development studies to more rapidly close potential gaps that could delay the development of medical countermeasures. Management of advanced research and development within ASPR will allow for improved coordination of all necessary requirements and steps to address FDA regulatory issues, from the

research phase of a product to its procurement for the Strategic National Stockpile. In addition, late stage advanced development will include modeling and simulation assessments that are critical to the identification of appropriate countermeasures that will provide the maximum benefit to the public in the event of an emergency.

- Project BioShield: $22,363,000 in direct funding is requested to ensure a sufficient level of oversight and implementation infrastructure for medical countermeasure procurement under Project Bioshield. Funding will support a regulatory affairs and quality assurance component to oversee both product development regulatory issues and implement internal controls and quality assurance programs including on-site oversight of contract manufacturers, pre-award audits, and legal and subject matter experts. In addition, critical management systems will be fully implemented, to include a web-based stakeholder portal for information management and sharing, professional staff training in medical countermeasure research, development and acquisition, document management, financial control systems, and program management.

- International Early Warning Surveillance: $9,028,000, an increase of +$40,000, is requested to develop the public health infrastructure in the Western Pacific, Southeast Asia, the Americas and other regions to further enhance epidemiological and laboratory capabilities and capacities and associated information technology to foster accurate and prompt reporting of and response to naturally occurring and intentional infectious disease outbreaks. In the Western Pacific and Southeast Asia funds will be used for programs with a specific emphasis on increasing capacity as it relates to influenza detection, surveillance and response. Targeted funds will also be used to continue the HHS partnership to enhance the capacity of public health systems along the U.S. border to rapidly detect infectious disease outbreaks.

- Media/Public Information Campaign: $2,396,000, a decrease of -$360,000, is requested to maintain the ongoing operations of the HHS-TV studio, in order to provide 24-hour emergency health preparedness information to the public.

## Program Performance Table

Given the uncertainty of final FY 2007 appropriation levels at the time ASPR developed the performance targets for FY 2008, the FY 2007 targets were not modified to reflect differences between the President's Budget and the Continuing Resolution levels. Enacted funding may require modifications of the FY 2007 performance targets. Performance measures that may be affected significantly are footnoted throughout the Performance Detail section.

| **Long Term Goal:** Enhance State and Local Preparedness | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Establish a Secure Information Technology and Physical Infrastructure for Healthcare Delivery. | *2008* | Integrate the information sharing functionality with private sector efforts and build on existing data systems including the integration of the Critical Infrastructure Data System, HaveBed and BurnBed systems into the situational awareness system. | |
| | *2007* | Establish the information sharing mechanism within the existing structure of the Secretary's Operations Center (SOC). | |

| | | | |
|---|---|---|---|
| | *2006* | Develop scorecard to measure the coordination and communication with each sector. ISAC variances will be addressed with plans to rectify and improve integration and communication. | Target has been met.<br><br>(See Performance Report) |
| | *2005* | Establish one or more specialized ISACs in collaboration with private-sector health professional groups. | Target has been met.<br><br>(See Performance Report) |
| **Data Source**: Sector Specific Plan (SSP) for the Healthcare and Public Health Sector: An element of the National Infrastructure Protection Plan (NIPP). | | | |
| **Data Validation:** The SSP initial draft was cleared through the Executive Secretary's process and all commentary from the department was included and was reviewed by private sector partners. Changes were made after the 2005 changes to the NIPP. The final NIPP was published in early 2006 and final revisions were be made to the SSP to ensure full compliance with the NIPP. The SSP was forwarded to DHS within 180 days and the tasks associated with the SSP are being scheduled in partnership with the private and government sector partners. | | | |
| **Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also HHS Strategic Plan Goals #2 – "Enhance the ability of the nation's health care system to effectively respond to bioterrorism and other public health challenges" and #4 – "Enhance the capacity and productivity of the nation's health science research enterprise." | | | |

**Performance Report:*

In FY 2006, ASPR coordinated efforts with DHS to host an expert panel meeting on May 8-12, 2006 in Baltimore, Maryland. The purpose of the meeting was to elicit opinions from various professionals in the healthcare and public health sector regarding information needed for understanding the status of healthcare infrastructure assets to ensure continuity of operations during both normal operations and during crises. The goal was to validate the data elements for a Critical Infrastructure Data System that will ultimately be merged with the functionality of a public health information sharing mechanism and integrated with the situational awareness system required in the Pandemic and All Hazards Preparedness Act of December 2006.

Also in FY 2006, the Government Coordinating Council (GCC) and the private Sector Coordinating Council (SCC) formalized their charters and were recognized by DHS in October and November of 2006, respectively. The two councils meet quarterly. The SCC divided the sector into 9 subsectors, with a subcouncil for each subsector. ASPR represents the sector in conversations with DHS on metrics for the sector.

In FY 2005, ASPR established the GCC and SCC, to support the public health information sharing mechanism and address critical infrastructure protection of the healthcare sector.

| Measure | FY | Target | Result |
|---|---|---|---|
| Percent of awardees that have developed plans to address surge capacity. | *2008* | 100% | |
| | *2007* | 100% | |
| | *2006* | 100% | Target has been met. (See Performance Report) |
| | *2005* | 100% | Target has been met. (See Performance Report) |
| **Data Source**: Awardees' FY 2004 end-of-the-year progress reports and FY 2005 mid-year progress reports. | | | |
| **Data Validation:** Data are self-reported by the awardees through annual or semi-annual reports. | | | |
| **Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2 - "Enhance the ability of the nation's health care system to effectively response to bioterrorism and other public health challenges." | | | |

**Performance Report:*

A Program Assessment Rating Tool (PART) review of the program was conducted for the FY 2005 budget. The program received a rating of "Results Not Demonstrated." The assessment indicated that the program had not yet demonstrated results due to its relative newness and the inherent difficulty in measuring preparedness for events that do not regularly occur. Performance measures focusing on the implementation of various aspects of awardees plans to address surge capacity were initially developed, but they no longer reflect the evolution of the program and the elements identified in the National Preparedness Goal that involve increasing medical surge capacity. The program is currently in the process of developing new measures to reflect the direction and focus of current and future proposed preparedness efforts. By FY 2005, 100 percent of the program's awardees had developed surge capacity plans and, as awardees were the same, 100 percent had such plans in FY 2006. This performance goal is intended to enhance hospital preparedness for biological, chemical, radiological, explosive incidents, public health emergencies and other potential mass casualty incidents. One of the key aspects of facility preparedness is the development of surge capacity plans, which are designed to address incidents involving at least 500 casualties per million.

| Measure | FY | Target | Result |
|---|---|---|---|
| Increase the ratio of preparedness exercises and drills per total program dollar by 50% each year. | *2006* | 0.0000634 | Not yet available |
| | *2005* | N/A | .0000423 (baseline) |
| **Data Source**: Data are based on the applications submitted. | | | |
| **Data Validation:** Data are self-reported. | | | |
| **Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2 - "Enhance the ability of the nation's health care system to effectively response to bioterrorism and other public health challenges." | | | |

| Measure | FY | Target | Result |
|---|---|---|---|
| Increase preparedness, response capabilities, and surge capacity of hospitals, other health care facilities (including mental health facilities), and trauma care and emergency medical service systems, with respect to public health emergencies. | *2008* | Exercises and drills to test the functionality of the health care coalitions; Integrate exercises with the other preparedness grant programs (e.g. CDC and DHS); test the target capabilities for the National Preparedness Goal; Share best practices for coalitions in support of surge capacity; Competitive funding to encourage innovation in disaster preparedness, including mobile medical capabilities; Expanded reporting of available assets; Operational and compliant ESAR VHP systems in the remaining States and Territories. | |
| | *2007* | Competitive funding to pilot test healthcare coalitions at the community and regional levels; Develop compliant ESAR-VHP systems in high population areas; Identify best practices for mobile medical capabilities. | |
| **Data Source**: Reports from states and health care facilities; after action reports and corrective action plans; Memoranda of Understanding among coalition partner; minutes of meetings | | | |
| **Data Validation:** Observation of exercises and drills; data reported to the SOC; | | | |
| **Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2 - "Enhance the ability of the nation's health care system to effectively response to bioterrorism and other public health challenges." | | | |

| Measure | FY | Target | Result |
|---|---|---|---|
| Implementation of health professional bioterrorism preparedness training for health professionals in practice. | *2007* | 21,594 health professionals trained** | |
| | *2006* | 91,000 health professionals trained | Progress has been made towards this target. (See Performance Report) |
| | *2005* | 96,000 health professionals trained | Target has been met. (See Performance Report) |
| **Data Source**: Data was extracted from grantee reports. | | | |
| **Data Validation:** Data are reviewed by project officers in final acceptance. | | | |
| **Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2 - "Enhance the ability of the nation's health care system to effectively response to bioterrorism and other public health challenges." | | | |

**Performance Report:*

This performance goal refers to the number of health professionals trained to address emergency preparedness and response issues. In FY 2003, 92,908 providers were trained; in FY 2004 129,971 providers were trained; and in FY 2005 239,078 providers were trained. Providers trained for each year exceeded targets by over 200 percent. The current estimate of health professionals that have been or will be trained with FY 2006 funding is 261,880. The estimate for FY 2007 is 275,460.

**Note: The reduced target reflects the substantial reduction proposed in the FY 2007 President's Budget. The target may need to be modified after enactment of the FY 2007 budget.

| **Long Term Goal:** Improve DHHS response assets to support municipalities and States | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Develop effective and efficient DHHS-wide response to public health threats and emergencies. | *2008* | Continue to develop and revise existing threat-based response plans consistent with interagency scenarios. Continue to train personnel to lead ESF #8 planning and response during emergencies. Develop policies and plans to support a North American cross-border response during public health emergencies. Conduct regional site-specific surveys to determine availability of regional hospitals, medical personnel, public health specialists, and other assets to be utilized in a response. Develop capacity for consistent, uninterrupted, interoperable communications between field elements and headquarters. Develop web-based training modules addressing multiple scenarios and disciplines. Train human services assessment teams to communicate human services needs to the planning section of the Joint Field Office and Recovery Support Center in ESF #6 as well as emerging needs to the HHS SOC. | |

| | | | |
|---|---|---|---|
| | *2007* | Develop threat-based response plans consistent with interagency scenarios; continue to evaluate the Department's ability to respond to these scenarios and respond to actual events ; update training programs to fill gaps identified in the evaluation process; respond to public health and medical threats and emergencies; participate in the planning for and execution of congressionally mandated exercises (e.g., TOPOFF). Implement a program activity to support rostering, training and equipping all ESF#8 personnel. Expand HHS ability to view and respond to the Situational Awareness Picture with increased Regional coordination, improved GIS data, RF radio equipment, and deployable comms/IT packages. Pre-stage equipment & supplies in each region. Increase regional personnel for planning and response. Conduct regional site-specific surveys to determine availability of regional hospitals, medical personnel, public health specialists, and other assets to be utilized in a response. Develop capacity for consistent, uninterrupted, interoperable communications between field elements and headquarters. Develop web-based training modules addressing multiple scenarios and disciplines. Train human services assessment teams to communicate human services needs to the planning section of the Joint Field Office and Recovery Support Center in ESF #6 as well as emerging needs to the HHS SOC.** | |
| | *2006* | Continue to train senior executives, managers and operations personnel to lead and support the IRCT; identify and replace outdated equipment and technologies used to support the IRCT and the SOC; support the ongoing development and implementation of National public health and medical response policies and plans; identify and implement HHS' requirements assigned to HHS as detailed in Congressional language and Presidential Directives (e.g., HSPD #10). Begin to implement lessons learned from Katrina hurricane response, other operational responses, exercises and national security special events. | Target has been met.<br><br>(See Performance Report) |
| | *2005* | Update response policy of IRCT and HHS incident management system; participate in final planning for TOPOFF III and plan in the exercise; manage IRCT deployments and HHS emergency responses. | Target has been met. (See Performance Report) |

**Data Source:** Katrina Lessons Learned reports on Mission Fulfillment and Incident Command, HHS Concept of Operations Plan for Public Health and Medical Emergencies (CONOPS), Incident Response Coordination Team (IRCT) System Description, the Secretary's Operations Center logs of response operations, TOPOFF III after action reports and other exercise evaluations.

**Data Validation:** Policies, plans and evaluations are reviewed and cleared by ASPR and HHS senior leadership, and interagency partners, including DHS.

**Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2 - "Enhance the ability of the nation's health care system to effectively response to bioterrorism and other public health challenges."

**Performance Report:*

In FY 2006, there were many lessons to be implemented from Hurricane Katrina and other responses. Building on the White House Katrina Lessons Learned report, HHS convened meetings with all of its operating divisions to clearly articulate ESF #8 missions and re-define the incident management structure for the Department. ASPR has altered the incident command structure of an ESF #8 response in the 'field' to more clearly align with other

agencies' communications and functional needs. Personnel to staff the field coordination unit, the Incident Response Coordination Team (IRCT, formerly SERT) have been identified, and they are being trained to fulfill their roles. A Senior Health Official has been identified for each of the 10 regions and these Officials are being trained. Plans are in place to expand the Regional Emergency Coordination Program to better support preparedness planning and response operations. The headquarters Emergency Management Group (EMG, formerly Incident Management Team) is codifying procedures and is developing training programs. A web-based incident documentation/management system is being developed.

In FY 2005, ASPR completed the development of interim incident management policies which were tested during the TOPOFF III exercise; continued SERT training to include a cadre of over 200 trained SERT personnel; hired ten (10) regional emergency coordinators; successfully responded to multiple hurricanes, national security special events (e.g., Presidential Inauguration) and exercises (e.g., TOPOFF III) capturing lessons learned after each event. During the response to hurricanes Katrina and Rita, ASPR deployed over 2000 public health and medical personnel to the affected areas and created a process for deploying civilian volunteers in support of the federal response. An ESF #8 Standard Operating Procedure was developed as part of the NRP implementation. Developed a training program for burn nurses and other response personnel.

**Note: The target reflects activities planned in the FY 2007 President's Budget. The target may need to be modified after enactment of the FY 2007 budget.

| Measure | FY | Target | Result |
|---|---|---|---|
| Develop, clear, balanced, and timely communication with the public regarding terrorism risks. | *2008* | Increase and strengthen emergency and crisis risk communications network within the international and national public health community.<br>Continue outreach efforts to inform news media and other key stakeholders of informational products, exercises and training opportunities available related to emergency and crisis risk communications<br>Expand short form programming to priority projects that reach larger audiences through convergence media and alternate distribution vehicles such as video on demand (VOD), podcasts, and webcasts. | |

| | | | |
|---|---|---|---|
| | *2007* | Continue development and distribution of emergency and crisis risk communications packages for use prior to, during and after a terrorist attack or other public health emergency for international and national public health communicators.<br><br>Publish and begin distribution of reporter's field guide on terrorism and other public health emergencies. Complete Public Health Emergency Response: A Guide for Leaders and Responders publication.<br>Update public health emergency-related radio public service announcements in voice and text format, for weather-related hazards including hurricane, tornado and flood. Create public health emergency-related radio public service announcements in voice and text format, for pandemic flu preparation, response and recovery.<br><br>Continue outreach efforts to inform news media and public health community of all the above initiatives. Begin construction on the edit and graphics suites; create new programming for emergency preparedness risk communication; increase cooperative activities with state and local public health communications community. | |
| | *2006* | Complete primary renovation of HHS-TV studio; produce new programming for emergency preparedness risk communication. | Target has been met. (See Performance Report) |
| | *2005* | Expand communications activities to include countries experienced with terrorism to enhance resiliency strategies. | Target has been met. (See Performance Report) |

**Data Source:** "Terrorism and Other Public Health Emergencies - A Reference Guide for Media", public health communications strategies and messages for terrorism and other public health emergency scenarios, after action reports on risk communication exercises.

**Data Validation:** Interagency review by appropriate subject matter experts, field testing of strategies and messages during developing incidents and major exercises.

**Cross Reference:** HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2 - "Enhance the ability of the nation's health care system to effectively response to bioterrorism and other public health challenges."

**Performance Report:*

In FY 2006, ASPR began national distribution of media reference guide on terrorism and other public health emergencies; completed first draft of Public Health Emergency Response: A Guide for Leaders and Responders; conducted tabletop pandemic influenza response exercise for international, federal and state public communications officials; established international and federal crisis and emergency risk communications working groups for message development and coordination; used new State Incident Communications Coordination Line for avian influenza message coordination with all state health communicators. During the response to hurricanes Katrina and Rita, activated HHS Public Affairs Emergency Operations Center and deployed public affairs staff with IRCT's to Louisiana, Mississippi and Texas, rotating personnel as part of HHS Public Affairs Emergency Plan using staff from several operating divisions and regional offices. Created feed of radio public service announcements and distribution system with health advice to the public through stations in areas affected by hurricanes Katrina and Rita.

In FY 2005, ASPR created and delivered a high-level crisis and risk communications training tool for local and community leaders– North Atlantic Treaty Organization (NATO) member nations have asked that the tool be adapted for their specific needs; established and tested emergency communications capabilities with Health Canada, the Public Health Agency of Canada, and the National Health Service of the United Kingdom; developed public service announcements (PSAs) providing emergency risk communications messaging for CBRN events.

| Measure | FY | Target | Result |
|---|---|---|---|
| Develop a mass casualty care capability to enhance medical surge capacity in response to a variety of threat scenarios | *2008* | Coordinate the sustainment of existing FMS units and accelerate the acquisition of new FMSs to meet the goal of 30,000 patient beds. Establish a burn bed surge capability. Sustain and expand the cadre of surge personnel with specialized skills anticipated to be in short supply during disasters. Explore expanding the radiological medical management program to other threats. Continue to develop operational playbooks for each of the National Planning Scenarios and specific response capabilities as indicated. Test completed operational playbooks and revise as needed. Conduct training on the playbooks as needed. | |
| | *2007* | Coordinate expansion of FMS with enhanced capabilities toward the goal of 30,000 patient beds. Build a cadre of surge personnel with specialized skills anticipated to be in short supply during disasters. Sustain and enhance monitoring and medical management of a radiological/nuclear public health emergency.<br><br>Continue development of operational playbooks for each of the National Planning Scenarios and for specific response capabilities such Federal points of distribution (PODs) for medical countermeasures consistent with the Department's efforts to improve mass prophylaxis capabilities.<br><br>Continue development of medical management guidelines with National Library of Medicine (REMM-Radiological Event Medical Management as prototype). | |
| | *2006* | Support development of 20 or more FMCS/FMS with enhanced capabilities toward the goal of 30,000 patient beds; develop a concept of operations for a web-based healthcare provider credentialing system; implement plans for the monitoring and medical management of a radiological/nuclear public health emergency. | Progress has been made towards this target. (See Performance Report) |
| | *2005* | Establish FMCS pilot prototypes; conduct research on development of web-based healthcare provider credentialing system; develop plans for the monitoring and medical management of a radiological/nuclear public health emergency. | Target has been met.<br><br>(See Performance Report) |
| **Data Source:** "Federal Medical Contingency Station-Type III-Basic Prototype Evaluation" (Report CD305T3) dated May, 2005; After Action Report (AAR) on the FMS deployment during 2005 hurricane season dated April 2006. Draft playbooks for pandemic influenza, improvised nuclear devices, and hurricanes. Website for the Radiological Event Medical Management (REMM). Draft RFI "Portal for Verification of Healthcare Professionals Qualifications." | | | |
| **Data Validation:** After action reports, statements of standard operation procedures, and deployment plans are reviewed by a variety of inter and intra-agency workgroups including the Homeland Security Council Deputies | | | |

| Committee. |
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| **Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2 – "Enhance the ability of the nation's health care system to effectively respond to bioterrorism and other public health challenges" and HHS Strategic Plan Goal #4 "Enhance the capacity and productivity of the nation's health science research enterprise." |

**Performance Report:*

FY 2006: The FMS prototypes were used to develop Federal Medical Stations that were deployed to Louisiana, Mississippi and Texas in response to hurricanes Katrina and Rita to support the medical needs of evacuee populations. HHS deployed 5,500 beds (22 units) and associated med/surge supplies and pharmaceuticals in support of these events. The deployed assets have been replenished and the concept of operations has been refined. These units are ready to deploy during the 2006 hurricane season. Enhancements to the program are being undertaken to include pilot testing of an electronic health record and a patient tracking system. To expand the reach of the FMSs, "go bags" have been created so strike teams of medical personnel can respond into the community to assess the needs of vulnerable populations who may not have evacuated.

ASPR worked closely with HRSA to evaluate the requirements for the concept of operations for the credentialing portal. ASPR met with state and local representatives to define how the portal would interface with existing state systems established through the Emergency System for Advanced Registration of Volunteer Healthcare Professionals (ESAR-VHP). A concept of operations and a pilot test for deployment of civilian and civil service volunteers is being developed for the 2006 hurricane season that will inform the development of the portal should funding be provided in 2007.

ASPR in collaboration with the National Library of Medicine (NLM) established a unique information technology (IT)/web-based system for the medical management of a mass casualty radiation/nuclear event, known as REMM. Based on IT expertise from ASPR, the National Cancer Institute and NLM, a panel of subject matter experts is defining the criteria for medical management of individuals exposed to radiation. The panel has developed clinical algorithms that are put into a web-based system that will guide clinicians in managing patients exposed to radiation. ASPR also developed a concept for triage of radiation casualties that informed the response plan for improvised nuclear devices.

ASPR, in collaboration with ESF #8 partners, developed operational playbooks to guide emergency response to hurricanes, pandemic influenza, and detonation of improvised nuclear and conventional devices. The operational plans also guide procurement and capabilities development goals by identifying federal mass casualty asset gaps. Additional playbooks to address the National Planning Scenarios are under development for anthrax, smallpox, and conventional explosive devices. For a biological event, points of distribution (PODs) for countermeasures will be required. A playbook for Federal PODs is being developed. The ESF #8 SOP is being revised based on lessons learned and NRP revisions.

Surging of medical personnel for mass casualty events is being addressed through multiple avenues. ASPR is researching and developing the requirements for a credentialing portal that will provide an internet-based system for verifying the credentials of health care professionals. ASPR is also building a cadre of surge personnel with specialized skills anticipated to be in short supply during disasters. For example, ASPR developed a Burn Nurse Training Program that has trained approximately 200 Public Health Service Registered Nurses who will be able to respond

to a burn mass casualty event. The program recruited additional nurses by offering a burn continuing education program in conjunction with the annual Commissioned Officers Association Conference. In addition, surge staffing is being implemented through a program that will allow ASPR to hire specific types of health care professionals during disasters. Respiratory therapists are the first professional category that is being hired. Training programs are being developed to support the learning needs of those hired under this program such as a web-based module to build competency in using the 2 types of ventilators currently housed in the Strategic National Stockpile (SNS).

Expertise for specific types of terrorist or naturally occurring events is being developed by creating a cadre of subject matter experts within ASPR. Besides providing expertise during response operations, these experts are creating decision support tools and monitoring capabilities and laboratory networks to enhance radiological expertise in the community.

FY 2005: To build surge bed capability ASPR developed Federal Medical Stations (FMS), formerly Federal Medical Contingency Stations (FMCS). By the end of FY 2005 four 250 bed Federal Medical Contingency Station prototypes were created to support hospital decompression in mass casualty events, with two having been pilot tested in Atlanta and Denver.

| Measure | FY | Target | Result |
|---|---|---|---|
| Develop expanded and enhanced NDMS capability/capacity to respond to public health and medical threats and emergencies. | *2008* | Improve team response times; regionalize equipment caches; expand the number of operational teams; develop patient tracking systems; assess possibility of including nursing homes, hospice, and other medical facilities in NDMS. | |
| | *2007* | Transfer NDMS to HHS; work to enhance NDMS to be fully functioning and to integrate it into HHS-wide response capabilities. | |
| **Data Source**: To be determined. | | | |
| **Data Validation:** To be determined | | | |
| **Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2 – "Enhance the ability of the nation's health care system to effectively respond to bioterrorism and other public health challenges" and HHS Strategic Plan Goal #4 "Enhance the capacity and productivity of the nation's health science research enterprise." | | | |

| **Long Term Goal:** Define requirements for and deliver safe and effective medical countermeasures to identified threats (biological, chemical, radiation and nuclear) to the SNS through coordination of interagency activities, interfacing with industry and acquisition management. | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Deliver licensed, licensable and approvable medical countermeasures for priority chemical, biological, radiation and nuclear agents. | *2008* | Issue RFPs for needed products in accordance with the PHEMCE Strategy (due to be published in early CY 2007) and PHEMCE Implementation Plan (due to be published by mid CY 2007).<br>Begin delivery of the modified vaccinia Ankara (MVA) smallpox vaccine to the SNS.<br>Continue delivery of botulinum antitoxin, anthrax immune globulin to the SNS. | |
| | *2007* | Complete delivery of 2$^{nd}$ 5M doses of AVA; complete delivery of 2$^{nd}$ 2.3M bottles of pediatric KI to SNS; begin delivery of anthrax immune globulin to the SNS; delivery of additional botulinum antitoxin to the SNS. | |

| Measure | FY | Target | Result |
|---|---|---|---|
| | *2006* | Complete delivery of the 1st 5M doses of Anthrax (AVA) vaccine to the SNS, begin delivery of the 2nd 5M doses of AVA; Complete delivery of the 1st 1.3M bottles of pediatric KI delivered to the SNS; begin delivery of 2nd 2.3M bottles of Pediatric KI to the SNS; complete delivery of Ca- and Zn-DTPA to SNS.<br>Modify rPA anthrax vaccine contract to acknowledge delay in delivery of vaccine to SNS. | Targets met for AVA, pediatric KI, DTPA have been met.<br>Target not met for rPA anthrax vaccine due to development delays.<br>(See Performance Report) |
| | *2005* | Manage the development of second-generation anthrax and smallpox vaccines through animal and clinical trials. | Target has been met.<br>(See Performance Report) |

**Data Source:** http://www.hhs.gov/ASPR/bioshield/PBPrcrtPrjct.htm; rPA anthrax vaccine Interagency Animal Studies Working Group minutes; rPA Integrated Project Development team minutes kept on a password-protected site (https://collaboration.saic.com/sites/hhs-rpa Project - Team Collaboration Site); MVAORDC-NIAID Development Team (emails and document files at HHS Intranet F: (Personal Folder).

**Data Validation:** Contracts awarded and draft Request for Proposal for industry comment are negotiated and issued, respectively, in accordance with Federal Acquisition Regulations (FAR) and the HHS Acquisition Regulations (HSSAR).

**Cross Reference:** HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2: "Enhance the ability of the nation's health care system to effectively respond to bioterrorism and other public health challenges" and HHS Strategic Plan Goal #4 "Enhance the capacity and productivity of the nation's health science research enterprise."

**Performance Report:*

In FY 2006, the rPA anthrax vaccine contract was unilaterally modified to reset the timeline for delivery of vaccine to the SNS due to delays in product development. Subsequently, in December 2006, the contract was terminated because a critical milestone could not be met due to issues associated with manufacturing the product. HHS remains committed to pursuing a next general anthrax vaccine. In FY 2006, two existing contracts were modified, AVA and pediatric KI to purchase and deliver additional product to the SNS. Additionally, a contract for calcium and zinc DTPA, a chelating agent that removes transuranic particulate radiation from the body, was awarded and the product delivered to the SNS and contracts awarded for botulinum antitoxin and options on existing contracts exercised to purchase and stockpile anthrax therapeutic agents. In FY 2007, additional contract awards are anticipated for modified Vaccinia Ankara smallpox vaccine, and therapies to treat acute radiation syndrome.

In FY 205, awarded a contract for next generation anthrax vaccine (rPA); issued a draft RFP for industry comment concerning next generation smallpox vaccine; collaborated in development efforts of both vaccines including animal and clinical trials with NIAID/NIH. Awarded contracts for anthrax vaccine and pediatric potassium iodide.

| Measure | FY | Target | Result |
|---|---|---|---|
| Obtain sufficient evidence for the safety, efficacy and product characteristics of candidate medical | *2008* | Issue RFPs for advanced development of candidate products that have shown initial proof of concept as new countermeasures for the health effects of chemical, biological, radiological or nuclear exposures. | |

| | | | |
|---|---|---|---|
| countermeasures for priority chemical, biological, radiation and nuclear agents to accelerate their potential for procurement under Project BioShield. | | | |
| **Data Source**: HHS Public Health Emergency Medical Countermeasure Strategy and Implementation Plans (to be published in late FY2006 and early FY 2007) | | | |
| **Data Validation:** Contracts awarded and draft Request for Proposal for industry comment are negotiated and issued, respectively, in accordance with Federal Acquisition Regulations (FAR) and the HHS Acquisition Regulations (HSSAR). Interagency Agreements are developed with federal laboratories to address specific advanced research questions. | | | |
| **Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2: "Enhance the ability of the nation's health care system to effectively respond to bioterrorism and other public health challenges" and HHS Strategic Plan Goal #4 "Enhance the capacity and productivity of the nation's health science research enterprise." | | | |

| **Long Term Goal:** Mitigate the adverse public health effects of a terrorist attack. | | | |
|---|---|---|---|
| **Measure** | **FY** | **Target** | **Result** |
| Establish productive partnerships with other Nations in Combating Public Health Threats and Emergencies. | *2008* | Continue support of global partnerships. Evaluate progress of countries/regions in early detection reporting surveillance and response. Continue support of the WHO early warning and response activity; continue the U.S. Mexico and Canada border activities. | |
| | *2007* | Leverage global partnerships to increase preparedness and response capabilities around the world with the intent of stopping, slowing or otherwise limiting the spread of a pandemic to the United States. | |
| | *2006* | Begin to assess and modify bilateral and multi-lateral agreement focusing on the capacities of integrated data management, outbreak training, communications, and other needed projects best carried out by WHO; expand surveillance program to include activities in Latin America and in other regions of interest. Continue the U.S. Mexico and Canada border activities. | Target has been met.<br><br>(See Performance Report) |
| | *2005* | Continue major efforts in early warning infectious disease surveillance; Establish an expanded number of specific projects to strengthen influenza surveillance capacity and response for H5N1 pandemic influenza in the most affected countries in Southeast Asia; continue the neighboring border states/provinces in the U.S, Mexico and Canada activities: to improve cross-border bioterrorism and/or infectious disease early warning surveillance capabilities. | Target has been met.<br><br>(See Performance Report) |
| **Data Source:** Interagency Agreements and their action plans describe the roles and responsibilities of the parties, the period of the agreement, process for modification and the activities to be supported under the agreement. | | | |
| **Data Validation:** Each agreement specifies the interval for reporting progress. Validation of progress in reaching performance goals and the rate of spending is accomplished through the review of written reports and verbal communication with the servicing partner. | | | |
| **Cross Reference**: HHS Top 20 Goal #15 "Prepare for an Influenza Pandemic" and #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2: "Build the capacity of the health care system to respond to public health threats in a more timely and effective manner, especially bioterrorism threats." | | | |

**Performance Report:*

In FY 2006, ASPR supported global early warning surveillance initiatives through continued

funding to WHO regional offices and existing and new bilateral cooperative agreements with affected and at risk countries. Strengthened and extended the global coverage of influenza surveillance and laboratory capacity and capability through awards to international partners. Made awards to 20 states to provide rapid and effective laboratory confirmation of urgent infectious disease case reports in the border regions of Mexico and Canada.

In FY 2005, strengthened global early warning surveillance and response through additional funding to WHO regional offices and bilateral cooperative agreements with affected and at risk countries to provide enhanced global and national security; enhanced surveillance, laboratory capacity and response capability for H5N1 in Asia; strengthened animal influenza surveillance and development of the global animal influenza surveillance network Made awards to 14 states to provide rapid and effective laboratory confirmation of urgent infectious disease case reports in the border region.

| Measure | FY | Target | Result |
| --- | --- | --- | --- |
| Establish effective collaboration with Counter-Terrorism Initiatives of Other Agencies. | *2008* | Assess and mature HHS security programs to provide a comprehensive Department wide approach to counterterrorism and counterintelligence programs. | |
| | *2007* | Evaluate HHS security programs, procedures and processes; develop counterterrorism and counterintelligence training programs tailored to the unique needs of the Department. | |
| | *2006* | Enhance intelligence analysis to better support HHS through closer ties to TTIC perhaps with the assignment of a detailee to that new organization. | Target has been met. (See Performance Report) |
| | *2005* | Improve electronic connectivity with the intelligence community. Participate in relevant meetings and conferences. Provide intelligence information to Senior HHS officials. | Target has been met. (See Performance Report) |
| **Data Source:** ASPR develops and/or reviews security risk and vulnerability assessment products. These products are developed internally, by contract support and through interagency partners (e.g., U.S. Marshals Service). ASPR receives classified information from the national security community on a routine basis. | | | |
| **Data Validation:** Security matters are routinely discussed as part of the Departmental Security Council, which ASPR chairs. Information received from the national security community is discussed with senior executives within the Department ranging from the Director of the Office of Emergency Operations and Security Programs to the Secretary of HHS. This process, along with an interagency validation process, allows the Department to continually assess the information that is received. | | | |
| **Cross Reference**: HHS Top 20 Goal #17 – "Enhance Emergency Response and Renew the Commissioned Corps." Also, HHS Strategic Plan Goal #2 - "Enhance the ability of the nation's health care system to effectively response to bioterrorism and other public health challenges." | | | |

**Performance report:*

FY 2006: ASPR continues to mature its intelligence and security capability. In addition to the HHS representative assigned fulltime to the National Counterterrorism Center (NCTC), ASPR has hired one senior counterintelligence/counterterrorism specialist and is in the final stages of another senior CI/CT specialist and senior physical security officer. OPEO has hired a part-time intelligence analyst to analyze and prepare intelligence products tailored to the needs of HHS. OPEO representatives routinely participate in senior interagency working groups that focus on information sharing, physical security, and cyber-security.

FY 2005: Maintained a permanent part-time liaison to the DHS HSOC; established a full-time

detailee to TTIC; and maintained routine connectivity with the NJTTF.

ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE
Measures and Results Summary Table

| | Measures | Total Reported | | Total Met | Total Not Met | | |
|---|---|---|---|---|---|---|---|
| **FY** | **Total in Plan** | **Results Reported** | **% Reported** | **Met** | **Improved** | **Total Not Met** | **% Met** |
| 2005 | 9 | 9 | 100 | 9 | 0 | 0 | 100 |
| 2006 | 10 | 9 | 100 | 6 | 3 | 0 | 67 |
| 2007 | 11 | N/A | N/A | N/A | N/A | N/A | N/A |
| 2008 | 11 | N/A | N/A | N/A | N/A | N/A | N/A |

## CYBER-SECURITY

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $9,482,000 | $9,482,000 | $9,982,000 | +$500,000 |
| FTE | – | – | – | – |

### Statement of the Budget Request

The FY 2008 request for Cyber-Security of $9,982,000 will support the HHS IT Security program to ensure the security of HHS' systems, critical infrastructure and assets.

### Program Description

The Office of the Chief Information Officer (OCIO), under the Assistant Secretary for Resources and Technology (ASRT), is responsible for ensuring the security of the Department's systems and assets that are used to disburse billions of dollars through Medicare and Medicaid, critical social services such as Head Start, childcare and child support enforcement, a life-giving organ transplant system, food and pharmaceutical quality, groundbreaking biomedical research, accurate and timely disease treatment information and the detection of disease outbreaks and bioterrorism.

IT security and critical infrastructure protection (CIP) are essential components underlying HHS' mission – namely, the stewardship of our information resources and preservation of our trust and credibility.

The HHS IT Security Program focuses on the protection of critical assets – information systems data – so that the people using the systems can depend on the electronic environment being reliable, available, accurate, and authorized. The IT Cyber-Security projects aim to prevent, detect, and respond to security events. Critical Infrastructure Protection ensures that those IT assets, systems, and services that are essential to the conduct of critical business functions are safeguarded from disruption, failures, and compromise.

### Rationale for the Budget Request

The FY 2008 request for Cyber-Security is $9,982,000, an increase of $500,000 over the FY 2007 CR level. The requested funds will be used to continue implementation of consistent cyber-security programs and policies across the Department, as required by NIST standards and the Federal Information Security Management Act (FISMA).

The increased funding in FY 2008 will also allow the HHS IT Security program to:

- address recommendations made by the Government Accountability Office (GAO) in GAO-06-267;
- adjust existing policies and procedures and corresponding implementation in response to suggestions made by the independent auditing firm of PricewaterhouseCoopers (PWC) in connection with the Department's FY 2006 financial statement audit;

- respond to recommendations made in the FY 2006 Office of the Inspector General (OIG) FISMA Executive Summary; and
- provide more effective perimeter defense and vulnerability scanning to proactively identify vulnerabilities before they are exploited for access to the critical infrastructure and Departmental assets.

While the Department has begun addressing these areas, the additional funding is necessary to ensure these endeavors are implemented fully and consistently at all levels of HHS.

**GAO-06-267:** In February 2006, the GAO performed an assessment to determine the effectiveness of information security at HHS. Funding for FY 2008 will be applied in responding to GAO's suggested actions. The GAO report recommended the following actions:

- Develop comprehensive risk assessments that address key elements;
- Complete system security plans for all systems;
- Provide specialized training to all individuals with significant security responsibilities;
- Conduct tests and evaluations of the effectiveness of controls on operational systems;
- Ensure that remedial action plans address all previously identified weaknesses and key corrective action information;
- Implement intrusion detection systems for the detection and reporting of security incidents and events; and
- Develop and test continuity of operations plans for all of their systems.

**PWC FY 2006 Audit Findings:** PWC, under the oversight of the OIG, performed an audit of HHS' FY 2006 financial statements, which includes an overall assessment regarding the effectiveness of internal controls, as well as the Department's compliance with laws and regulations. As a result of its efforts, PWC recommended the following with respect to HHS systems:

- Enhance the documentation of systems polices and procedures to support the preparation of financial statements and ensure compliance through a monitoring process;
- Continue to establish an integrated financial management system for HHS;
- Develop formal written procedures to consider and approve policy changes;
- Ensure the proper enforcement of security controls by contractors;
- Provide specific guidance to the contractors regarding performing risk assessments and mitigating risk;
- Develop overall HHS platform configuration security standards for all operating platforms and databases;
- Develop an effective patch management process for all critical systems to reduce systems vulnerabilities to a minimum;
- Train all employees and contractors on security awareness and responsibilities to effectively communicate security policies and expectations; and
- Maintain effective program change controls processes for all applications.

**OIG FISMA Executive Summary Recommendations:** FISMA directs each Inspector General to perform an annual independent evaluation of the agency's information security program and practices. For FY 2006, the OIG independently audited the information systems security programs at six of the HHS operating divisions (OPDIVs) in the context of FISMA. These FISMA evaluations resulted in several OPDIV-specific recommendations focused on the following areas:

- Security program infrastructure;
- Integration of security into major applications;
- Plans of Action and Milestones (POA&M);
- Network management;
- Contractor oversight;
- Security training; and
- Personnel security.

**Vulnerability Detection:** In addition to responding to recommendations made in the aforementioned reports, FY 2008 funds will go to the implementation of technology that enables application vulnerabilities to be detected prior to full implementation; the evaluation and implementation of DHS "Einstein" network monitoring and event investigation capability; the development and implementation of an HHS-wide vulnerability scanning and remediation program; and the implementation and monitoring of HHS configuration management requirements. The requested level will provide the following:

- An immediate return on investment (ROI) by identifying system vulnerabilities and reducing the number of security events by at least 25 percent.
- Reliable change management process to review processes and implement immediate updates as vulnerabilities are discovered. It is estimated that at least 15 percent of the existing vulnerabilities will be eliminated in the first 6 months.
- Identification of critical weaknesses before they can be exploited thus decreasing the likelihood of loss of systems and data availability. This will also result in a common tool with consistent reporting across all OPDIVs.
- Increased management control (A-123, 127, and 130 compliance)
- Web-based vulnerability and analysis tools provide ability to scan applications, a capability that does not currently exist throughout HHS. Implementation will eliminate compromise or defacement of web pages.
- Coordination to allow numerous different network administrators to work together across OPDIVs to remediate vulnerabilities and respond to security events, increasing interoperability of systems and eliminating the need for written documentation of interconnection agreements between systems. Total cost of investment should be returned within the first year of production.
- Implementation of data protection after it is accessed and "at rest" to prevent possible compromise of personal or other sensitive information such as a breach of personally identifiable information downloaded to a laptop computer or other portable device. HHS will develop a strategy to address this threat as a breach of this nature could cost several million dollars to address (e.g., a stolen laptop computer at the VA resulted in millions of dollars to notify all affected veterans, seriously tarnished reputation of the VA, and may have additional costs associated before the issue is resolved).
- Unsecured and unmonitored remote access points will be monitored in a more effective manner, allowing more secure access to HHS information, and increase HHS ability to react to Pandemic or other serious events requiring secure remote access.
- Applications will not run unnecessary service thereby reducing the risk of compromise. A 20 percent or greater reduction is anticipated in the first year of implementation.
- Software that is vulnerable to exploitation because it is outdated, vulnerable, or left in default configurations will be detected and corrective action implemented before these vulnerabilities are exploited.

Failure to implement an effective Cyber-Security program will result in successful exploits of sensitive HHS information systems and compromise of mission critical data. Maintenance and updating of infrastructure will be required Department-wide in order to proactively identify and address vulnerabilities before they are successfully exploited.

Performance Analysis

The HHS strategic plan for IT security identifies specific goals, performance measures, and supporting projects to focus HHS' efforts and investments for advancing HHS' security and continuity of critical service programs. Our plan identifies and prioritizes these to achieve measurable outcomes in support of the IT security vision. The core of this IT security plan focuses on the Security Program, which is designed to achieve the following aims:

- Ensure compliance with US Code and Federal legislation;
- Ensure a robust enterprise security program at HHS;
- Ensure common standards and practices; and
- Ensure that new or potential security vulnerabilities are swiftly identified and addressed.

Clear benefits of an effective HHS IT security program are the successful mitigation or prevention of the following:

- Adverse impact on public health practices due to corruption of medical data;
- Loss of critical services that can adversely affect health and safety of the public;
- Unauthorized or illegal disclosure of confidential, private, or other sensitive information regarding individuals, medical records, proprietary data, intellectual property, etc;
- Loss of irreplaceable scientific research data;
- Financial fraud and other computer crime;
- Breach of confidential business data such as assurances of contractual requirements and agreements with business partners;
- Loss of access to health and welfare information by the public, researchers, policy makers, healthcare professionals and others;
- Loss of trust resulting from compromised content or corruption of information for use by the public, researchers, policy makers, healthcare professionals and others;
- Economic consequences of addressing security breaches such as clean-up efforts, shutting down computers, systems, and networks during clean-up and validation, restoration costs of systems and data, lost productivity, litigation, etc.; and
- Damage to the credibility, reputation, image, and public trust of HHS and its OPDIVs.

In FY 2006, OCIO was able to:

- Perform the Project Matrix Phase II Process for new CIP Functions and assets in the Secretary's Command Center and vaccine stockpile, identified as a result of HHS efforts to defend against bioterrorism.
- Perform on a continuous basis Project Matrix Phase I Process for CIP Functions and Assets, to determine weaknesses, risks, and vulnerabilities resulting from interfacing with public and private sector systems.
- Provide continuous assistance to OPDIVs in order to improve FISMA compliance and implement corrective actions for HHS critical IT assets.
- Implemented improved and continuous security monitoring for all HHS system, assets, and services.

In FY 2007 and FY 2008, plans are for OCIO to:

- Provide continuous assistance to the OPDIVs, to improve FISMA compliance and implement corrective actions for HHS critical IT assets.
- Refine and implement improved and continuous security monitoring for all HHS system, assets, and services.
- Implement 24/7 security monitoring capability.
- Improve ProSight performance by interoperability between modules and implementing changes required by new OMB FISMA requirements and NIST standards.
- Refresh Project Matrix asset baseline and improve coordination with Department of Homeland Security.
- Implement web based training in accordance with OPM requirements.
- Develop HHS IT security program as a Federal Government Center of Excellence.
- Implement recommendations made by the Government Accountability Office (GAO) in GAO-06-267.
- Adjust existing policies and procedures in response to suggestions made by PWC.
- Respond to recommendations made in the FY 2006 OIG FISMA Executive Summary.
- Implement a vulnerability detection capability for the Department.

# MEDICAL RESERVE CORPS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $9,748,000 | $9,748,000 | $15,113,000 | +$5,365,000 |
| FTE | 6 | 5 | 5 | – |

## Statement of the Budget

The FY 2008 request for the Medical Reserve Corps (MRC) program is $15,113,000, an increase of $5,365,000 above the FY 2007 Continuing Resolution (CR) Level.

## Program/Activity Description

President Bush announced the creation of the USA Freedom Corps and the Citizen Corps in his January 2002 State of the Union address. In March 2002, the Office of the Surgeon General was assigned responsibility for carrying forward, on behalf of the Department, the development of the Medical Reserve Corps as a Citizen Corps partner program.

The MRC has changed how over 600 communities improve public health and prepare for emergencies. MRC members are identified, credentialed, trained and prepared in advance of an emergency, and are utilized throughout the year to improve the public health system. While the MRC provides volunteers with an opportunity to make a difference in the health and safety of those nearest to them, it also fills gaps in both public health initiatives and preparedness. This has enabled local communities to achieve a higher degree of resiliency and independence.

Medical Reserve Corps units are organized locally to meet the needs in their community. They are encouraged to contribute to local public health initiatives, such as those meeting the Surgeon General's priorities for public health. As this is a community-based program, each MRC is responsible for determining its own structure and developing its own policies and procedures. MRC units may be established and implemented by local governmental agencies or non-governmental organizations, but strong partnerships with local medical, public health and emergency management entities are necessary.

The MRC Demonstration Project (started in FY 2002 and continued in FY 2003) provided start-up grants to 166 communities across the US. Many other communities have realized the importance of the MRC concept and have established MRC units without funding support. As of January 2007, there are over 615 MRC units in all 50 states, Washington, DC, Guam, Palau, Puerto Rico and the US Virgin Islands, with more than 113,000 volunteers.

## Rationale for Budget Request

The FY 2008 request for the Medical Reserve Corps (MRC) program is $15,113,000, an increase of $5,365,000 above the FY 2007 CR level.

Though the MRC was originally developed as a network of local, community-based units established to meet locally determined needs, much national attention has been focused on the program in light of its astounding growth and its response following the 2005 Hurricanes. This attention has led to a call for an expansion of the MRC program. For example, in 2005 HHS was charged with the establishment of systems to pre-enroll, credential, train, and deploy MRC members who are willing to provide emergency health and medical services after a catastrophic event. Then, in the February 2006 *Federal Response to Hurricane Katrina: Lessons Learned* report, the White House recommended that "HHS should organize, train, equip, and roster medical and public health professionals in preconfigured and deployable teams" to include the PHS Commissioned Corps, the DoD, the VA, the NDMS, and members of the MRC.

In support of the President's national strategies, and in keeping with the National Response Plan, the MRC program office will undertake efforts to expand the capacity of MRC units throughout the nation. All work will be closely coordinated with OSG, ASPR, state coordinators, MRC regional coordinators, Regional Health Administrators and other Federal officials.

The vital, ongoing work of MRC program will continue, but additional efforts will be made to establish the necessary mechanisms and processes to involve MRC members who are willing, able and approved to deploy with HHS on national-level responses. This subset of MRC members may be referred to as the "Public Health Service Auxiliary." A plan for its establishment is being developed, and MRC will design and implement the PHS Auxiliary as the deployable cadre of MRC volunteers. The following are some of the tasks that will need to be undertaken:

- Establish PHS Auxiliary Work Group (include potential Auxiliary members, MRC unit leaders, and representatives of pertinent agencies and partner organizations)
- Research existing Auxiliary organizations (Coast Guard Auxiliary, Civil Air Patrol)
- Develop and implement PHS Auxiliary concept
- Develop and submit any necessary Paperwork Reduction Act and Privacy Act documents
- Draft policies and procedures
- Develop "branding" and recruitment materials (logo, slogan, trademark, brochures, etc)
- Develop operational guidance and member manuals
- Develop member database
- Develop member screening plan (credentials verification, background checks)
- Establish ID card system
- Develop training requirements
- Identify/procure equipment/supplies (i.e. go-kits, PHS Auxiliary shirts)
- Develop deployment mechanisms
- Integrate with PHS response teams
- Develop evaluation plan

The proposed FY 2008 budget will support staff, travel, cooperative agreements, contracts, grants and contract management, technical assistance, outreach, and other programmatic activities.

## Performance Analysis

| Performance Goal | Results | Context |
|---|---|---|
| Number of MRC units in communities across the US: 30% increase, which would add 144 units. | MRC has regularly exceeded this goal:<br>FY 2004 - 217<br>FY 2005 - 321<br>FY 2006 - 483 | This performance goal refers to the provision of outreach, technical assistance and coordination by the MRC program office staff and the MRC regional coordinators, which assists local communities in establishing MRC units. |
| MRC core competencies:<br>used by 10% of MRC units in 2007.<br>used by 25% of MRC units in 2008. | The MRC core competencies were officially launched in April 2006 | This performance goal refers to the capability of MRC volunteers to function in a competent manner in the potential missions, situations and activities of the MRC unit. Goal revised from FY 2007 PB to reflect a more realistic implementation plan. |
| Website hits: at least 5,000,000/year<br>Number of listserv users/message sent: 10% increase<br>Presentations/Exhibits: at least 150/year | MRC has regularly exceeded this goal (see results below) | This performance goal refers to the efforts of the MRC program office staff and the MRC regional coordinators to firmly establish the MRC as a national system of community-based units that work together to improve the public health infrastructure of the nation. Actual results for 2005 and 2006 assumed to be one-time in nature, due to increased outputs for Katrina activities and competition for NACCHO funds. Goals reflect estimate of realistic performance. |

## Performance Narrative

The MRC Program Office supports local efforts to establish, implement, and sustain MRC units nationwide. Our goals and objectives are to:

**Provide effective national leadership and coordination**

- Develop and sustain partnerships that promote the MRC mission
- Promote the integration of MRC units with local and State agencies
- Encourage chains of communication between local, state, regional and national MRC leaders
- Facilitate national level MRC-focused meetings
- Maintain and review MRC unit registrations
- Establish guidelines, criteria and competencies for MRC units and members
- Institute policies and procedures for efficient MRC program operations
- Leverage relationships, interagency agreements, cooperative agreements and contracts to ensure program success
- Participate in development and implementation of federal activation processes for volunteers

**Promote awareness and understanding of the critical role that MRC units play in communities across the nation**

- Identify and assess ways that MRC units contribute to community health and safety, as well as HHS/OSG goals, throughout the year and during times of need
- Develop MRC marketing and "brand recognition" strategies and materials
- Develop and distribute appropriate information and promotional materials
- Communicate about MRC activities to a variety of audiences (policy makers, Federal, state and local agency officials, public health and medical professionals, community and MRC unit leaders, association and professional groups, and members of the general public)
- Maintain MRC Website as a clearinghouse for updated MRC and preparedness-related information
- Participate on a variety of public health, medical and emergency management message boards and listservs
- Draft articles for inclusion in newsletters, journals and other print publications

**Enhance the capacity of MRC units to achieve their local missions**

- Assess MRC units' level of development and target technical assistance as appropriate
- Develop and provide technical assistance guidance documents based on contemporary best practices and MRC units' lessons learned
- Provide online venues for information sharing between MRC units
- Convene meetings for information sharing between MRC units
- Provide resources for MRC unit training
- Leverage resources for MRC unit administration and management

The first measure used to evaluate the success of the MRC program is the registration of new units; the goal is to see 30% growth per year. The rapidly increasing number of MRC units (especially those outside of the MRC Demonstration Project that did not receive any funding support) indicates the level of acceptance of the MRC concept, mission and purpose within communities and States throughout the nation. While there was a tremendous growth rate in 2006 (primarily due to increased awareness following Hurricane Katrina), a relative decline in the growth rate is expected in 2007 and 2008.

| Date | New MRC Units | Total Number of MRC Units |
|---|---|---|
| Program Inception – December 2003 (MRC Demonstration Project) | 166 | 166 |
| January – December 2004 | 66 | 232 |
| January – December 2005 | 118 | 350 |
| January – December 2006 | 247 | 597 |

A second measure of acceptance is the count of MRC volunteers. These fast growing numbers, which are self-reported by MRC units across the country, show that individuals across the nation (many of whom are medical and public health professionals) have accepted the MRC mission.

| Date | Total Number of Volunteers |
|---|---|
| December 2004 | 34,127 |
| December 2005 | 61,961 |
| December 2006 | 112,110 |

The second performance goal is the level of use of the MRC core competencies. The core competencies were developed in partnership with the National Association of County and City Health Officials (NACCHO) as a baseline that the local MRC training courses and programs should, at a minimum, address. These competencies were officially launched in 2006 and mechanisms to determine their acceptance and use are being established. We expect to begin reporting on this in the near future. The goal is to see these competencies used by 10% of the MRC units in 2007 and by at least 25% of units in 2008.

The MRC program office, through its partnership with the Public Health Foundation, also provides an online learning management tool called "MRC-Train" to all MRC units, free of charge. This allows access to hundreds of courses, many of which also provide continuing education credits for healthcare professionals. More information about the core competencies and MRC-Train can be found at http://www.medicalreservecorps.gov/TRAINResources

The third performance goal actually includes a combination of measures that show how the MRC flourishes due to information sharing. Information is shared through the MRC Listserv, Web site, and local, state and national meetings. The MRC Listserv is used by the MRC program to send important information out to MRC leaders, volunteers and others interested in the MRC program. The MRC Web site is updated regularly with new resources and best practices for and from MRC units. Lastly, by sharing information at MRC meetings and professional conferences, awareness and understanding are increased and stronger partnerships are built.

**MRC Listserv**

| Date | Subscribers | Messages Sent |
|---|---|---|
| Inception – December 2004 | 322 | 28 |
| January – December 2005 | 1479 | 65 |
| January – December 2006 | 1876 | 35 |

**MRC Web site**

| Date | Hits on MRC Web site |
|---|---|
| Inception – December 2004 | 1455689 |
| January – December 2005 | 5918437 |
| January – December 2006 | 9450798 |

**Meeting/Conference Participation**

| Date | Presentations or Exhibits |
|---|---|
| Inception – December 2004 | 33 |
| January – December 2005 | 67 |
| January – December 2006 | 181 |

MRC program office activities include policy development, intra- and interagency coordination, program management, grants management, contract oversight, technical assistance, and outreach.

Since its inception, the MRC program has:

- Implemented the MRC Demonstration Project, which awarded small grants (of up to $50,000 per year for 3 years) to help jump start the establishment of local MRC units. Forty-two grants were awarded in September 2002 and an additional 124 grants were awarded in October 2003.
- Awarded a $8 million cooperative agreement in FY 2006 with National Association of County and City Health Officials (NACCHO) to build the capacity of MRC units and to strengthen the ties between the MRC at all levels and the nation's public health system. We expect this relationship to continue in 2007 and 2008.
- Encouraged the development of MRC units in communities outside of the MRC Demonstration Project. As of January 2007, over 450 additional communities have registered MRC units without receiving grant funding through the MRC program office.
- Created the MRC logo and filed for trademark protection.
- Developed a technical assistance contract to provide valuable expert advice to developing and established MRC units. A series of technical assistance documents were written to serve as a guide for local leaders to assist with establishment and implementation of MRC units.
- Established an MRC website (www.medicalreservecorps.gov) with resources for developing and established MRC units. The website includes an electronic message board and document clearinghouse to allow MRC communities to share information.
- Held consultation meetings with numerous governmental and non-governmental organizations at the local, regional and national levels.
- Displayed the MRC exhibit booth at professional conferences to boost awareness of the program.
- Conducted leadership conferences at the national and regional levels to facilitate coordination, cooperation and information sharing.

# PANDEMIC INFLUENZA

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $5,152,000,000 | $78,000,000 | $948,091,000 | +$870,091,000 |
| FTE | 11 | 24 | 24 | – |

## Statement of the Budget Request

The FY 2008 request for pandemic preparedness is $948,091,000. This request includes $870,000,000 to fund the third year of the *HHS Pandemic Influenza Plan*, with a focus on expanding domestic cell- and egg-based influenza vaccine capacity, developing next generation pandemic influenza vaccines, warm base vaccine production, purchasing pre-pandemic H5N1 vaccines and influenza antivirals for stockpiling, and accelerating research and development of rapid diagnostic tests. Additionally, $78,091,000 is requested in the Public Health and Social Services Emergency Fund for ongoing OS efforts that include management and administrative activities as well as international surveillance and response activities.

In addition to this request, a total of $244,000,000 will fund on-going annual activities at FDA, CDC, and NIH.

## Program Description

Influenza pandemics are global events in which most, if not all, persons worldwide are at risk for infection and illness. In past pandemics, influenza viruses have spread worldwide within months. With the rapid growth in population and accessibility of air travel, a new, efficiently transmissible influenza strain could be expected to cross the globe even faster, in hours and days as opposed to the weeks and months of the past. The current H5N1 (avian influenza) situation in Asia heightens the concern and need to prepare. Since 1997, the avian influenza virus has continued to evolve, and scientists believe that it may be one mutation away from developing the ability to efficiently transmit from person to person. Of added concern is that it is becoming increasingly lethal for an expanding number of species and for mammals, not just birds. The case fatality rate for the human cases that have occurred was approximately 50 percent a year ago, and today is approaching 60 percent. Historians and scientists believe that the case fatality rate for the 1918 pandemic, which is believed to have killed at least 500,000 Americans and 50 million worldwide, was approximately 1 to 3 percent. In the absence of the necessary health care, medical supply and laboratory surge capacity, as well as effective antivirals and vaccines, a moderate pandemic could cause an additional 120,000 to 500,000+ deaths in the US alone and a severe pandemic may cause up to 5-10 million U.S. lives.

HHS has actively tracked all animal outbreaks and human cases of highly pathogenic H5N1. In August 2005, animal outbreaks had been reported in twelve countries around the world, with 112 total human cases confirmed in four of those countries. Eighteen months later, in January 2007, the number of countries confirming animal outbreaks has jumped to forty-seven, with 269 total human cases confirmed in ten of those countries with 163 deaths..

In November 2005, HHS released parts 1 and 2 of the three-part *HHS Pandemic Influenza Plan*. The *HHS Pandemic Influenza Plan* is a blueprint for pandemic influenza preparation and

response. It provides guidance to national, State, and local policy makers and health departments. The *HHS Plan* includes an overview of the threat of pandemic influenza, a description of the relationship of this document to other Federal plans, and an outline of key roles and responsibilities during a pandemic. It also specifies needs and opportunities to build robust preparedness for and response to pandemic influenza.

- Part 1, the HHS Strategic Plan, which outlines Federal plans and preparation for public health and medical support in the event of a pandemic;
- Part 2, Public Health Guidance for State and Local Partners, which provides detailed guidance to state and local health departments in 11 key areas; and
- Part 3, which is currently under development, will consist of HHS Agencies' Operational Plans.

In addition, the Department has been actively developing and formulating the *HHS Pandemic Influenza Implementation Plan* to improve the response to an influenza pandemic. The HHS Implementation Plan was developed in conjunction with the White House *Homeland Security Council Implementation Plan*, released in May 2006. Part 1 of the HHS Plan was issued in December 2006

In FY 2006, the Department was appropriated a total of $5.6 billion in emergency supplemental funding packages to prepare the Nation for a pandemic. This funding enhanced HHS's preparedness through investments in increasing vaccine capacity and accelerating cell-based vaccine development; retrofitting facilities for emergency production of pandemic influenza vaccine; the advanced development of antigen sparing pandemic influenza vaccines, advanced development of new and promising influenza antivirals, antiviral and other countermeasure purchases; State and local preparedness; quarantine stations; surveillance and epidemiology; outbreak response; rapid diagnostics development; and reference strain laboratory capacity expansion

<u>Rationale for the Budget Request</u>

With the $870,000,000 request for no-year funding, HHS funding ($234,000,000 ) will continue to work toward its goal to acquire 20 million egg-based courses of pre-pandemic vaccine for stockpiling by 2009. Currently, HHS has approximately 4 million courses of H5N1 clade 1 vaccine on hand. With FY 2006 supplemental funding, HHS has purchased an additional 2.7 to 3.5 million courses of H5N1 clade vaccine. Additional funds are included to accelerate cell-based technologies ($309,000,000). Funds will be used for clinical trials needed to license cell-based vaccine and for facility costs. This funding will support development of next generation of recombinant pandemic influenza vaccines, which may reduce the time needed to manufacture and issue a pandemic vaccine by two-fold.

These investments will enable HHS to accelerate cell-based technologies so that together with the egg-based manufacturing capacity, manufacturers can produce enough vaccine for every American within six months of the onset of a pandemic. HHS also requests $248,000,000 to achieve our Federal antiviral purchase goal of 50 million courses of antivirals. Currently HHS has approximately 38 million courses on hand/on order. Finally, the no-year request includes $79,000,000 to accelerate research and development of diagnostic tests. This funding is for both high throughput and point of care rapid diagnostics to take advantage of scientific opportunities and develop this technology at a faster pace.

The FY 2008 request for OS Pandemic Influenza preparedness activities through the Public Health and Social Services Emergency Fund is $78,091,000. This funding will be used to ensure effective risk communications, foster international collaboration, support the advanced development of diagnostic tools, and maintain management and administrative support.

The FY 2008 request for Pandemic Influenza preparedness activities will support the following activities:

*Ensuring Effective Communications ($4,000,000)* -- Through the Office of the Assistant Secretary for Public Affairs (ASPA), HHS has undertaken a number of steps to educate the public, including the creation and maintenance of the website www.PandemicFlu.gov, development and distribution of the *Individuals and Families Pandemic Planning Guide*, and the release of television and radio pubic service announcements. HHS also held pandemic planning summits with public health and emergency management and response leaders in 56 States and localities which receive pandemic preparedness funding.

Despite these efforts, greater public education is still needed, especially among vulnerable populations. Audience research conducted by ASPA in July 2006 found that, while awareness of avian and pandemic influenza is high, knowledge is very low with respect to how a pandemic might spread, how it is treated, and the steps individuals should take to begin planning and preparing for a pandemic, including practicing good public health hygiene (infection control measures include hand hygiene, cough etiquette, and social distancing). ASPA's efforts include media outreach, stakeholder outreach, audience research, message testing and risk communications. The requested FY 2008 funding level will allow ASPA to maintain a communications operation to respond to a pandemic.

*Pandemic Preparedness and Planning ($35,000,000)* – Preparedness and response is key to effective containment of an outbreak of influenza with pandemic potential in the US or abroad. To prepare for a global epidemic, the Office of Global Health Affairs (OGHA) and the Office of the Assistant Secretary for Preparedness and Response (ASPR) will work with the technical agencies of the Federal government, as well as international partners, to ensure that the global community has the capacity and the commitment to take coordinated and effective action to contain an outbreak at its site of origin, and to limit its spread. A major objective is to provide assistance to nations lacking the resources to independently detect and respond to an outbreak, and to implement associated performance measures to judge the effectiveness of HHS investments. ASPR will continue working towards the facilitation of country-specific pandemic preparedness plans that are coordinated with international strategies. The targeted programs will expand medical, veterinary, and laboratory expertise and capacity abroad; enhance laboratory diagnostic capacity and technical capabilities; and improve surveillance.

*International in-country advanced development and industrialization of human pandemic influenza vaccines ($15,000,000)* – In FY 2008, ASPR will continue the accelerated international development of an in-country H5N1 vaccine for humans to prevent avian H5N1 influenza globally. The funding will address global and specific country needs for further pilot lot and commercial scale manufacturing of H5N1 vaccines for clinical trials and pandemic usage, scale-up development for vaccine manufacturing, vaccine production equipment, and development and validation of product release assay methods and clinical sample analysis.

*Advanced development of rapid tests/detection ($15,000,000)* – The prevention and containment of a pandemic influenza epidemic requires the ability to produce vaccine that targets the current

virus strain in circulation. HHS will continue to accelerate the development of modular, high throughput diagnostic kits, equipments, reagents, and methods (antigen and genetic-based tests) for rapid bedside detection of human, avian and pandemic influenza viruses at the subtype and virus variant level on a national scale. This will be accomplished by advancing current technology through assay development and validation processes; engaging in stringent proficiency testing and validation studies for rapid tests; and implementing quality systems that insure compliance in the total development process as well as through the Public Health Information Network-compliant electronic reporting of laboratory results and other critical communications from local jurisdictions to State public health laboratories and to HHS.

*Management and Administration ($9,000,000)* – Funds will be used for: salaries of scientists, project managers, contracting officers and other program staff; travel, including site visits to facilities and for convening technical evaluation panels; rent and utilities; intermittent subject matter experts, and contractor support.

# TREATMENT FOR WORLD TRADE CENTER RESPONDERS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $– | $– | $25,000,000 | +$25,000,000 |
| FTE | – | – | – | – |

Statement of the Budget Request

The FY 2008 request includes $25,000,000 to support treatment for World Trade Center Responders.

Program Description

Since 2002, HHS has been dedicated to tracking and screening World Trade Center responders and others exposed to the dust, debris, and stressors of September 11, 2001 attacks. Currently, HHS is overseeing the expenditure of $75,000,000 in funds for the treatment, screening, and monitoring of World Trade Center workers and first responders.

Rationale for the Budget Request

The FY 2008 budget includes $25,000,000 for treatment of World Trade Center related illnesses for first responders. The World Trade Center Task Force, comprised of the Department's top science and public health policy experts, continues to evaluate data and options for how best to ensure treatment needs of responders are met.

# HEALTHCARE PROVIDER CREDENTIALING

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $– | $– | $3,300,000 | +$3,300,000 |
| FTE | – | – | – | – |

Statement of the Budget Request

The FY 2008 request includes $3,300,000 for healthcare provider credentialing – a vital part of the Department's Federal Mass Casualty Initiative.

Program Description

Healthcare provider credentialing, both before and after a mass casualty event, is essential to protect the health and safety of victims, to match expertise with need, and to satisfy liability-related requirements. Funds will be used to create a mechanism to conduct primary source verification of health care professionals' credentials from relevant Federal, State and non-governmental sources. This information will be accessed through a single electronic portal available to parties who have received prior permission for such a query from the practitioner. The network of primary source data will be sufficiently inclusive to permit credentialing determinations of spontaneous volunteers. The system will be designed to work collaboratively with State-based systems such as the HRSA-based Emergency System for Advance Registration of Volunteer Health care Personnel (ESAR-VHP).

Rationale for the Budget Request

The FY 2008 request for the Healthcare Credentialing Portal will accomplish the following objectives:

- Assist States in managing spontaneous volunteers who respond to assist during large-scale emergencies.
- Quickly credential civilian health care professionals who have spontaneously volunteered to participate in a disaster response.
- Collaborate with Federal, State, local and private partners for a seamless integration and sharing of currently available data.

Funds will support system design and development and oversight, database interface implementation, system testing, implementation of standard operating procedures, regional deployment, and other related costs.

## SECURITY COORDINATION AND IMPROVEMENT

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget | Increase or Decrease |
|---|---|---|---|---|
| Budget Authority | $– | $– | $1,500,000 | +$1,500,000 |
| FTE | – | – | TBD | – |

Statement of the Budget Request

The FY 2008 request includes $1,500,000 to improve the coordination of security-related activities and strategic information within the Office of the Secretary and HHS.

Rationale for the Budget Request

HHS security functions are currently decentralized. Therefore, many security functions have operated with suboptimal objective oversight. HHS seeks to improve accountability, establish a departmental systems approach to collaborations among STAFFDIVs and OPDIVs, and unify policies across the Department on critical issues. HHS also plans to cluster key technical expertise and to eliminate duplications.

Currently, the Security Clearance and Drug Testing Office reports directly to the Deputy Secretary. HHS anticipated establishing an improved structure for the Office of the Secretary in FY 2007. The additional funds requested in FY 2008 will be used to improve HHS' internal security, improve internal coordination, and improve coordination with other government organizations.

## DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Assistant Secretary for Preparedness and Response | 234 | 279 | 446 |
| Medical Reserve Corps | 6 | 5 | 5 |
| Pandemic Influenza | 11 | 24 | 24 |
| Total | 251 | 308 | 475 |

| Average GS Grade | |
|---|---|
| 2006 | 13.6 |
| 2007 | 13.6 |
| 2008 | 13.4 |

## DETAIL OF POSITIONS

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Executive Level I | – | – | – |
| Executive Level II | – | – | – |
| Executive Level III | – | – | – |
| Executive Level IV | – | – | – |
| Executive Level V | – | – | – |
| Executive Level VI | – | – | – |
| Subtotal | – | – | – |
| Total – Executive Level Salaries | $– | $– | $– |
| ES-6 | 4 | 4 | 4 |
| ES-5 | 2 | 2 | 2 |
| ES-4 | 1 | 1 | 1 |
| ES-3 | 0 | 1 | 2 |
| ES-2 | 1 | 0 | 0 |
| ES-1 | 0 | 0 | 0 |
| Subtotal | 8 | 8 | 9 |
| Total – ES Salaries | $1,265,934 | $1,317,837 | $1,438,912 |
| GS-15 | 39 | 42 | 76 |
| GS-14 | 39 | 40 | 85 |
| GS-13 | 66 | 62 | 113 |
| GS-12 | 44 | 44 | 72 |
| GS-11 | 12 | 10 | 22 |
| GS-10 | 1 | 1 | 4 |
| GS-09 | 13 | 15 | 28 |
| GS-08 | 4 | 4 | 11 |
| GS-07 | 4 | 4 | 13 |
| GS-06 | 3 | 3 | 7 |
| GS-05 | 1 | 1 | 2 |
| GS-04 | – | – | – |
| GS-03 | – | – | – |
| GS-02 | – | – | – |
| GS-01 | – | – | – |
| Subtotal | 226 | 226 | 433 |
| Commissioned Corps | 81 | 83 | 83 |
| Ungraded | 22 | 32 | 32 |

| | FY 2006 Actual | FY 2007 CR | FY 2008 Budget |
|---|---|---|---|
| Total positions | 337 | 349 | 557 |
| Total FTE usage, end of year | 251 | 308 | 475 |
| | | | |
| Average ES level | 5 | 6 | 6 |
| Average ES salary | $158,242 | $164,730 | $159,879 |
| Average GS grade | 13.6 | 13.6 | 13.4 |
| Average GS salary | $88,420 | $91,118 | $89,721 |
| Average Special Pay (Commissioned Corps) | $103,857 | $104,254 | $101,994 |
| Average Ungraded | $102,032 | $117,959 | $119,219 |

## NEW POSITIONS REQUESTED

| | FY 2008 | | |
|---|---|---|---|
| Positions | Grade | Number | Annual Salary |
| Deputy Division Director . . . . . . . . . . . . | ES-3 | 1 | $135,000 |
| Senior Program Analyst . . . . . . . . . . . . . | GS-15 | 34 | $125,078 |
| Program Analyst . . . . . . . . . . . . . . . . . . | GS-14 | 45 | $106,331 |
| Program Analyst . . . . . . . . . . . . . . . . . . | GS-13 | 51 | $89,985 |
| Program Analyst . . . . . . . . . . . . . . . . . . | GS-12 | 28 | $75,671 |
| Program Analyst . . . . . . . . . . . . . . . . . . | GS-11 | 12 | $63,135 |
| Staff Assistant . . . . . . . . . . . . . . . . . . . . | GS-10 | 3 | $57,463 |
| Staff Assistant . . . . . . . . . . . . . . . . . . . . | GS-9 | 13 | $52,180 |
| Staff Assistant . . . . . . . . . . . . . . . . . . . . | GS-8 | 7 | $47,245 |
| Staff Assistant . . . . . . . . . . . . . . . . . . . . | GS-7 | 9 | $42,659 |
| Staff Assistant . . . . . . . . . . . . . . . . . . . . | GS-6 | 4 | $38,238 |
| Staff Assistant . . . . . . . . . . . . . . . . . . . . | GS-5 | 1 | $34,437 |
| TOTAL . . . . . . . . . . . . . . . . . . . . . . . . . | | 208 | |

# NONRECURRING EXPENSES FUND
## LEGISLATIVE PROPOSAL

**Description of Proposal**: HHS proposes to establish the Nonrecurring Expenses Fund, a no-year account to capture expired unobligated balances from discretionary accounts prior to cancellation. This Fund would be used for nonrecurring expenses such as facilities infrastructure, Information Technology (IT) infrastructure, or other Department-wide Secretarial priorities. Transfers would occur up to five years after expiration, when it is certain that original obligations have been fully paid and closed out. Advance notification of all proposed uses of the Nonrecurring Expenses Fund would be submitted to the Appropriations Committees.

**Why HHS Needs This Fund:** HHS is seeking alternative financing mechanisms to cover one-time costs, which are difficult to accommodate in the normal budget process. HHS believes that a fund of this type would help align resources with such variable needs.

The proposed source of funds could provide much-needed funding for three primary areas of concern:

- Facilities Infrastructure – The Real Property Asset Management initiative of the President's Management Agenda (PMA) requires a condition index of 90. With over 30 million square feet of space and a combined facilities index of 86, fulfilling HHS's responsibilities under the PMA will cost more than $600 million. Funding from the Nonrecurring Expenses Fund could help HHS meet the PMA requirement and fulfill agency mission requirements.

- IT Infrastructure – IT presents similar budgeting challenges; Y2K is a classic example. In recent years, HHS has needed large investments to fund a new accounting system (UFMS), in order to meet the financial management goals of the PMA, as well a new I-Procurement system. HSPD-12 requirements have also created budgeting challenges, and recent history suggests that information security will be a future challenge. Such challenges are usually unpredictable and intermittent; therefore, funding from the Nonrecurring Expenses Fund could help HHS meet these needs.

- Secretarial Initiatives – New requirements frequently surface which were neither known nor contemplated when the pertinent budget request was developed 18 months earlier. For example, during FY 2006 HHS wanted to fund systems to save substantial labor costs and shorten the time to respond to constituents; HHS also wanted to fund a data collection system for the Secretary. These are just two recent examples that could be financed using the proposed Nonrecurring Expenses Fund.

It should be noted that this is not a new concept. The U.S. Department of Justice and the General Services Administration have had similar authority through their Working Capital Funds since 1991 and 1993, respectively. Both Funds are available for acquisitions of capital equipment, data processing systems, and financial management systems. In addition, the U.S. Agency for International Development has authority to extend the period of availability for funds for an additional four years.

## How This Proposal Will Help Meet These Needs

The following chart reflects the HHS discretionary balances that have been cancelled since FY 1995:

| FY in which Cancelling Occurred | Amount of Discretionary Funds Cancelled by FY ($ in millions) | | | | | | |
|---|---|---|---|---|---|---|---|
| | **1995** | **1996** | **1997** | **1998** | **1999** | **2000** | **2001** |
| 2000 | 330 | | | | | | |
| 2001 | | 220 | | | | | |
| 2002 | | | 290 | | | | |
| 2003 | | | | 322 | | | |
| 2004 | | | | | 392 | | |
| 2005 | | | | | | 630 | |
| 2006 | | | | | | | 282 |

Excluding $157 million of Y2K balances in FY 2000, these cancelled HHS balances averaged approximately $325 million per year. While this level of funding would not be guaranteed, and therefore cannot be relied on for on-going projects, historical levels indicate that this is a considerable resource, which could be tapped for unbudgeted items.

## How the Fund Would Work

Expired unobligated balances remaining in the fifth year after expiration would be reviewed, to ascertain that original obligations have been fully paid and closed out. Once this is determined, these balances would be transferred to the Nonrecurring Expenses Fund prior to cancellation. Advance notification of the proposed use of funds would be submitted to the relevant Appropriations Committees, and apportionment of these funds would be submitted to OMB with justification for the areas/ projects proposed to be funded with these resources. The account would be administered centrally by the Office of the Assistant Secretary for Resources and Technology, similar to the way in which the Public Health and Social Services Emergency Fund is centrally administered. Components would then be delegated the authority to obligate funds, as determined by the approved apportionment.

## How the Fund Would be Scored

It is HHS's understanding that the proposed language would not be scored as a discretionary cost, because the authority is prospective; that is, it provides authority to transfer expired amounts (beginning with those of the FY 2008 Appropriations Act) into the Nonrecurring Expenses Fund. Since such authority does not result in a reappropriation, no scoring issue arises.

However, this also means that it would be several years before HHS would actually be able to transfer expired funds into the Nonrecurring Expenses Fund. Nevertheless, HHS believes that this is still a solid long-term budget strategy.

## Proposed Language

**Language proposed for inclusion in the FY 2008 Labor/HHS/Education Appropriations Act:**

*There is hereby established in the Treasury of the United States a fund to be known as the "Nonrecurring expenses fund" (the Fund): Provided, That unobligated balances of expired discretionary funds appropriated for this or any succeeding fiscal year from the General Fund of the Treasury to the Department of Health and Human Services by this or any other Act may be transferred (not later than the end of the fifth fiscal year after the last fiscal year for which such funds are available for the purposes for which appropriated) into the Fund: Provided further, That amounts deposited in the Fund shall be available until expended, and in addition to such other funds as may be available for such purposes, for capital acquisition necessary for the operation of the Department, including facilities infrastructure and information technology infrastructure; and other Department-wide higher priorities, as the Secretary of Health and Human Services considers appropriate, subject to approval by the Office of Management and Budget: Provided further, That amounts in the Fund may be obligated only after notification of the Committees on Appropriations of the House of Representatives and the Senate of the planned use of funds.*

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## PROPOSED GENERAL PROVISIONS
## FOR FISCAL YEAR 2008

The President's Budget recommends that a number of general provisions be included in the FY 2008 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 provides authority for up to $50,000 in appropriated funds to be used for official reception and representation expenses which are specifically approved by the Secretary.

Sec. 202. This provision enables the Secretary to assign not more than 60 Public Health employees to assist in child survival activities and to work with AIDS through programs with the Agency for International Development, the United Nation's International Children's Emergency funds and the World Health Organization.

Sec. 203. This provision provides that no funds appropriated under this Act be used in the implementation of section 1503 of the National Institutes of Health Revitalization Act of 1993, Public Law 103-43.

Sec. 204. This provision proposes to limit, to a maximum of Executive Level II per year ($168,000), the rate at which the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration may pay an individual when using a grant or extramural funding appropriated under this title.

Sec. 205. This provision limits the rate at which the Head Start Program may pay an individual when using a grant or extramural funding appropriated under this title, to a maximum of Executive Level II per year ($168,000).

Sec. 206. This provision allows the Secretary to use not more than 2.4 percent of any appropriations authorized under the Public Health Service Act for the evaluation of the implementation and effectiveness of the Public Health Service Act programs.

Sec. 207. This provision proposes to authorize the Secretary to transfer up to 3 percent of discretionary funds between appropriations for the Department of Health and Human Services in this, or any other Act (e.g., Agriculture and Rural Development Act, Interior Act, and Labor, Health and Human Services, Education, and Related Agencies Act), with a limitation that no such appropriation could be increased by greater than 3 percent, and that an appropriation may be increased by an additional 2 percent after notification of the Appropriations Committees in both Houses of Congress. The Appropriations Committees in both Houses of Congress are to be notified at least 15 days in advance of any transfer.

Sec. 208. This provision provides 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, centers and divisions from the total amounts identified by these two Directors as funding for research pertaining to the human immunodeficiency virus.

Sec. 209. This provision 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, will be available to the Office of AIDS Research account as necessary to carry out section 2353(d)(3) of the Public Health Service Act.

Sec. 210. This provision provides that none of the funds appropriated in this Act may be available to any entity under title X of the Public Health Service Act unless the award applicant certifies to the Secretary that it encourages family participation in family planning services for minors and provides counseling to minors on how to resist coercion into engaging in sexual activities.

Sec. 211. 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 denies an entity participation in the program based on the information that the entity will not provide, pay for, or provide referrals for abortions.

Sec. 212. This provision provides that no provider of services under title X of the Public Health Service Act be exempt from State laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape or incest.

Sec. 213. This provision proposes that none of the funds appropriated by this Act can be used to withhold substance abuse funding from a State, if the State certifies to the Secretary of Health and Human Services by May 1, 2008, that it will commit additional State funds to ensure compliance with State laws prohibiting the sale of tobacco products to individuals under 18 years of age. The State is to submit a report to the Secretary on all fiscal year 2007 State expenditures and all fiscal year 2008 obligations for tobacco prevention and compliance activities, by program activity, by July 31, 2008. Expenditures in FY 2008 must be greater than or equal to FY 2007 expenditures.

Sec. 214. This provision provides authority to support HHS in carrying out international HIV/AIDS and other infectious, chronic, and environmental disease and other health activities abroad.

Sec. 215. This provision provides authority for the Office of the Director of the National Institutes of Health (NIH) to enter directly into transactions 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. 216. This provision enables the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) to transfer funds that are available for Individual Learning Accounts to "Disease Control, Research, and Training." The funds can be used for any full time equivalent (FTE) employee employed by CDC or ATSDR.

Sec. 217. This provision proposes to cancel the unobligated balances available under the HRSA

Health Centers Loan Guarantee Program authorized under section 330(d) of the PHS Act and Title II of P.L. 104-208.

Sec. 218. Subsequent to such cancellation, all institutions of higher education with a student loan revolving fund established under these authorities will, by September 30, 2008, pay to the Secretary of HHS the Federal portion of all liquid assets of such a fund, as determined by the Secretary on June 30, 2008; in addition, these institutions shall not make any new loans under these authorities until such payment to the Secretary has been made.

Sec. 219. Of the unobligated balances available under the heading,''Centers for Disease Control and Prevention'' in Public Law 109-149, $29,680,000 are cancelled.

Sec. 220. The Director of the Centers for Disease Control and Prevention may reallocate up to one percent of any discretionary funds appropriated for the current fiscal year for the Centers for Disease Control and Prevention between the agency's programs, projects, and activities: Provided, That the transfer should not decrease any program, project, or activity by more than three percent: Provided further, That the reallocation authority granted by this section shall be available only to meet CDC's public health mission: Provided further, That the appropriations committees of both Houses of Congress are notified within 15 days of any reallocation.

Sec. 221. Not to exceed $35,000,000 of funds appropriated by this Act to the Institutes and Centers of the National Institutes of Health 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.

## 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 provision provides 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, publication, radio or TV broadcast or film presentation designed to support or defeat legislation pending before Congress, except as a presentation to Congress 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 funds 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.

Sec. 509. This provision provides that none of the funds made available in this Act may be used for creation of a human embryo, embryos for research, or research in which a human embryo or embryos is destroyed. For the purposes of this section, human 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 affects the Department of Education and pertains to the availability of funds for local educational agencies' under part D or title II of the Elementary and Secondary Education Act of 1965, amended by the Children's Internet Protections Act and No Child Left Behind Act.

Sec. 515. This provision provides that none of the funds appropriated in this act may be used to enter into agreement, under section 7 (b)(4) of the Railroad Retirement Act of 1974, with a non-governmental institution to serve as disbursing agent for benefits payable under the Railroad Retirement Act of 1974.