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HHS PERFORMANCE PLAN
AND
PERFORMANCE REPORT SUMMARY

INTRODUCTION

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THIS IS A SUMMARY DOCUMENT.

HHS is a large, decentralized Agency that administers approximately 300 program activities, with over 750 annual performance goals. To best accommodate the linkage of these performance goals to the budget requests for these program activities, HHS has incorporated the performance goals into the budget submissions for the HHS components that administer the programs. To view all performance goals for all HHS program activities, including the latest performance results and other required information, readers are referred to the performance plans and reports included in the budget justification for the individual HHS components.

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The Department of Health and Human Services seeks to enhance the well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services. We accomplish this mission through the separate and collaborative efforts of our operating divisions and staff offices within the Office of the Secretary:

Administration on Aging (AoA) serves as the primary federal focal point and advocacy agent for older Americans. Through a network of state and area agencies on aging, AoA funded programs deliver comprehensive in-home and community services; and make legal services, counseling, and ombudsmen programs available to elderly Americans

Administration on Children and Families (ACF) leads the nation in improving the economic and social well-being of families, children, and communities though federal grant programs like Head Start, Child Support Enforcement, Child Welfare Services, Child Care and Development, and Temporary Assistance to Needy Families.

Agency for Health Care Research and Quality (AHQR) enhances the quality, appropriateness, and effectiveness of health services and access to such services, through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions.

Centers for Disease Control and Prevention (CDC) monitors health; identifies and investigates public health problems; promotes healthy behaviors; and develops and advocates sound public health policies to prevent and control disease, injury, and disability.

Food and Drug Administration (FDA) promotes improvement in the health of the American public by ensuring the effectiveness and/or safety of drugs, medical devices, biological products, food, and cosmetics; and by encouraging the active participation of business and the public in managing the health hazards associated with these products.

Health Care Financing Administration (HCFA) pays Medicare benefits; provides states with matching funds for Medicaid benefits; conducts research, demonstrations, and oversight to ensure the safety and quality of medical services and facilities provided to Medicare beneficiaries; and establishes rules for eligibility and benefit payments.

Health Resources and Services Administration (HRSA) promotes equitable access to comprehensive, quality health care for all, with a particular focus on underserved and vulnerable populations.

Indian Health Service (IHS) provides comprehensive health services for American Indian and Alaska Native people, with opportunity for maximum tribal involvement in developing and managing programs to improve health status and overall quality of life.

National Institutes of Health (NIH), through its 25 institutes, centers, and divisions, supports and conducts medical research, domestically and abroad, into the causes and prevention of diseases and promotes the acquisition and dissemination of medical knowledge to health professionals and the public.

Program Support Center (PSC) provides a broad range of administrative services to HHS components and other Federal agencies on a competitive, fee-for-service basis. PSC services are provided in three business areas: human resources, financial management, and administrative operations.

Substance Abuse and Mental Health Services Administration, (SAMHSA) through its three centers, works to improve quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illness, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society.

Assistant Secretary for Management and Budget (ASMB) advises the Secretary on all aspects of administration and financial management, and provides general oversight and direction of the administrative and financial organizations and activities of the Department.

Assistant Secretary for Planning and Evaluation (ASPE) provides policy analysis and advice; guides the formulation of legislation; coordinates strategic and implementation planning; conducts regulatory analysis and reviews regulations; oversees the planning of evaluation, non-biomedical research, and major statistical activities; and administers

evaluation, data collection, and research projects that provide information needed for HHS policy development.

Office for Civil Rights (OCR) promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination. Through prevention and elimination of unlawful discrimination, the Office for Civil Rights helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

Office of Inspector General (OIG) improves HHS programs and operations and protects them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations OIG provides timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public.

Office of Public Health and Science (OPHS) provides senior professional leadership across HHS on population-based public health and clinical preventive services by providing scientifically sound advice on health and health policy to the Secretary, Departmental officials and other governmental entities and communicating on health issues directly to the American public; conducting essential public health activities through eleven program offices, and providing professional leadership on cross-cutting Departmental public health and science initiatives.

SECTION I:

SUMMARY PERFORMANCE REPORT

PROGRESS TOWARDS ACHIEVING DEPARTMENTAL INITIATIVES

SUMMARY PERFORMANCE REPORT – PROGRESS TOWARDS ACHIEVING DEPARTMENTAL INITIATIVES

The Government Performance and Results Act (GPRA) is a valuable tool that will enhance HHS efforts to improve programs that serve the American people. With the continued development of performance goals and measures for approximately 300 programs, HHS is compiling an extensive body of information that is informative across programs and agencies. Such data will become increasingly important to HHS's leadership and program coordination efforts. Although the Department consists of large agencies with many and disparate functions, HHS coordinates the focus and direction of its program activities through Departmental initiatives developed in the annual HHS budget decision-making processes. Performance measurement will increasingly strengthen these processes as data on program performance trends become available and serve as indicators to support the identification of strategies and objectives to continuously improve programs across the Department. Although the GPRA information processes are still developing, we are confident that the GPRA measures for HHS programs will support the assessment of the Departmental initiatives that Secretary Shalala has pursued over the last four years, and will contribute to the development of Departmental initiatives and performance goals in the future.

Detailed information on GPRA results for all HHS program activities is presented in the performance reports and plans for HHS program components, which are contained in the individual agency chapters of the Congressional Justification of the FY 2001 budget for HHS. Those performance reports include FY 1999 results data for over half of the approximately 750 performance measures included in the final performance plans submitted to Congress in February 1999. The predominant portion of the measures for which FY 1999 data are not yet available is for programs for which HHS must rely on States and other outside entities for performance data. As required by OMB guidance, HHS will report the results of all such FY 1999 performance measures in future performance reports submitted to Congress.

Budget decision-making in HHS has been key to Departmental coordination of program activity and performance measurement in HHS. In recent years, HHS modified its Departmental budget formulation processes specifically to better bring together information and leaders from throughout the Department to define the program initiatives that will move HHS toward the continued accomplishment of its mission and toward coordinated program improvement. Anticipating that GPRA information will increasingly enhance this decision-making process, HHS incorporated GPRA annual planning and reporting into the budget formulation process and into the HHS budget documents. While emphasizing our belief that performance information will become increasingly useful as measures mature and performance trends emerge, the FY 1999 performance reports of HHS components taken as a whole, as well as additional program information from previous years, indicate: 1) that HHS performance plans are employing measures that address the national needs that generate our budget initiatives, and 2) that improved results, strategies, performance goals, and coordination are already in evidence for areas covered by the budget initiatives of the Department.

In the pages that follow, we summarize performance conditions and progress related to both Departmental budget initiatives and to the Department's GPRA strategic goals, as reflected in reported GPRA performance data for HHS. The information that is provided for FY 1999 and previous years signifies that the pursuit of program coordination and improvement are Departmental traits, and marks HHS as an entity that is focused on concerted progress toward the achievement of the mission, goals and objectives of the FY 1997 HHS Strategic Plan through its Departmental initiatives. As GPRA implementation continues to mature, program executives and managers throughout HHS expect to use trend data on performance results to seek the coordinated improvement of HHS programs on an ongoing basis, specifically by: 1) assessing performance activity and results, 2) engaging in program evaluation activity where deeper assessment is required, 3) redefining program strategies to produce improved results, and 4) modifying future performance targets to be consistent with available resources and up-to-date priorities and policy decisions.

HHS Goal 1: REDUCE THE MAJOR THREATS TO THE HEALTH AND PRODUCTIVITY OF ALL AMERICANS

SUMMARY PERFORMANCE REPORT

HHS cross-cutting budget initiatives since FY 1998 have reflected extensive Departmental emphasis on reducing threats to the health and productivity of Americans. Most initiatives have focused on a set of threats that require emphasis and priority over multiple fiscal years, particularly tobacco use, substance abuse, domestic violence and injury, and unhealthy sexual behaviors.

Youth Tobacco Use

Reducing tobacco use by children and youth remains a high-priority initiative throughout HHS and the Administration. CDC's Heart Disease and Health Promotion program seeks to prevent tobacco use. SAMHSA administers the Synar Amendment to support programs for compliance to reduce the sale of tobacco to minors and measures changes in youth smoking. FDA efforts emphasize its regulatory role and aim to increase the number of compliance checks performed at retail shops to enforce the requirement that minors do not purchase tobacco products.

Reducing Tobacco Use: Between 1991 and 1997, tobacco use among youth increased from 27.5 percent to 36.4 percent. In response to this disturbing trend, the Department established an initiative to reduce tobacco use among minors, led by CDC, FDA, SAMHSA, and OPHS. The Department will measure the impact of its activities through the shared CDC and OPHS FY 1999 goal to stop the increase in youth smoking at the FY 1997 level of 36.4 percent. While data that indicate the level of achievement for this crosscutting goal will not be available until 2000, CDC expects that tobacco control programs should start producing annual rates of decline in youth tobacco use by FY 2001. For that reason, CDC and OPHS's FY 2001 targets to reduce youth tobacco use to 35.9 will be the first to reflect an anticipated reduction in youth smoking.

Enforcement at Retail Establishments: The FDA's enforcement efforts supports the Departmental initiative by reducing the number of retailers who sell tobacco products to minors. Since FY 1997, FDA has entered into contracts with all 50 states to conduct compliance checks at retail establishments that sell tobacco products. By expanding its coverage from 10 states in FY 1997 to 43 states and territories in FY 1999, FDA has been able to increase the number of compliance checks from 6,464 in FY 1997 to approximately 106,000 in FY 1999. FDA expects the number of compliance checks to increase in FY 2000 as a result of contracts signed in FY 1999 that expanded coverage to all 50 states and 3 territories.

Implementing the Synar Amendment: SAMHSA significantly exceeded its FY 1999 performance target of doubling from 4 to 8 the number of States whose rate of tobacco sales

to minors violations is at or below 20 percent. The agency reported that 21 States achieved this level of performance in FY 1999. SAMHSA, in turn, made its FY 2001 target more rigorous, projecting that 36 States would achieve this level of compliance.

Youth Substance Abuse

HHS continues to work closely with the ONDCP toward the achievement of measurable reductions in drug and alcohol abuse, particularly among young people. HHS program initiatives have focused on both prevention and treatment activities in SAMHSA. IHS youth substance abuse programs for the AI/AN populations also focus on prevention and treatment. OPHS has supported efforts to work with community coalitions and others. Research activities, particularly the programs of the National Institute on Drug Abuse of NIH, are also an important aspect of this HHS initiative.

Effectiveness of Treatment: In its 1996 National Treatment Improvement Evaluation Study (NTIES), SAMHSA found a clear linkage between the provision of substance abuse treatment services and improved life outcomes for both children and adults. The following are examples of NTIES findings on treatment effectiveness: 78 percent reduction in the percentage of individuals engaging in both the sale of illicit drugs and violent crimes; 19 percent increase in the rate of employment; 42 percent decrease in the percentage of individuals who were homeless; 53 percent decrease in alcohol and other drug-related medical visits; 28 percent decrease in inpatient mental health visits; and 34-56 percent decrease in "high risk" sexual behaviors associated with the transmission of HIV.

Assessing Outcomes of Treatment: The NTIES findings have led SAMHSA and State substance abuse programs to pursue the development of outcome measures on a wider scale. Since 1997, through the Treatment Outcomes and Performance Pilot Studies (TOPPS) initiative, SAMHSA and the States have identified a set of outcome indicators for children and adults that can be used across States to assess substance abuse program performance. With the experience of NTIES and TOPPS, SAMHSA has established FY 2001 outcome performance targets for the 19 States that will participate in TOPPS II. Although this effort will not provide national performance outcome estimates, it will provide significantly better information on treatment impacts for those States, and will provide a knowledge base to allow for expansion to more States in future years.

Coordination on Reduction of Drug Use: SAMHSA and HHS have also adopted the following ONDCP long-term prevalence targets as agency and Departmental goals: By 2002, reduce the prevalence of past month use of illegal drugs and alcohol by youth by 20 percent as measured against the 1996 base year. By 2007, reduce this prevalence by 50 percent.

Public Information: SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) experienced tremendous growth in the number of requests it received for information. In 1999, SAMHSA dramatically exceeded its target of a five percent increase from its 1997 baseline; NCADI had a 129 percent increase, for an average of 40,285 requests for information per month. Based on its 1999 performance, SAMHSA has set more ambitious

future targets. In 2001, SAMHSA projects that it will reach 260 percent of its 1997 baseline. NCADI is responding to the demand generated by the ONDCP National Youth Anti-Drug Media Campaign. NCADI has implemented call center operations 24 hours a day, 7 days a week, to serve the ONDCP media campaign as well as various public education campaigns, and has also taken on responsibility for SAMHSA's National Treatment Helpline.

Effective Use of Prevention Funds: SAMHSA also strives to improve how states spend their substance abuse prevention dollars by encouraging them to promote six prevention strategies: information dissemination, education, alternative activities, problem identification and referral, community mobilization, and environmental activities. SAMHSA exceeded its 1999 goal of 80 percent by having 90 percent of States spending prevention funds in each of the six strategy areas.

Substance Abuse among Tribal Youth: Because studies indicate that the longer individuals are engaged in treatment (including aftercare/continuing care) the better the prognosis, IHS has developed a goal focused on assuring adequate follow-up care for adolescents discharged from IHS supported Regional Treatment Centers (RTCs). IHS met its FY 1999 target to determine baselines for the rates and intensity of follow-up care. The follow-up rate within the critical first 30 days was 64.5 percent for the 815 youths discharged from the 12 RTC in FY 1999. This rate drops to 55.2 percent for those who receive follow-up at 30 days and at least a second follow-up by 6 months, and down to 40.9 percent for those who receive follow-up contacts at 30 days, at least a second follow-up by 6 months, and at least a third at 12 months after discharge. IHS has set a target to increase the follow up rate by 10 percent in FY 2000. In addition, IHS will establish a baseline for a measure to assess continued abstinence (six months of less alcohol and drug use than before treatment) in FY 2000.

Domestic Violence and Injuries

In its budget initiatives, HHS has introduced cross-cutting strategies to reduce the threat of family and domestic violence, particularly against women and children, and to reduce injury for all Americans. The HHS initiatives reflect efforts to provide more responsive services to individuals who suffer violence, to develop research about risk factors for perpetuating violence, and to change the ways that society thinks about and tolerates violence.

Surveillance: Much is unknown about the factors that contribute to intimate partner violence or violence against women. Since 1994, CDC has funded a number of projects to increase the understanding of the risk factors associated with violence against women, the methods of violence and the effectiveness of specific intervention or prevention programs. One such project is a biannual survey to determine the incidence and prevalence of violence against women, which will be developed in FY 2000.

Recognizing Domestic Violence: Recognizing that family violence victims (child, spouse or elder) come to the health care system with a variety of physical injuries, illnesses or medical conditions directly related to abuse, IHS developed a goal to assure that providers consistently screen for indications of violence, abuse or neglect and make appropriate referrals. A written

protocol makes this more likely because these efforts become part of the local quality assurance process. IHS exceeded its FY 1999 goal to assure that at least 50 percent of IHS, Tribal, and Urban facilities with urgent care or emergency departments would have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect. A survey of 223 clinics and hospitals that showed that 64 percent had written policies and procedures in place. In addition, the survey demonstrated that having policies and procedures in place actually raised the likelihood that patients are regularly screened for violence abuse and neglect.

Addressing Domestic Violence: ACF plans to increase the number of Federally recognized Indian Tribes that have family violence prevention programs. Although ACF set a target of 162 Tribes having such programs in FY 1999, it surpassed its goal with 174 Tribes having these programs in place. In FY 2001, ACF's goal is to have 189 Tribes with family violence prevention programs. In addition, ACF operates the National Domestic Violence Hotline in order to provide referrals and counseling to those experiencing abuse. In its first year of operation, the Hotline answered 73,540 phone calls and the number of incoming calls is projected to increase to an average of 10,000 phone calls per month in FY 2001.

Bicycle-Related Injuries: In FY 1996, an estimated 352,000 children sought emergency-room care for a bicycle-related injury, 30 percent of which were head, facial and ear injuries. Studies indicate that bicycle helmets prevent 69-88 percent of serious head or brain injuries. As part of the Department's efforts to reduce bicycle-related injuries, CDC has established a demonstration project to increase the use of bicycle helmets by child bicyclists in CDC-ffunded project areas. Although final data for this measure will not be available until April 2000, preliminary data from FY 1998 indicate that helmet usage increased in all five project areas.

Reducing Injuries: Because injuries are a leading cause of hospitalization and death for American Indian and Alaskan Native people, IHS set a FY 1999 goal to assure that the injury death rate was no greater than 93 per 100,000 deaths. While FY 1999 data will not be available until XX, the rate for FY 1994-1996 has dropped to 92.6 per 100,000, from 95 per 100,000 in FY 1992-1994. In fact, injuries have dropped from the leading cause of death in the early part of the decade to the second leading cause of death currently. And while seven IHS Areas still have rates that are above the FY 1999 target, most of these areas are in the rural west where travel distances are long and residents are at high risk for motor vehicle-related injury. However, these Area rates have been trending downward, due to efforts to reduce impaired driving, the tribes passing tougher drunk driving and occupant restraint laws, and stricter enforcement of these laws.

Reducing Sexually Transmitted Diseases

Sexually Transmitted Diseases (STDs) are one of the most critical challenges in the nation today because of their severe, costly consequences for women and infants; their tremendous impact on the health of adolescents and young adults (especially among minority populations); and the integral role they play in the transmission of HIV infection. HHS cross-cutting budget initiatives

have given emphasis to both prevention and treatment strategies. HHS consistently seeks to promote healthy behaviors and discourage risky ones. For example, we strive to extend HIV counseling, testing, and referral services where young, low-income, and minority children are at high risk of infection. Surveillance of risky behavioral factors predisposing children and youth to sexually transmitted disease has been a significant challenge for the Department as we pursue information that is relevant to prevention policies and approaches for decision-makers.

HIV/AIDS Prevention in Youth: CDC's HIV/AIDS program monitors students' exposure to HIV/AIDS prevention education in schools, which has been demonstrated to reduce risk behaviors among youth, and youth behaviors that affect their risk of becoming infected with HIV. In FY 2000, the program will report on its FY 1999 goal to maintain the percentage of high school students who have been taught about HIV/AIDS prevention in school at 90 percent or greater. The FY 1997 rate is 92 percent, up from 86 percent in 95. In addition, CDC has set FY 2000 targets to reduce the percentage of high school students who have ever engaged in sexual intercourse to 45 percent from 48 percent in FY 1997 and to reduce the percentage of currently sexually active high school students who engage in sexual intercourse without a condom to 38 percent from 43 percent in FY 1997.

Gonorrhea and Chlamydia: CDC and OPHS performance goals focus on women aged 15-44 seen at publicly funded family planning and STD clinics for several reasons: women of child-bearing age experience high incidence rates of gonorrhea and chlamydia; women infected with Neisseria gonorrhea or Chlamydia trachomatis can develop pelvic inflammatory disease which may, in turn, lead to adverse reproductive consequences (e.g. ectopic pregnancy, tubal factor infertility;) family planning and STD clinics represent clinic settings with the highest prevalence rates for these diseases; and CDC resources support family planning and STD clinics, therefore, performance measures at these sites are good indicators for program effectiveness.

- *Gonorrhea*: In 1998, 355,642 cases of gonorrhea were reported to CDC, for an overall rate of 132.9 cases per 100,000 population. This was an 8.9 percent increase in cases compared with 1997, and the first increase since 1985. The increase in 1998 was seen in all demographic groups defined by age, sex, and race/ethnicity, and occurred in all major geographic regions except the Northeast. Possible reasons for the increase in gonorrhea include expansion of screening programs (motivated by the availability of simultaneous testing for genital chlamydial infections), increased use of new diagnostic tests with improved sensitivity, improvements in surveillance systems, and, in some segments of the population (including men who have sex with men), true increases in morbidity. This is also reflected in the most recent data for the joint CDC/OPHS goal to reduce the incidence of gonorrhea in women aged 15-44 in publicly funded family planning and STD clinics to less than 250 per 100,000 by FY 1999. FY 1998 data show a rate of 292 per 100,000, rising from 261 in FY 1997 and 259 in FY 1996.

- *Chlamydia*: In 1998, CDC reported a genital chlamydia infection rate of 233.7 cases per 100,000 population, the highest rate reported since cases were first reported in the mid-1980s. The increase in reported infections reflects the continued expansion of chlamydia screening programs and the increased use of more sensitive diagnostic tests for this

condition. Over the same period, data on chlamydia prevalence obtained by monitoring positivity rates of persons screened in a variety of clinic settings have consistently documented declining levels of infection in many parts of the U.S. In FY 1998, CDC reports a prevalence rate of 5.4 percent among women under the age of 25 in publicly funded family planning and STD clinics, already surpassing the FY 1999 target of less than six percent. However, among high risk women under 25, the prevalence rate was 11.7 percent, well above the FY 1999 target to lower the prevalence rate to 8 percent.

Primary and Secondary Syphilis. From 1990 to 1998, the primary and secondary syphilis rate declined by 86 percent, from 20.3 to 2.6 per 100,000, the lowest level since reporting began in 1941. Syphilis has declined in all regions of the United States and in all racial/ethnic groups, however rates remain disproportionately high among non-Hispanic blacks and in the South, and focal outbreaks continue to occur. To address these regional differences, CDC set a goal to reduce the incidence of primary and secondary syphilis through the development of syphilis elimination action plans for each state with a rate of greater than or equal to 4 per 100,000 population. In FY 1998, CDC achieved its FY 1999 target to increase the percent of U.S. counties that have an incidence of primary and secondary syphilis in the general population of less than or equal to 4 per 100,000.

Congenital Syphilis: In 1998, 801 cases of congenital syphilis were reported to CDC, for a rate of 20.6 cases per 100,000 live births, moving towards CDC's FY 1999 target of less than 20 per 100,000. In parallel with the decline in primary and secondary syphilis, the rate of congenital syphilis has declined dramatically from a peak of 107.3 per 100,000 live births in 1991. No or late syphilis serologic testing during pregnancy, often related to lack of prenatal care or late prenatal care, remains the major reason that congenital syphilis persists in the U.S. Congenital syphilis is a high priority for programmatic activity and each positive test in a child is considered a medical emergency with immediate health services follow-up. Effective prenatal screening programs for patients at high risk of syphilis account for a substantial portion of the reduction.

HHS Goal 2: IMPROVE THE ECONOMIC AND SOCIAL WELL-BEING OF INDIVIDUALS, FAMILIES AND COMMUNITIES IN THE UNITED STATES

SUMMARY PERFORMANCE REPORT

Over the last four years, cross-cutting Departmental budget initiatives supporting this strategic goal have focused especially on improving the economic and social well being of the most vulnerable in the nation: children and their families, the elderly, the disabled, and the disadvantaged. Prominent Departmental initiatives to improve the lives of children have involved a cross-section of HHS programs, including: Head Start, Child Care, Child Support, Children's Health, Youth Substance Abuse, the State Children's Health Insurance Program (SCHIP), Medicaid, and Maternal and Child Health. The HHS initiatives have also sought continuous improvement for the elderly with elder care, improvements in Medicare, increased health plan choices, and reform of long-term care. As an integrated Department, HHS has also pursued improved health for the nation as a whole, with initiatives that focus on improvements in areas reflected in the leading health indicators that will be established under the Department's *Healthy People 2010* program.

Children's Health and Development

HHS's cross-cutting budget initiatives for the healthy development of children have focused on the availability, access, and quality of care in multiple settings. Initiatives have covered health, safety, emotional, economic well being, and knowledge development for pre-schoolers and older children. HHS efforts cut across component agencies and also foster communication with and by State and local agencies that serve children. For example, through Administration and HHS initiatives of recent years, HCFA, HRSA, ACF and the States are reaching out to uninsured children and their families through multiple program mechanisms to ensure that they have access to health insurance coverage and services.

Childhood Vaccinations: Data show that cases of vaccine-preventable childhood diseases have been reduced by 97 percent from peak levels before the vaccines were available. Similarly, vaccination of preschool age children is at an all-time high for all groups. To ensure that preschool age children continue to be vaccinated against preventable diseases, CDC and HCFA have developed complementary goals to increase the percentage of 2-year old children to receive all recommended childhood vaccinations. CDC's efforts focus on maintaining a 90 percent coverage rate among children 19-35 months for each recommended vaccine. While FY 1999 data will not be available until 2000, data from FY 97 indicate that CDC met that goal for all but two vaccines. HCFA will continue to develop its goal to increase the percentage of Medicaid two-year-old children who are fully immunized. The first group of 16 states began developing their methods of measurement and performance baselines in FY 1999, and will complete setting their baselines by the end of FY 2000.

IHS Well Child Visits: A recognized standard of care, well child visits have been associated with improved post-neonatal mortality and opportunities to improve family health and safety in the longer term. Of particular importance are educational interventions with parents concerning diet and nutrition, injury prevention, and prevention of family violence. As part of larger efforts to improve child and family health, IHS set a FY 1999 goal to determine the proportion of the American Indian and Alaskan Native children receiving a minimum of four well-child visits by 27 months of age. Provisional FY 1999 data indicate that out of 9,873 children, 3,799 or 38.5 percent of the children met this criteria. IHS has set a FY 2000 target to increase coverage by three percent over the FY 1999 baseline.

Health and Learning Readiness of Head Start Children: Head Start has begun to assess how program efforts influence the development of emergent literacy, numeracy, and cognitive skills; gross and fine motor skills; and social skills of participating children through its Family and Child Experiences Survey (FACES). Specific measures focus on maintenance of improvements in vocabulary, math, and social skills as well as increasing rates of improvement in letter identification and gross and fine motor skills. Baseline data collected from 1997-1999 indicate that children experienced improvement in all of these dimensions. For example, the data shows that Head Start helps children improve their vocabulary skills during both their Head Start year and kindergarten years at a faster rate than the average rate of improvement for children of all income levels. ACF is establishing performance goals to assess learning development using the measurement scales employed for the FACES.

Adoption: As part of the National Performance Review's "High Impact Agency" initiative and consistent with the Present's adoption goal for 2001, ACF adopted a goal of increasing the number of children who are adopted from the public foster care system to 51,000 by FY 2001. Adoptions have increased from 28,000 in FY 1996 to 36,000 in FY 1998.

Economic Independence for Families

Recent HHS budget initiatives have reflected the conviction that the effective development of children depends heavily on family security, independence and health. Employment and income are the fundamental elements of independent care for children in households. New and reformed program activities administered and supported by HHS seek to strengthen families by helping them participate in the workforce, receive financial support that is legally theirs, and meet their obligations at home.

Employment of Former Public Assistance Recipients: ACF's goal under the National Performance Review's "High Impact Agency" initiative was to increase self-sufficiency for low-income families by moving one million welfare recipients into new employment by 2000. ACF achieved its goal earlier than anticipated, with 46 states reporting 1.3 million job entries for FY 1998. ACF projects that it can increase the percentage of adult recipients who become newly employed to 43 percent of all adults receiving cash assistance in FY 2001.

Child Support: A total of 1.5 million paternities were established and acknowledged in FY 1998, a 12.1 percent increase over FY 1997. Total child support collections were $15.5

billion for FY 1999. ACF has set ambitious future targets for child support collections, aiming to increase the collection rate for children of IV-D cases to 71 percent of current child support due by FY 2001. In order to dramatically improve collection rates, a Federal/State work group developed incentive funding recommendations in alignment with previous collaborative strategic planning and performance measurement development efforts. The formula, to be phased in starting in FY 2000, will be instrumental in driving the CSE program toward achievement of the performance targets.

Employment of Refugees: ACF assisted 52,298 refugees obtain employment in FY 1998, thus meeting and surpassing its 1999 goal more than a year ahead of schedule. ACF's Office of Refugee Resettlement provides resources and technical assistance to States and other grantees in order to help refugees achieve economic self-sufficiency and social adjustment within the shortest time possible following their arrival in the U.S. For FY 2001, ACF is requesting increased funding to provide cash and medical assistance and employment services to an increased number of refugee admissions from Kosovo, Bosnia and Africa.

The Aging Population

Elderly and disabled persons who can continue to live and participate in the community produce positive benefits for our society: health care costs are controlled, the stress level of families who do not have to commit their loved ones to institutions remains low, and the individual is happier and more likely to contribute to his or her environment.

Vaccinations for Senior Citizens: To reduce the incidence of deaths related to influenza and pneumoccoccal disease, health professionals recommend lifetime vaccination for pneumoccoccal disease and annual vaccination for influenza for persons aged 65 and over. CDC and HCFA share complementary goals to increase the number of annual influenza and lifetime pneumoccoccal vaccinations among selected populations aged 65 and over. For example, CDC and HCFA share FY 1999 goals to increase the annual influenza vaccination rates to near 60 percent. Although final data for this measure is not yet available, CDC data indicates that the rate of vaccination for influenza among persons aged 65 and over increased from 33 percent in FY 1989 to 63 percent in FY 1997.

Nutrition Services: AoA has initiated a number of activities to help seniors have an active and healthy aging experience by increasing their ability to live independently and reducing the need for instutionalization. One of those activities is nutrition services, which provides seniors with opportunities for better nutrition and improved health. AoA measures its performance with targets describing the number of home-delivered and congregate meals it serves. For example, AoA established an FY 1999 goal to maintain the number of home-delivered meals it serves at 119 million (the FY 1995 baseline). AoA expects to increase this number to 166 million in FY 2001.

Access Services: AoA also fosters independence among seniors through the provision of transportation and information and assistance services. AoA measures its performance for each service using indicators of the number of contacts or rides. For example, AoA

established a goal in FY 1999 to maintain the number of one-way rides over the FY 1995 baseline of 39.5 million. Although data on this measure will not be available until FY 2001, trend data indicates that AoA has increased the number of rides from 39.5 million rides in FY 1995 to 46.6 million in FY 1997. AoA's FY 2001 target to increase the number of rides to 50.7 million reflects this trend.

HHS Goal 3: IMPROVE ACCESS TO HEALTH SERVICES AND ENSURE THE INTEGRITY OF THE NATION'S HEALTH ENTITLEMENT AND SAFETY NET PROGRAMS

SUMMARY PERFORMANCE REPORT

HHS budget initiatives for all of the last four years have pursued improved access to health care for the approximately 44 million Americans who hold no health insurance, and have supported efforts to ensure that those who have coverage can retain it. The initiatives are broad based and involve multiple HHS components. They have initiated improvements in primary care for vulnerable populations, and seek to overcome inadequate capacity in rural and inner-city locations. They pursue continued insurance coverage for individuals changing employment, and enhanced coverage for those eligible for both Medicare and Medicaid. They pursue cost-effective options and choices to help individuals retain coverage. Even after several years of demonstrated improvements, the financial and management integrity of the Medicare program remains one of the highest priorities of HHS, and similar attention is being focused on Medicaid.

Availability of Primary Health Care Services

The role of the Federal government in the primary health care area is not to provide a wide range of services to the general population, but to target specific services to particular groups, focusing on the supply of services, staffing availability, and working with others to anticipate changes in the way that services are delivered.

State Children's Health Insurance Program (SCHIP)/Medicaid: Approximately 11 million children under age 19 lack health insurance coverage. The President, Congress and the Department have all committed to insuring more children through the State Children's Health Insurance Program. As critical players in the Department's initiative to enroll more children in SCHIP and Medicaid, the States have implemented several process improvements to help achieve that goal. Specifically, in FY 1999 each State developed a SCHIP plan that describes the strategic objectives, performance goals, and performance measures they will use to assess the effectiveness of their plans. These process improvements will support the achievement of HCFA's FY 2001 national goal to increase the number of children enrolled in regular Medicaid or SCHIP by 1 million over the previous year.

Access for Minority, Low Income, and Uninsured Persons: In FY 1998's Health Centers and the National Health Service Corps programs served 10.4 million persons, providing primary care and preventive services to a population that was largely minority (64 percent) and low income (86 percent) and disproportionately uninsured (41 percent). In support of its role as a safely-net provider, HRSA will report on the continued provision of preventive and primary care services to low income, minority, and uninsured individuals for FY 1999 and beyond.

Maternal and Child Health: In partnership with the States, HRSA's Maternal and Child Health Bureau works to advance the health of our Nation's mothers, infants, children, and adolescents. In FY 1998, the States began reporting on a set of goals developed to measure the national impact of the Maternal and Child Health (MCH) State Block Grant, which served 20.2 million children in FY 1997. In FY 1999, the program established baselines for the measures and set targets for FY 2001. Selected MCH goals include:

- Decrease the infant mortality rate from the FY 1997 rate of 7.1/1000 to 6.9/1000 in FY 2001, and decrease the ratio of the black infant mortality rate to the white infant mortality rate from 2.4 to 1 in FY 1996 to 2.1 to 1 in FY 2001.
- Increase the percent of infants born to pregnant women receiving care beginning in the first trimester from 82.5 percent in FY 1997 to 90 percent in FY 2001.
- Increase the percent of children with special health care needs in the State with a medical/health home(as defined and recommended by the American Academy of Pediatrics) from 69 percent in FY 1997 to 80 percent in FY 2001.
- In the Healthy Start Initiative, decrease the percentage of low birth weight babies born to Healthy Start clients from 12.09 percent in FY 1998, to 11.75 percent in FY 2001.

Improving Access for American Indians and Alaskan Natives Through Facilities Construction: Construction of new health care facilities to replace old, inadequate facilities is the first step in improving access for underserved locations. Efficient space for health care delivery allows for more appointments and for patients to see more health care providers in one trip. Likewise, modern facilities help recruit and retain health care providers, which means more continuity of health care delivery. Once a facility has been completed, IHS has experienced an average increase of approximately 60 percent more patient visits than in the old facility. Facilities are selected through a priority ranking system determined by workload, age, isolation or alternatives to construction, and existing space data. IHS met its FY 1999 goal to complete construction of the Hopi (Polacca), Arizona Health Center, and start construction of the Ft. Defiance, Arizona Hospital and the Parker, Arizona Health Center by the end of FY 1999.

Head Start Health Services: Head Start emphasizes the importance of the early identification of health problems. Every child is involved in a comprehensive health program, which includes immunizations, medical, dental, and mental health, and nutritional services. ACF wants to assure that Head Start children are able to receive medical treatment when they are identified as needing medical services. In FY 1999, ACF was just short of its goal of 88 percent, with 87 percent of Head Start children receiving care after being identified as needing services. ACF has committed to more

ambitious future targets, projecting that 92 percent of children will be able to receive necessary treatment in FY 2001.

Health Care Services for Persons with Specific Health Care Needs

Changes in the US society have generated new demands and needs for services. Efforts in the Department highlight problems of specific populations, methods to assess the effectiveness of programs, and the need to establish coordinating or oversight roles within HHS. Concern about access to services is found in the various HIV programs administered by HRSA; ACF's Developmental Disability program; CDC's efforts to improve the prevention, diagnosis and treatment of tuberculosis; and MCH's concern about service needs for children with multiple problems. HRSA's involvement in organ procurement and bone marrow donors represents emerging issues. Similarly, new emphasis has been placed within SAMHSA on the need to address the treatment gap for substance abuse victims as well as the need for community-based services for children with serious emotional disturbances.

HIV/AIDS: HRSA's HIV/AIDS Bureau is a focal point for the Federal response to the needs of persons living with HIV disease and provided HIV health care and related services to an estimated 500,000 persons in FY 1999. Goals for the six Ryan White Care Act programs focus on increasing access to health care services and anti-retroviral therapy and reducing perinatal transmission. The programs have also established goals to serve women and minorities in proportions that exceed their representation in overall AIDS prevalence by a minimum of five percent. Despite the reduction seen in overall AIDS morbidity, the proportion of AIDS cases among women and minorities continue to increase, and the benefits provided by new combination drugs have not uniformly reduced the incidence of AIDS among minorities. The performance noted below reflects significantly increased efforts across all of the programs to target communities of color.

- *Access to primary medical, dental, mental health, substance abuse, rehabilitative and home health care*: HIV Emergency Relief Grants: Providing the core response in metropolitan areas hardest hit by the AIDS epidemic, Title I grantees reported 2.79 million visits in FY 1998, moving towards the FY 1999 target of 2.88 million visits. Also in FY 1998, the program exceeded its FY 1999 targets to serve 30 percent women and 64 percent minorities, serving 30.7 and 67.7 percent respectively.

  HIV Care Grants to States: In FY 1998, Title II programs reported 1.45 million visits, a 26.2 percent increase over FY 1997 and exceeding the FY 1999 target by approximately 230,000 visits. The program also exceeded its FY 1999 targets for serving minorities and women in FY 1998: 29.4 percent program beneficiaries in FY 1998 were women and 64.1 percent minorities, compared to the FY 1999 targets of 27 percent women and 59 percent minorities served.

- *Access to Primary Care:* In FY 1998, the Title III Early Intervention program exceeded its FY 1999 target of 90,433 clients receiving primary care services. A total of 105,398 persons received primary care services in FY 1998, a 9.3 percent increase compared to FY 1997. In addition, the program provided services to 72,242 minorities in FY 1998, an increase of 14 percent (8,819 minority clients) over FY 1997. The program has exceeded its 1999 target to serve 60,000 minorities for the past two years.

- *Access to Anti-retroviral Therapy:* In FY 1999, an average of 64,500 persons received anti-retroviral therapies each month through the AIDS Drug Assistance Program (ADAP). While an average of 9,500 additional clients were served per month in FY 1999 compared to FY 1998, the program did not meet its FY 1999 target to serve an average of 78,088 persons per month. However, the FY 1999 target was set prior to the full implementation of the data collection system for this measure in FY 1999 and was based on an incorrect estimate for the baseline.

- *Reduction in Perinatal Transmissions:* In FY 1998, the Title IV program continued to increase the numbers (9,469) of enrolled women receiving comprehensive services, including appropriate services before, during or after pregnancy to reduce perinatal transmission, with a 16 percent increase over FY 1997. Pediatric AIDS cases as a result of perinatal transmission continues to decrease, demonstrating the effectiveness of the Title IV program's perinatal HIV transmission reduction activities. The program reports a 27.4 percent decline in mother-to-child HIV perinatal transmission from 310 in FY 1997 to 225 in FY 1998, moving towards its FY 1999 target of 214 perinatal transmissions.

Mental Health Services for Children: SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families Program served an estimated 15,600 children by providing high quality mental health services in 1999. SAMHSA set a FY 1999 goal of reducing the average number of days spent in residential treatment by 20 percent from its 1997 baseline; the program exceeded its goal by achieving a 44 percent reduction. SAMHSA also surpassed its 1999 goal of having 77 percent of children receiving services attend school most of the time; instead, 88.9 percent of this population attended school regularly. Finally, SAMHSA had set a FY 1999 goal of reducing the percentage of children with more than one

living arrangement after 6 months in services by 20 percent. SAMHSA exceeded this goal by achieving a 64.5 percent decrease.

Integrated Mental Health and Substance Abuse Prevention Services: SAMHSA's Starting Early, Starting Smart (SESS) program is testing the effectiveness of integrated mental health and substance abuse prevention and treatment services to high risk young children and their families. The 1998 baseline data on physical and behavioral health as well as language and cognitive skills helped to determine future targets for improvement in these areas. For example, 42.9 percent of all care givers reported that participating children are in good to excellent health in 1998. In 2000 and 2001, program staff will strive to improve outcomes of participating children in each domain by five percent each year.

Organ Transplants: The number of organ transplants increased 60 percent between 1988 and 1998, but the number of transplant candidates is rising faster than the number of donors. In response to this challenge, HRSA's National Organ and Tissue Donation Initiative established a network of public and private partnerships with a goal to increase the number of organ donors by 20 percent from FY 1999 to FY 2001. FY 1998 data show 5,799 donors, up from 5,477 the year before, an increase of 5.9 percent and moving towards the FY 1999 goal of 6,300 donors. From the end of 1998 until the end of 1999, the number of people waiting for organs increased from 60,712 to 66,983, or 10.3 percent. Although the rate of increase in the number of people waiting slowed in 1999, it continues to outpace the increase in cadaveric donation. The network also has a goal of increasing the number of minority donors from 1,342 in FY 1997 to 1,802 in FY 2001. FY 1998 data show 1,378 minority donors.
Bone Marrow Registry: HRSA's National Bone Marrow Donor Program has established a goal to increase the number of unrelated bone marrow donors in its national registry by 7.5 percent each year, from 2.58 million donors in FY 1996 to 4.35 million donors in FY 2001. The Program exceeded its FY 1999 target of 2.84 million donors, with 3.76 million potential volunteer donors registered. The Program has facilitated more than 9,000 transplants, over 1,300 of these in FY 1999. The Program also has a goal of increasing minority donors by 10 percent each year, from 526,000 in FY 1996 to 1,100,000 in FY 2001. In FY 1998, the registry included 800,000 minority donors.

Medicare Program Integrity and Management

The integrity of the Medicare program and particularly the reduction of Medicare fraud and abuse have been Departmental priorities throughout Secretary Shalala's tenure. Building on the success of Operation Restore Trust as a demonstration, HHS has successfully influenced the expansion of these types of activities throughout the Medicare program. Currently, the main focus on preventing and detecting fraud and abuse is through the Medicare Integrity Program (MIP) and the Health Care Fraud and Abuse Control (HCFAC) account which are helping further the Department's efforts, with the assistance of the Department of Justice, to protect the integrity of the Medicare trust funds and the General Fund. HHS has also pursued improved management and particularly financial management for Medicare, focusing on changes that will result in improved findings in audits of financial statements and reductions in funds paid in error. The

difficulty of acquiring adequate resources from a stable funding source to manage the Federal government's largest health care programs remains a fundamental concern directly related to effective administration of Medicare and Medicaid.

Medicare Fee-For-Service Error Rate: A key Medicare program integrity goal of HCFA and the Department is to pay Medicare claims properly the first time. Paying right the first time reduces the resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. Although final data will be available later in FY 2000, HCFA expects to achieve its FY 1999 target of a 9 percent error rate for Medicare fee-for-service payments, having achieved a 7.1 percent rate in FY 1998. In three years, HCFA reduced the error rate as follows: 1996–14percent; 1997–11percent; 1998–7.1percent. Based on this successful performance, HCFA has increasingly rigorous targets for FY 2001 (6 percent) and FY 2002 (5 percent).

Improper Payment for Home Health Services: The partnership between HCFA and the HHS Office of Inspector General (OIG) to reduce Medicare errors and fraud has been critical to reestablishment financial integrity in that program. HCFA adopted a goal to reduce major payment errors for home health services specifically in response to an OIG review for the four States cited immediately below. For home health agencies in California, Illinois, New York and Texas, HCFA exceeded projected performance for FY 1999 and reduced the proportion of home health services for which improper payment was made from 40 percent to 19 percent, which is significantly lower than the FY 1999 target of 35 percent. HCFA continues to pursue the more rigorous target of 10 percent in FY 2000.

Comprehensive Plan for Program Integrity: Instances like that identified by the OIG for home health services have contributed to HHS's commitment to a comprehensive approach to addressing program integrity for Medicare and Medicaid. In FY 2001, HCFA will expand measurement to 100 percent of the initiatives in its Comprehensive Plan for Program Integrity, and measure the effectiveness of each initiative based on successfully achieving at least 90 percent of the performance measures established for each of the ten initiatives in the Comprehensive Plan.

Electronic Commerce: Continually improving the efficiency of Medicare transactions is a fundamental management objective of HCFA and HHS. Increasing standardization and the percentage of transactions performed electronically will increase the efficiency of the Medicare contractors and save Medicare administrative dollars. Performance data indicate that HCFA increased the rate of electronic media claims (EMC) overall, achieving its goal of maintaining a 97 percent EMC rate for fiscal intermediaries, and slightly exceeding its FY 1999 target of 80 percent for carriers with a reported EMC rate of 81 percent. HCFA seeks to maintain the targeted rates for both FY 2000 and 2001, and in FY 2001 will expand performance measurement to the following additional transactions: electronic coordination of benefits, electronic remittance advice, eligibility inquiries and response, and claims status inquiries and response.

Operation Restore Trust: AoA and HCFA have partnered with the Office of the Inspector General to combat fraud, waste and abuse through Operation Restore Trust. During FY 1998

and FY 1999, AoA and its grantees trained more than 16,000 volunteers to serve as Medicare and Medicaid educators in their communities. During FY 1999, more than 5,000 cases involving questionable charges for medical services were referred by the volunteers to health care providers, appropriate Medicare carriers, or the HHS Inspector General for follow-up and investigation. AoA has set the following goals for Operation Restore Trust for FY 2000 and FY 2001: 1) Increase the number of trainers who educate Medicare beneficiaries; 2) Increase the number of substantiated complaints generated by the program's activities; and 3) Increase the amount of Medicare funds recouped that are attributable to the project.

HHS Goal 4: IMPROVE THE QUALITY OF HEALTH CARE AND HUMAN SERVICES

SUMMARY PERFORMANCE REPORT

The Department plays many roles that significantly influence the delivery and the quality of health care in this country. HHS is an advocate on behalf of consumers. We disseminate health care information, and are a major purchaser and provider of health services. HHS supports and conducts research that identifies what health care can do and works to ensure that new knowledge is consistently translated into practice nationwide. HHS has a responsibility to protect consumers by ensuring that health care is safe, fair, effective and accountable. For example, research in recent years has improved our understanding of mental illnesses and has broadened our ability to effectively treat these illnesses. To better apply scientific knowledge to practical services, we will promote integrated, locally-based mental health service programs. Supporting pursuits in focused and broad areas of improvement, we are releasing a new report, *Healthy People 2010*, that prescribes the national agenda to eliminate health disparities and increase the quality and length of life for all Americans. To achieve the goals of *Healthy People 2010*, HHS will pursue the following objectives: 1) promote healthy behaviors; 2) enhance community interventions; 3) advance prevention science; and 4) ensure solid performance for our prevention efforts.

Appropriate Use of Effective Health Care Services

HHS programs support health care services for millions of Americans and so have the potential to influence the appropriateness and quality of services provided throughout the country. Through its programs, HHS has found that some very effective approaches and procedures for health care treatment and prevention are underutilized in certain regions or for certain populations. To capitalize on the increased quantity of research results related to effective health care practices, HHS exerts influence in numerous settings to move appropriate treatment protocols into common practice.

Peer Review Organizations – Heart Attacks: Through its Peer Review Organizations, HCFA is influencing providers to employ effective practices in treatment. Consequently, HCFA adopted the measures for its Peer Review Organizations as an indicator of hospital performance. HCFA set a goal to decrease 1 year mortality among Medicare beneficiaries hospitalized for heart attack. During the baseline years of 1995 - 1996, 31.4 percent of Medicare beneficiaries hospitalized for heart attack died within a year. HCFA seeks to reduce that rate to 27.4 percent by FY 2001.

Peer Review Organizations – Mammograms: The percentage of women over age 65 who receive a mammogram is also a measure of the quality of care. HCFA's Peer Review Organizations adopted this measure for Medicare beneficiaries as an indicator of the quality of preventative care. In 1994, the percentage of Medicare beneficiaries age 65 and over who

received a mammogram was 55percent. Data indicating HCFA's progress toward meeting its goal of 59 percent in FY 1999 will be available in Summer of 2000.

Nursing-home care: While HHS focuses significant attention on avoiding institutional care, the Department is fully committed to protecting the rights of nursing home residents and enhancing their care. HCFA has reported the achievement of its FY 1999 goal to reduce the prevalence of the use of physical restraints among all nursing homes from 17.2 percent in 1996 to 14 percent in 1999. With reported prevalence of under 12 percent in 1999, HCFA has adopted a more rigorous target of 10 percent for FY 2000 and FY 2001. To focus additional attention on the care of nursing home residents, HCFA is developing performance targets for a reduction in the prevalence of pressure ulcers in long-term care facilities, and will include nursing homes in a developmental goal to improve the Survey and Certification Program.

Clinical Laboratory Proficiency Testing: Proficiency testing by clinical laboratories increases the confidence of health care professionals with laboratory results, and reduces the costs that result from repeat testing. Data indicate that Medicare labs fell just short of 1999 performance objectives: 89 percent of total lab scores contained no failures, compared to a target of 90 percent; 94 percent of labs that needed to be enrolled in proficiency testing were enrolled, compared to the 1999 target of 95 percent. HCFA is confident in the capacity of the program to fully achieve these compliance objectives, and has retained the planned performance levels for FY 2000.

Eliminating Tuberculosis: The elimination of tuberculosis first became a departmental priority in 1989. Shortly thereafter, a number of factors, including a decline in the public health infrastructure, contributed to the re-emergence of the disease. In 1992-1993, some of the crumbling public health infrastructure was rebuilt, and tuberculosis declined again from 1993-1998. Reducing the case rate of tuberculosis will put the Nation back on track toward eliminating the disease in the U.S. CDC has established goals to assess the Department's progress in reducing the TB case rate. Although results for FY 1999 will not be available until mid-2001, trend data suggest that the Department is making progress. For example, the percentage of TB patients that completed a course of curative treatment within 12 months, a key indicator of effective treatment for tuberculosis, increased from 67.6 percent in FY 1994 to 72.4 percent in FY 1997.

Disparities in the Receipt of Quality Health Care Services

HHS has coordinated its activities in response to the persistence of health care disparities across different populations associated with financial status, geography, culture, race and other factors. The HHS initiative provides for several agencies to undertake efforts related to reducing disparities in treatment of specific diseases. Other aspects of the initiative allow HHS agencies and partners to use the knowledge that emanates from these efforts to address the needs of population sectors under their purview. Other aspects focus on the geographical distribution of conditions and capacity, and to ensure that there is nondiscriminatory access to HHS services.

Access For Minority, Low Income, and Uninsured Americans: HRSA's Health Centers provide preventive services and risk reduction to a population that is largely minority (64 percent) and low income (86 percent) and disproportionately uninsured (41 percent). There is mounting evidence that access to a usual and regular source of care can reduce and even eliminate health status disparities among subsets of the population, and Health Center patients are far more likely to have a usual and regular source of care than poor people of color in the Nation. The high quality primary health care received in HRSA's Health Centers has been shown to reduce hospitalizations and emergency room use, reduce annual Medicaid costs, and helps prevent more expensive chronic disease and disability for these populations. The most recent data indicates:

- In FY 1997, Health Center Medicaid patients were 22 percent less likely to be hospitalized for potentially avoidable conditions than Medicaid beneficiaries who obtain care elsewhere. Low rates of avoidable hospitalizations indicate access to appropriate ambulatory services and are a measure of the high quality of care delivered. Low rates also indicate fewer access barriers that cause patients to postpone needed services, delay needed services, and fail to comply with treatment regimens. In part because of lower rates of hospitalization, reductions in Medicaid costs range from 30 to 34 percent.

- Monitoring performance in chronic disease management serves as a marker for the quality of care delivered at Health Centers and ultimately measure their ability to eliminate health disparities within the population served. Patients at Health Centers have rates of hypertension and diabetes that far exceed national prevalence rates for comparable racial/ethnic and socioeconomic groups. Yet, Health Center diabetics are twice as likely to have their glycohemoglobin tests performed at regular intervals (43 percent FY 1997) than the national norm, and hypertensives are more than three times as likely (90 percent FY 1995) to report that their blood pressure is under control.

- Breast and cervical cancer screening are effective measures for reducing future morbidity and mortality and are indicative of the ability of the Health Centers to reduce or eliminate disparities in early detection of disease. In FY 1995 female patients at Health Centers received age-appropriate breast and cervical cancer screening – 88.5 percent up-to-date Pap tests; 62.5 percent up-to-date mammograms; 80.5 percent up-to-date clinical breast exams – at rates exceeding the Healthy People 2010 goals.

Working towards HHS' goal of eliminating health disparities, the Health Centers will report on performance measures focusing on chronic disease management, preventative care, and avoidable hospitalizations for low income, minority and uninsured individuals. FY 1999 data on these measures will be available in FY 2000

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Diabetes and American Indians and Alaskan Natives (AI/AN). Diabetes continues to be a growing problem in AI/AN communities with rates increasing rapidly in several IHS Areas and age at diagnosis occurring at younger ages. IHS achieved its FY 1999 goal to establish IHS Area age-specific prevalence rates (as a surrogate marker for diabetes incidence) for diabetes for the AI/AN population. Rates are available by IHS Area and sex for four age groups: 0-19, 20-44, 45-64, and 65 and over. Among the IHS population age 20 and over,

9.6 percent have diagnosed diabetes. The Alaska Area has the lowest rate (2.9 percent), and Nashville and Tucson Areas have the highest rates (16.1 and 17.9 percent, respectively). Because of the high prevalence of diabetes in the AI/AN population, IHS has established several performance goals based on interventions that have been demonstrated to significantly reduce the incidence of complications related to diabetes. FY 1998 data serve as the baselines for targeted improvements in FY 1999: 35 percent of clients with diagnosed diabetes report "good" glycemic control and 27 percent report normal blood pressure; 79 percent had been assessed for dyslipidemia (i. e., cholesterol and triglyceride); and 33 percent had been assessed for nephropathy. FY 1999 targets are 38, 30, 81, and 36 percent respectively.

Disparities in the Availability of Sanitation Facilities: In FY 1999, IHS provided sanitation facilities to 3,557 new and like-new homes and 13,014 existing homes for a total of 16,571, which exceeded IHS' FY 1999 goal to provide sanitation facilities for 14,130 homes. Compelling evidence supports that reductions in the rates for infant mortality, gastroenteritis morbidity, and other environmentally related diseases of as much as 80 percent since 1973 are attributable to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. In addition, satisfactory environmental conditions (e.g., safe piped water and adequate sewage disposal) place fewer demands on IHS' primary health care delivery system.

Syphilis Elimination: Syphilis disproportionately affects a small percentage of the population, particularly African-Americans living in poverty. Syphilis elimination efforts focusing on populations in areas where syphilis persists will help close one of the most glaring racial gaps in health status. CDC will measure the effectiveness of its effort to eliminate syphilis in project areas using an indicator of racial disparity. Beginning in FY 1999, CDC has set targets to reduce racial disparity in syphilis by 15 percent each year over the FY 98 baseline of 34.2 percent, and by an additional 15 percent over the previous year's performance in FY 2000 and FY 2001.

Data on Racial/Ethnic Disparities: In order to document the nature and extent of disparities between racial/ethnic groups and track improvements in health status, the HHS Office of Public Health Services has established a goal to collect and establish baseline and comparison data by FY 2001 for relevant racial and ethnic subgroups for a set of 12 health indicators for which no data are currently available. These include infant mortality, mammogram, Pap test, coronary heart disease and stroke death rates, lower extremity amputations in persons with diabetes, new cases of end-stage renal disease, diagnosed AIDS cases, HIV mortality rate, and adult and child immunizations. In FY 1998, OPHS collected racial/ethnic data for 5 of 12 indicators, moving towards its goal of 9 of 12 in FY 1999.

Consumer Protection

The dramatic changes that have taken place in science and the health care system have supported the Department's initiatives to ensure that consumers have access to and receive the highest quality health care services available and have adequate information that allows them to make choices about health care plans and services. Similarly, recognizing that consumers, particularly the elderly and disabled, have the right to ongoing protection in medical institutions, HHS

continues to focus resources across its agencies and programs to improve nursing-home care, provide recipients of long-term care with consumer representation, and to further assure consumer protection for persons with disabilities.

HRSA's National Practitioner Data Bank (NPDB) tracks all significant adverse professional actions against physicians and dentists as well as malpractice settlements and judgments against all licensed health care professionals and can be queried by licensing, privileging, and credentialing authorities prior to granting licensure or extending clinical privileges. FY 1999 data indicate that the NPDB provided responses for 3,235,631 queries, exceeding its target of 3,200,000. Queriers received 399,943 matched responses containing malpractice payment, adverse action, or exclusion report information, and 2,835,318 responses which confirmed that the named practitioner had no malpractice payments, adverse actions, or exclusions. Based on previous user surveys conducted by the OIG, an estimated 10,800 licensure, credentialing, or membership decisions were affected by these match responses during FY 1999. The performance targets were increased by 21 percent in FY 2000 and 26 percent in FY 2001 to reflect the trend in actual performance.

Enhancing Patient Safety: AHRQ has already funded initial research efforts on preventing medical errors. Research findings have influenced three major medical facilities to adopt technology that has significantly reduced the probability of medical errors. The prevalence of medical errors continues to undermine the U.S. health care system. Building on previous activities, AHRQ will undertake a major initiative in FY 2001 to study medical errors and improve health care quality, safety, and efficiency in order to enhance patient safety.

Discrimination in Access to HHS Programs: The Office for Civil Rights (OCR) enforces nondiscrimination in access to HHS services by resolving discrimination complaints and conducting pre- and post-grant reviews and investigations. Each completed *corrective action or no violation finding* reported in the goals below represents a provider in compliance with the law, either because the provider made changes in policies and practices or because OCR determined that there was no violation. The levels selected for the FY 1999 targets reflect OCR's commitment to focus its efforts in high-priority areas.

- *HHS grantees and providers found to be in compliance with Title VI in limited English proficient reviews/investigations*: OCR's baseline for FY 1998 was 98 corrective actions and no violation findings, the FY 1999 target was 125, and OCR completed 146, exceeding the target by 21 corrective actions and no violation findings.

- *Managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act:* OCR's baseline for FY 1998 was 10 corrective actions and no violation findings, the FY 1999 target was 40, and OCR completed 27. While the FY 1999 target was not met, this represents a 170 percent increase in corrective actions and no violation findings focused on managed care organizations. Furthermore, the percent of all post-grant reviews and investigations completed that addressed managed care increased from 4.4 percent to 10 percent from FY 1998 to FY 1999. Given that the total post-grant reviews and investigations completed in all program areas increased by only 18.9 percent above FY 1998, the nearly three-fold increase in corrective actions and

no violation findings focused on managed care is considerable. FY 2000 and FY 2001 targets have been adjusted to a more modest 10 percent increase that continues the proportional level of effort focused on this priority area.

- *State and local TANF agencies and service providers found to be in compliance with Title VI, Section 504 and ADA*: OCR's baseline for FY 1998 was eight corrective actions and no violation findings, the FY 1999 target was 16, and OCR completed 23, exceeding the target by seven corrective actions and no violation findings.

- *State agencies and adoption agencies (local) found to be in compliance with the nondiscrimination provisions of the Small Business Job Protection Act*: OCR's baseline for FY 1998 was 20, and the FY 1999 target was 30. OCR fell short of this target, completing 20 corrective actions and no violation findings in FY 1999. However, OCR received one-third fewer complaints involving interethnic adoption issues during FY 1999. In addition, OCR completed more than 50 technical assistance and outreach activities focusing on this priority area, an increase of 30 from FY 1998. FY 2000 and FY 2001 targets have been adjusted to a more modest 10 percent increase, and OCR plans to monitor the mix of case investigations and outreach initiatives to determine whether there is a continuing shift to outreach and technical assistance as OCR's primary program activity for this objective.

Residents in Long-Term Care Facilities: The Administration on Aging strives to improve consumer protection in long-term care facilities through its Long-Term Care Ombudsman program, which helps residents and their families resolve problems related to care and conditions in long-term care facilities. In FY 97, the program achieved a national and partial resolution rate of 70 percent, which it intends to maintain through FY 2001.

Individuals with Mental Illness in Residential Facilities: SAMHSA's Protection and Advocacy for Individuals with Mental Illness (PAIMI) program ensures protection and advocacy for individuals with mental illness who reside in public and private residential facilities. State Protection and Advocacy program staff also provide public education and trainings about the rights of those with mental illness. Program staff addressed 8,687 complaints of abuse in 1998 and set a goal of investigating 9000 abuse complaints in FY 1999. The FY 1999 performance data will be available in March 2000.

Protection Against Fraud, Waste, and Abuse. OIG conducts independent and objective audits, evaluations, and investigations, which are reported to Department officials, the Administration, the Congress, and the public. OIG examines Return On Investment (ROI) as a measure of its effectiveness and includes both expected recoveries (including fines, penalties, restitution, forfeitures, and final audit disallowances) and savings (including funds not expended as a result of OIG recommendations and funds put to better use) in its calculations. The actual FY 1999 total expected recoveries and savings per OIG dollar invested was $99, $39 more than the FY 1999 target of $60. Although the financial implications of its work are important, OIG recognizes the importance of its qualitative impact on HHS programs. Although it may take several years in some cases to accumulate this information, OIG is

tracking process outcomes such as “Anticipated Actions” and desired final outcomes such as “Anticipated Implications” of its work by type of impact and means of impact.

HHS Goal 5: IMPROVE PUBLIC HEALTH SYSTEMS

SUMMARY PERFORMANCE REPORT

HHS continues to emphasize the importance of maintaining a coordinated effort to improve national public health systems. HHS must address a myriad of challenges associated with the safety and efficacy of food, drugs, and other health care products. We have critical needs for comprehensive, coordinated, and accessible health information. We must continue to confront the threat of terrorism through medical response capabilities. Departmental initiatives to improve the science base supporting product approvals and adverse action reporting by FDA will improve product safety and assurance. These issues will remain priorities in the years ahead.

Safety and Effectiveness of Food, Drugs, and Medical Products

Extraordinary advances in transportation, changes in demographics, and the increasing resistance of bacteria, parasites and viruses have made emerging and re-emerging infectious diseases the leading cause of death worldwide. Food-borne illnesses represent a similar emerging threat to public health that requires a focused approach to monitoring and assuring food safety. It is central to the mission of FDA to ensure that new products that are safe and effective become available on a timely basis and that an increasingly international food supply is safe.

Preventative Control Systems–HAACP: FDA ensures the safety of the food supply through the implementation of food safety standards at all points along the food production chain. Preventative control systems such as the HACCP (Hazard Analysis Critical Control Point) allow manufacturers and food preparers to identify points in the process where safety problems can occur and establish measures to prevent them. In FY 1999, FDA set a target to ensure that 50 percent of the domestic seafood industry had functioning HACCP systems. Although fewer than 50 percent of these processors met all the criteria for operating a functioning HACCP system, only 4 percent of the firms inspected warranted regulatory action due to problems that raise significant public health concerns. In evaluating the public health outcomes of HACCP implementation in this industry, FDA has met the intent of using HACCP as a strategy to prevent microbial contamination of seafood produced in the United States.

Premarket Review–Timeliness: FDA has consistently met or exceeded its goals for premarket review established by the Prescription Drug User Fee Act. For example, FDA expects to meet its FY 1999 target to review and complete first action on 90 percent of standard original New Drug Application submissions on time (within 12 months of receipt). Completion of on-time reviews will allow FDA to bring a greater number of new products to market each year. In CY 1998, 30 new medicines that have never been marketed before in this country were approved and made available to the public. In addition, 344 generic medicines were approved.

Premarket Review–Inspection Coverage: FDA is required by law to conduct biennial inspections of all licensed establishments to determine compliance with Current Good Manufacturing Practice (CGMP) regulations with applicable product and establishment standards and license commitments. In FY 1999, FDA exceeded its goal for biennial inspection of registered blood banks, source plasma operations, and biologics manufacturing establishment. In FY 1997 and FY 1998, FDA fell just short of its 50 percent target by inspecting 46 percent of establishments. In FY 1999, however, FDA was able to inspect 64 percent of establishments.

Premarket Review–Conformance: FDA has established performance goals for conformance with FDA requirements as indicators of the agency's success in ensuring the quality and accuracy of mammograms. FDA has consistency met its goal for ensuring that 97 percent of mammography facilities met with inspection standards, with less than 3 percent of facilities with serious inspection problems. Performance data indicate that FDA achieved a conformance rate of 97 percent in FY 1997, FY 1998, and FY 1999.

Postmarket Surveillance--Adverse Event Reporting: To ensure the safety of drugs that are already on the market, FDA implemented an adverse event reporting system. FDA evaluates spontaneous reporting data from the Adverse Event Reporting System (AERS) to identify any serious, rare, or unexpected adverse events or an increased incidence of events. Based on its evaluation, FDA may decide to disseminate risk information, such as Dear Healthcare Professional letters, and may initiate regulatory action. The AERS has been operational for nearly two years. In FY 1999, approximately 261,000 Individual Safety Reports (ISRs) were received for entry into the AERS. In November 1998, FDA published an *Advanced Notice of Proposed Rulemaking for Electronic Reporting of Postmarketing Adverse Drug Reactions* that would require manufacturers of marketed human drugs to submit ISRs to the agency electronically. In response, FDA set a FY 1999 goal to implement AERS for the electronic receipt and review of voluntary and mandatory Adverse Drug Event (ADE) reports. In FY 1999, FDA conducted a pilot program for electronic submission of ISRs involving manufacturers with approved products. In addition, FDA developed and piloted an AERS data retrieval system to provide reviewers with quick access to the AERS data and reduce their reliance on hard copy reports.

Public Health Systems and Surveillance

Significant, cross-cutting effort within HHS is focused on the monitoring, surveillance and assessment of health programs. These range from the concern with the public health response to terrorism to the historical concern about identifying and monitoring infectious diseases. Advances in science have necessitated an equivalent focus on systems that facilitate rapid dissemination, communication, and education in health sciences, and the development of distributed capacity to translate knowledge into broad health improvement.

Countering Bioterrorism: The Department established a Countering Bioterrorism initiative in response to the growing threat of biological terrorism. The initiative focuses on strengthening the public health capacity at the federal, state and local level to respond to a

terrorist event. In FY 1999, CDC distributed $41 million in cooperative agreements to 48 states and 3 cities for upgrading their capabilities for preparing and responding to terrorist events. In addition, CDC achieved its FY 1999 goal of creating a national pharmaceutical "stockpile" available for deployment to respond to terrorist use of potential biological or chemical agents, including the ability to protect 1-4 million civilians from anthrax attacks.

Surveillance of Foodborne Illness: Improving public health agencies' capacity to monitor foodborne illness is a key component of the Food Safety Initiative. CDC has adopted and achieved goals to increase surveillance of foodborne illness. In FY 1999, CDC established a goal to increase the proportion of reported foodborne outbreak investigations in which the causative organism or toxin is identified to 45 percent, from 40 percent in the baseline year of FY 1998. Performance data indicate that CDC exceeded the FY 1999 target by identifying 48 percent of the causative organisms or toxins.

Public Health Infrastructure: CDC has played a major role in achieving this century's most significant accomplishments in public health, such as the eradication of smallpox in 1977. However, the emergence of drug resistance in bacteria, parasites, viruses, and fungi is swiftly reversing advances of the last 50 years. CDC will measure its progress toward adapting the public health infrastructure to respond to these threats using several indicators of improvements in laboratory and epidemiologic capacity. In FY 1999, CDC met its goal of reducing the time for providing parasitic diseases reference laboratory diagnostic results to state laboratories from 24 hours to 2 hours for urgent cases and from 2 weeks to 2 days for routine cases for 90 percent of requests. This is the lowest amount of time that could be expected for accurate and reliable testing.

HHS Goal 6: STRENGTHEN THE NATION'S HEALTH SCIENCES RESEARCH ENTERPRISE AND ENHANCE ITS PRODUCTIVITY

SUMMARY PERFORMANCE REPORT

Health research has made enormous contributions to improving human health. Many of the diseases, injuries, and disabilities that our parents and grandparents faced a generation ago can now be prevented or treated. Today, we are at the brink of discoveries that have the potential to revolutionize the prevention, diagnosis, and treatment of disease as well as the delivery of quality health care in America and around the world. As a Department, HHS has recognized the potential for health research advances and continues to pursue a focused and balanced approach to funding research and the infrastructure necessary to take advantage of research opportunities.

Human Genome

HHS is maintaining the research initiatives of recent years, seizing additional opportunities, and responding to new public health needs. As HHS progresses with the completion of the human genome project, the Department emphasizes cross-cutting research to exploit genomic discoveries. Fundamental to the success of HHS's research objectives are its efforts to train and support the new kinds of scientists that will increasingly be able to take advantage of the power of biomedical computing, both to manage and analyze data and to model biological processes.

Human Genome Project: The Human Genome Project seeks to understand the genetic instructions that make us unique. Progress in completing the map of the human genome has already begun to yield information that has the potential to improve the prevention, diagnosis and treatment of disease and disability. Scientists have already unraveled more than 20 percent of the human genome. The Human Genome Project has successfully completed the pilot phase of sequencing the human genome, which tested strategies and developed technologies for larger sequencing projects, and has launched the full scale effort to sequence all 3 billion bases of human DNA. In FY 1999, NIH exceeded its target to complete 400 million base-pairs of the total human genomic sequence worldwide. Final data indicate that 442 million base-pairs were completed worldwide. It is expected that the project will produce at last 90 percent of the human genome sequence in "working draft" form by Spring 2000, considerably ahead of schedule. The working draft will then serve as the foundation for fine tuning the sequence leading to completion of the permanent high-quality, human DNA sequence by 2003 at the latest.

Improve the Prevention, Diagnosis, and Treatment of Disease and Disability

Because many diseases and disabilities are directly linked to lifestyle and unhealthy behaviors, HHS and its partners have been committed to disease prevention through education and

community interventions in a variety of health areas, including: cardiovascular disease, diabetes, nutrition, HIV prevention, and oral health. Research findings about normal and abnormal biological functions constitute an essential knowledge base to support advances in prevention and treatment science and to determine what efforts are possible and effective across the population.

Normal and Abnormal Biological Functions and Behavior: Understanding how disease, genetic alterations, and environmental factors affect the function of molecules, cells, tissues, organs and organisms and their consequences for human health are critical to improving our understanding of disease and developing methods for preventing, diagnosing and treating it. The nonlinear nature of basic research poses unique challenges for measuring research outcomes. However, in FY 1999, NIH developed a method for evaluating the agency's progress toward meeting established outcome goals, one of which addressed the question of how NIH research added to the body of knowledge about normal and abnormal biological functions and behavior. By evaluating advances in science and stories of discovery, an assessment group concluded that NIH had exceeded its goal for FY 1999. Specifically, the Working Group, which consisted of experts in the field of biomedical research, concluded that the outcomes demonstrated that NIH had sustained the excellence and responsiveness of the research system-an important achievement–while demonstrating willingness to take research risks necessary to advancing biomedical knowledge, and ultimately human health. The Working Group also highlighted a number of especially noteworthy outcomes that, in the judgment of the members, fulfilled the criteria for having substantially exceeded the goal. These advances fell into a number of broad categories: cell proliferation research, studies of gene function and expression, immunology, the biological bases of cardiovascular disease, the brain, learning and memory, behavior studies, and population studies.

Prevention, Diagnosis and Treatment: NIH-funded applied research has yielded significant advances in the prevention, diagnosis, and treatment of disease and disability. This year, NIH established a formal mechanism for evaluating the extent to which those contributions supported specific agency goals. As part of the research outcomes project that began in FY 1999, NIH established outcome goals for the prevention, diagnosis and treatment of disease and disability. Again, by evaluating science advances and stories of discovery, the assessment group concluded that NIH exceeded all three of these goals for FY 1999. Specifically, the Working Group concluded that the FY 1999 research outcomes represent a significant contribution to progress in developing new or improved approaches for preventing or delaying the onset of disease and disability. The research outcomes demonstrate NIH responsiveness to health needs and scientific opportunities and innovative uses of technologies. The Working Group also highlighted a number of especially noteworthy outcomes that, in the judgment of the members, fulfilled the criteria for having substantially exceeded the goal. These advances fell into a number of broad categories: longitudinal studies; studies related to the prevention and treatment of mental illness across the lifespan; therapeutic interventions that also prevent or slow disease progression; behavioral interventions; and community-based interventions.

Health Care Quality, Financing, Cost, and Cost Effectiveness

As we pursue advances in science to prevent and eliminate disease, HHS and its partners seek to adjust the health care system to shift its focus from treatment of illness to clinical prevention. Departmental cross-cutting activity is leading the health care system to address the challenges of improving the quality, safety and efficiency of care, particularly for a select number of high priority challenges among vulnerable populations. HHS continues to pursue the identification of research needs related to quality, the capacity to conduct research, and strategies and methods for integrating quality measurement and improvement into professional curricula and practice.

AHRQ Research Agenda: Consistent with the principal of the Agency for Healthcare Research and Quality (AHRQ) that its research should begin and end with its customers, AHRQ met its FY 1999 performance goal to develop an Agency research agenda reflecting consultations with its customers. AHRQ received input from: 1) responses to mailings to over 100 stakeholders and customers; 2) responses to its *Federal Register* notice: "Request for Planning Ideas;" 3) over 20 "expert" and user group meetings; and 4) consultations with peer review study section members and the National Advisory Council.

Relevance of Findings of AHRQ Research: In FY 1999, findings from at least 10 AHRQ research activities were published in major peer reviewed professional publications. AHRQ documented over 50 citations of research sponsored by the Agency. Conservatively, there were 3,146 newspaper, trade press, and magazine articles citing the agency. Most importantly, AHRQ documented thirteen cases of research findings being implemented in the health care system.

Dissemination of AHRQ Research: AHRQ pursues the dissemination of research primarily through partnerships established for that purpose. AHRQ established a performance goal to form 5 dissemination partnerships in FY 1999, and exceeded that target by forming 30 public-private and public-public partnerships in FY 1999. AHRQ's achievements in research dissemination are also reflected in its goals to promote the translation of research into practice. For example, in FY 1999, AHRQ found that 21 purchasers and/or businesses used AHRQ research findings to make decisions. In FY 2001, AHRQ projects that its evidence-based practice centers will produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality.

Disparities in Health Care Research: AHRQ plans to continue to address racial disparities by funding projects in FY 2001 to address eliminating disparities in health care, particularly for racial and ethnic minorities.

Research Capacity

Pre-and Post-Doctoral Trainees: In FY 1999, AHRQ supported 167 pre-and post-doctoral trainees, exceeding its FY 1999 goal of supporting 150 such trainees. AHRQ will strengthen its investment in future years by increasing the number of pre- and post-doctoral trainees it supports. In addition, AHRQ plans to support at least fifteen minority investigators through individual and center grants in FY 2001.

Research Training and Career Development: Through its Research Training and Career Development Program, NIH supports a critical aspect of scientific research: the development of a talent base capable of producing advances in science. To evaluate its success in attracting, developing and retaining a diverse group of scientists, NIH has established several performance goals to assess the agency's success in attracting qualified applicants. For example, in FY 1999, NIH met its goal to maintain an application flow consistent with success rates close to historical levels of 40 percent for fellowships, and 60 percent for research training grants and entry level career awards.

Facilities (NIH): NIH supports construction of facilities on the NIH campus, as well as grants to fund facility improvements at institutions outside of NIH. In FY 1999, NIH set goals to evaluate the progress of intramural construction projects, as well as to evaluate the grant-making process for extramural assistance. For example, NIH established a goal to complete 65 percent of the construction at the Louis Stokes Laboratories Building. Performance data indicate that NIH fell short of meeting its target (it completed 56.4 percent of the construction). However, the NIH assessment revealed that this shortfall could be attributed to the need to make space adjustments to support current and projected research requirements. Construction is expected to be complete in December 2000, rather than September 2000.

Dissemination of Biomedical Research

Technology Transfer: In FY 1999, NIH supported the transfer of new technologies from NIH research to the private sector to facilitate the development of new drugs, products and methods of treatment. Three of NIH's technology transfer targets directly assess the agency's progress in promoting technology transfer. In FY 1999, NIH increased the number of Cooperative Research and Development Agreements (CRADAs) executed by 10 percent, which is more than triple the targeted amount of 3 percent. Despite this success, however, NIH fell short of its goal to increase the number of Employee Invention Reports (EIRs) by 5 percent or more over the FY 1998 levels of 287. Performance data indicate that the increase in EIRs amounted to 2.5 percent, only half the targeted amount. Similarly, NIH fell short of its goal to increase the number of License Agreements executed by 3 percent over the 215 executed in FY 1998. Performance data indicate that the number of license agreements actually decreased in FY 1999 by 5 percent. NIH suspects that the decline in EIRs and License Agreements could have been caused in part by a level of stability having been reached in new intellectual property development. However, NIH will continue to evaluate data over the next 3-5 years to determine whether or not this has occurred.

Communication of Results: The National Library of Medicine (NLM) fulfills the critical function of communicating research results to scientists, practitioners and the public..In FY 1999, NIH established two performance goals to evaluate the NLM's ability to meet the information needs of its users. These goals were:1) to provide a single toll-free telephone number to reach customer service staff; and 2) to implement a system to track customer service interactions, measure response times, and record customer feedback on NLM products and services. NIH achieved both goals.

Dissemination of Public Health Information: CDC communicates public health news about disease outbreaks and trends in health and health behavior through the *Morbidity and Mortality Weekly Report*. CDC met its FY 1999 target to publish 77 issues of the *MMWR*, and expects to increase that number to 81 issues in FY 2000.

SECTION II:

KEY HHS MEASUREMENT ISSUES

APPROACH TO PERFORMANCE MEASUREMENT,
COMMITMENT TO
MANAGEMENT IMPROVEMENT,
DATA CHALLENGES,
and
PROGRAM EVALUATION

APPROACH TO PERFORMANCE MEASUREMENT

The Department of Health and Human Services (HHS) provides leadership in the administration of programs to improve the health and well-being of Americans, and to maintain the United States as a world leader in biomedical and public health sciences. The programs of the Department impact all Americans, either through direct services, the benefits of advances in science, or information that helps them choose medical care, medicine, or even food. Through Medicare and Medicaid, for example, HHS oversees the administration of the nation's largest health insurance programs, serving an estimated 72 million Americans. Through numerous grants and other financial arrangements with public and private service providers, HHS is committed to improve health and human service outcomes and the economic independence of individuals and families throughout the US.

As set forth in the laws that established the programs administered by HHS, partnership in administration is the central and fundamental management approach for program implementation and service delivery. The overwhelming majority of the approximately $427 billion dollars that will be expended for HHS programs in FY 2001 will be spent, not by HHS employees, but by program partners. The States, not the Administration for Children and Families (ACF), spend the funds that support the income assistance provided under Temporary Assistance for Needy Families (TANF). More than $8 out of every $10 appropriated to the National Institutes of Health (NIH) goes to the scientific community at large. Large fiscal agents such as Blue Cross and Blue Shield and Aetna pay the doctors, hospitals, and other health care providers that serve Medicare and Medicaid beneficiaries. It is through collaboration with States, local and tribal governments, and non-governmental partners that HHS must set and accomplish the program goals and objectives. The diversity and scope of HHS programs are also reflected in the large number of Congressional appropriations and authorizing committees and subcommittees involved in the determination of HHS resources and program strategies.

The HHS FY 2000 and 2001 Performance Plans and FY 1999 Performance Report consist of this summary and the performance plans and reports of HHS components, which are incorporated into their FY 2001 budget submissions to the Congress. The summary provides the overall Departmental context for the performance plans and reports, demonstrates how HHS's performance goals and measures support the HHS strategic plan, illustrates how GPRA performance information is becoming increasingly useful to HHS's cross-cutting budget initiatives, and addresses performance measurement challenges for the Department. The annual performance plans and reports of the HHS components include performance goals and measures for all of HHS's program activities and the focus on the linkage to the budget that is critical to the GPRA requirements for annual performance plans and performance reports.

Integration of the HHS Performance Plan and the Budget

Just as OMB Circular A-11, Part 2, has stipulated that "the program activity structure is the foundation for defining and presenting performance goals and indicators," HHS has determined that the Budget of HHS, which describes HHS program activities and necessary resources,

provides the structure for the development and presentation of the annual performance plan and report of an agency that administers some 300 program activities. The decision to present performance information in the format of the budget reflects HHS's intent to enhance its budget justification and decision making with performance measurement information, and to be attentive to the many Congressional committees that play a role in the Department's budget.

There are other significant advantages to incorporating the annual performance plans and reports into the HHS Budget. The Budget routinely describes program activities and specifies associated resource needs, which is information that is also required by GPRA for inclusion in annual performance plans and reports. Combining the GPRA performance documents and the budget ensures the consistency of information used for budget and performance planning purposes. Finally, because the HHS Budget routinely covers all HHS program activities, the placement of the performance plans and reports in the Budget provides the framework to ensure that performance information fully covers all of HHS's programs.

As a result, just as the HHS budget request is presented in multiple volumes that address the resource needs and justifications of the individual operating and staff components of HHS, so also is the HHS annual performance plan presented. The detailed and substantive information that fully explains program-level performance and that constitutes the full performance plans and reports for the individual HHS components appears not in this document, but is included in the separate budget presentations and annual performance plans and reports of those components. A thorough understanding of HHS program-level performance information requires the study of the annual performance plans included in the Congressional budget justifications of the HHS Operating Divisions.

DEPARTMENTAL COMMITMENT TO MANAGEMENT IMPROVEMENT

The Department of Health and Human Services is committed to exemplary management that ensures that programs are delivered in an efficient and effective manner. This commitment is expressed in a number of ways – through financial management initiatives, through improvements to information technology (IT) systems, through improvements in the procurement processes, and through efforts to develop and train our workforce.

This section of the HHS Summary focuses on three distinct ways in which the performance plans and reports of HHS reflect the importance of management activity to program performance and results. It provides examples of performance information for each of the Operating Divisions of HHS that illustrates HHS assessment of the means that have been used within the programs to achieve program results. It highlights a set of FY 1999 management measures and results that reflect the Department's focus on critical financial, technology, and administrative management functions. Finally, it illustrate how HHS performance plans have addressed important management challenges identified by the General Accounting Office and the HHS Office of Inspector General. All three aspects of management assessment reflect how HHS seeks to improve the effectiveness as well as the efficiency of program operations.

Management Measures in the Performance Plans of HHS Operating Divisions

The program-level management measures presented throughout the HHS performance plans reflect that management functions and activities are deemed to be relevant to the assessment of program results. The following is a partial list of management functions selected from the more detailed presentations of HHS component performance plans.

- Information and communication management
- Accounting and financial management
- Grants and acquisition management
- Program management training and technical assistance
- Program monitoring, assessment and evaluation
- Business process re-engineering
- Internal controls
- Customer protection and satisfaction
- Consumer education
- Repair and maintenance of facilities
- Workforce management
- Employee development and satisfaction

The list reflects that the coverage of management activities in the performance plans of HHS OPDIVs is extensive. The functions listed are subject to assessment in the performance measures of the 2001 Performance Plans of HHS Operating Divisions. The following describes and illustrates how each HHS Operating Division has addressed program management through its GPRA performance plan for FY 2001.

The Administration for Children and Families

ACF and its partners (which include other Federal agencies, State, local and tribal governments, and the private sector) administer 22 programs that are divided among 35 budget activities. These programs are operated through central office headquarters as well as through the 10 regional offices and provide grant funds totaling $40 billion. The agency's performance plan reflects ACF's complex partnership environment where relationships between partners, funding mechanisms and degrees of autonomy vary from program to program. Because States and local community organizations administer most of its programs, management concerns in ACF not only focus on the federal agency operations but also on improving State management and administrative data systems. Several of the specific performance measures included in the 2001 performance plan illustrate these areas of concern:

- Make the Child Support Enforcement process more efficient and responsive by increasing the cost-effectiveness ratio to $5.00 from the 1996 baseline of $3.93.

- Survey of State child support enforcement programs' satisfaction with federal performance.

- Increase from an estimated 94% to 100% the number of Head Start teachers with a degree in early childhood education, a child development associate credential, a State-awarded preschool certificate, a degree in a field related to ECE plus a State-awarded certificate, or who are in CDA training and have been given a 180 day waiver.

- Increase to 1500 the annual number of site visits by Tribal training and technical assistance contractors to the diverse Native American population, with particular emphasis on urban Native organizations, rural and non-Federally recognized Tribes.

The Administration on Aging

AoA has emphasized several administrative areas in its performance plan. These include workforce planning, use of federal dollars to leverage funds from other sources, improvement of data bases, and development of partnerships with local, state and other federal organizations. Several of the specific performance measures included in the FY 2001 performance plan illustrate these areas:

- Maintain then increase the level of provision of information and assistance services through the Older Americans Act and increase leveraged funding.
- Obtain reliable baseline data for caregiver support services through support of the National Institute on Aging's Caregiver Supplement to the National Long Term Care Survey and follow-on surveys.

- Create and distribute culturally-appropriate educational materials about mental illnesses common among older adults.

Agency for Healthcare Research and Quality

AHRQ's mission is to support, conduct and disseminate research that improves access to care and the outcomes, quality, cost, and utilization of health care services. The organization has identified three strategic goals that frame its activities: support improvements in health outcomes, strengthen quality measurement and improvement, and identify strategies to improve access, foster appropriate use, and reduce unnecessary expenditures. It has used its strategic planning process to frame its operations, emphasizing staff and customer input, developing operations plans for each components, and developing individual employee performance plans. The emphasis on strategic planning has led to a greater focus on evaluation; the organization expects to use results of evaluation studies for future decisionmaking processes.

The specific strategies that have been devised focus on AHRQ's multiple audiences (clinical services, health systems, and public policy actors). The agency has also highlighted its partnership relationships with other HHS organizations as well as state and local governments and private sector organizations. Several of the management related performance measures included in the 2001 performance plan are of particular interest:

- Maximize dissemination of information, tools and products development from research results for use in practice settings.

- Evaluate the impact of AHRQ sponsored products in advancing methods to measure and improve health care.

- Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and plans.

AHRQ has acknowledged other management measures that it will monitor internally in future years, including:

- Maintain acquisition performance management system to ensure (1) timely completion of transactions, (2) vendor and customer satisfaction, and (3) efficient and effective use of resources.

- Continued enhancement and expansion of Agency Intranet site to ensure staff have immediate access to all current information.

Centers for Disease Control and Prevention

The framework that underlies the CDC Performance Plan emphasizes the agency's relationship to the public health community and to the public in general. While the organization has highlighted specific program outcomes in its plan (often building on the *Healthy People 2000 and Healthy*

People 2010 documents), its approach has been constructed around its partners – representatives of state and local governments, academic institutions, business and labor, and community and professional organizations. Closely related to this strategy is the investment in data systems that provide both the agency and its partners with information about activities as well as the development of trained staff. Several of the specific performance measures included in the 2001 performance plan illustrate these areas:

- Public health microbiology fellows will be trained and available for employment in local, state, and federal public health laboratories.

- Sentinel surveillance systems for acute and chronic Hepatitis C Virus (HCV) will be established in select sites.

- Expand a special program to prepare a cadre of 60 trained public health professionals throughout CDC to complete short-term assignments with WHO.

- Develop new monitoring tools needed to address emerging topics (State and Local Area Integrated Telephone Survey - SLAITS).

- CDC will increase funding to support senior staff, and to establish infrastructure and collaborative processes in the nations state education agencies and state health departments to reduce tobacco use, excessive consumption of fat and calories, physical inactivity, and obesity among youth.

- CDC will develop reporting mechanisms and communication strategies to assure that results from these studies will stimulate new and improved interventions to prevent disease.

- Research findings will be disseminated by investigators receiving PRI funds.

- Increase the number of professional prevention effectiveness staff and fellows.

- Complete construction of infectious disease lab Building 109 to replace existing buildings 4, 6, 7, 8 and 9, Chamblee Campus.

- 100 percent audited financial statements with no qualifications.

Food and Drug Administration

FDA has employed several strategies that relate to management questions as it strives to achieve its long-term goals of strengthening the science base for regulatory decisionmaking and assuring the safety of regulated products. It has emphasized the process of setting standards for itself as well as others concerned about safety issues, recruitment of science partners to assess and manage risks, collaborative relationships with its various stakeholder communities, and bringing products of new technology to market. Several of the specific performance measures included in the 2001 performance plan illustrate these areas:

- Increase the number of audits and assessments of foreign food safety systems, with an emphasis on high volume exporters to the U.S. to ensure a level of food safety protection comparable to domestically produced foods.

- Improve biennial inspection coverage by inspecting 30 percent of registered animal drug and feed establishments.

- Assure that FDA inspections of domestic medical device manufacturing establishments, in conjunction with the timely correction of serious deficiencies identified in these inspections, result in a high rate of conformance (at least 90 percent) with FDA requirements.

- Increase by 12.5 percent the number of compliance checks conducted in FY 01 to 325,000 and conduct follow-up compliance checks of 100 percent of retailers found to be in violation of the rule.

Health Care Financing Administration

HCFA's mission is to ensure the health care security of its beneficiaries. It seeks to carry out this mission in the context of an environment that includes rapid changes in the health care and health insurance industries as well as interdependence with contractors, agents, States and others. This interdependence calls for partnership efforts that will leverage resources and working with others (particularly the States and third party contractors) to improve performance In addition, it works closely with other Federal agencies, both within and outside HHS. Performance measurement has received strong support within the agency, particularly involving the development of performance data systems. Performance information included in the 2001 performance plan illustrate these areas:

- Increase the percentage of beneficiaries who are satisfied with the health care services they receive through the Medicare program.

- Enroll beneficiaries into managed care plans in a timely fashion.

- Improve the management of the survey and certification budget development and execution process.

- Develop linked Medicare and Medicaid data files on dually eligible beneficiaries.

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

- Increase the efficiency of medical review conducted by the Medicare contractors on fee-for-service claims as part of its Program Integrity Comprehensive Plan.

- Improve the effectiveness of dissemination of information to Medicare beneficiaries and to those acting on their behalf.

- Meeting claims processing timeliness requirements for clean Medicare bills/claims submitted electronically.

- Increase the use of electronic commerce/standards in Medicare.

- Improve HCFA's information systems security policies and practices enterprisewide in order to meet the GAO standards in the Federal Information System Control Audit manual.

Health Resources and Services Administration

HRSA is an agency with multiple programs but a single goal: to assure 100 percent access to health care and 0 percent disparities for all Americans. The agency works to establish alliances and partnerships with a broad array of organizations ranging from state and local governments to foundations and corporations. These alliances and partnerships reinforce HRSA's four strategies: eliminate barriers to care, eliminate health disparities, assure quality of care, and improve public health and health care systems. In addition to utilizing its current range of resources that support direct service delivery and create training opportunities, the agency has established new competencies in areas such as surveillance, performance measurement, and systems analysis. Several of the specific performance measures included in the 2001 performance plan illustrate HRSA's management concerns:

- Award nursing loan repayment contracts.

- Improve total customer satisfaction among Federal agencies served.

- Increase the number of minority health care and social service providers who receive training in AETCs.

- Increase the number of organ donors nationally.

- Increase the number of graduates and/or program completers who enter practice in underserved areas.

- Annually produce results of data collection and analysis activities conducted to inform the market regarding issues relevant to health professions and nursing workforce.

- Conduct an orderly phase out of the loan insurance authority.

- Process payment of 90 percent of lump sum awards for the Vaccine Injury Compensation Program within 30 calendar days of receipt of a DOJ clearance letter.

- All State Offices of Rural Health will implement performance outcome measurement indicators and reported a summary of their outcomes.

- Obtain a clean audit opinion for HRSA.

Indian Health Service

The IHS Performance Plan highlights a set of performance indicators to address the significant health problems of the American Indian and Alaska Native population. These indicators are constructed around the mission of the agency: in partnership with American Indian and Alaska Native people, to raise their physcial, mental, social, and spiritual health to the highest level. Four strategic objectives are defined for this purpose: improve health status, provide health services, assure partnerships and consultations with its constituency, and performance of core functions and advocacy. Approximately half of the IHS budget is provided by the agency in direct services while the other half is delivered by Indian tribes to their own communities. Given this arrangement, the performance plan focuses on assuring adequate facilities and equipment for the provision of health services as well as providing adequate contract support services to the tribal health delivery system. IHS also works closely with other HHS agencies that provide services to the Indian population. Several of the specific performance measures included in the 2001 performance plan illustrate these areas:

- Increase to 80 percent the percentage of medical facilities with Urgent or Emergency departments or services that have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect.

- Expand the percentage of programs that have implemented the use of the Mental Health/Social Services data reporting system.

- Develop the specifications and implementation plan for an automated mutually compatible information system which captures health status and patient care data for Indian Urban health care programs and implement at field urban sites.

- Improve consumer satisfaction with the acceptability and accessibility of health care as measured by IHS consumer satisfaction survey.

- Develop environmental health surveillance system and complete community environmental assessment in 90 percent of communities.

- Reduce the net backlog of maintenance, alteration and repair.

- Improve to 88 percent the level of Contract Health Service procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements at the IHS-wide reporting level.

- Continue implementation of Managerial Cost accounting systems across IHS setting by investing in necessary information technology.

National Institutes of Health

NIH's mission to uncover new knowledge about the prevention, detection, diagnosis, and treatment of disease and disability is directly supported by a number of management objectives. The NIH performance plan accentuates three areas: first, activities that allow it to accomplish what it defines as sustained Federal stewardship; second, the development and training of the pool of scientific talent; and third, the support, construction and maintenance of laboratory facilities necessary for conducting research. The stewardship role involves establishing research priorities, the process of reviewing proposals and funding the best projects, dissemination of results, and establishing appropriate partnerships with other Federal agencies and research organizations which share research interests. Several of the specific performance measures included in the 2001 performance plan illustrate these areas:

- Increase awareness of NIH-sponsored research among health care providers and among high-risk, under-served, and/or affected publics.

- Improve the National Library of Medicines' customer service and information services for individuals seeking medical information.

- Enhance outreach to commercial entities by increasing the number of licensing agreements in FY 2001 by 3% over the number of licenses in FY 2000.

- Progress in responding to the Institute of Medicine Report recommendations for improving public input and priority setting.

- Improve and enhance electronic research administration and communication with the extramural community by enabling increasing numbers of institutions to begin administering grants electronically.

- Implement the Director's overall strategy to improve information technology management at NIH by developing a strategic vision and formal investment process.

- Expand the use of Performance Based Contracting by $21.2 million in FY 2001 to eligible contracts.

- Increase manager satisfaction with personnel system innovations by completing the development and beginning the pilot implementation of decision support systems for recruitment, selection, and employee performance.

- Complete the FY 2001 milestones in the personal property management improvement plan and achieve a loss rate of less than 6 percent of the property in the inventory.

- Expand the role of electronic capabilities in the administration of research training and career development activity to assure that at least 50 percent of all training appointments are received electronically.

- Utilize a systematic process to manage and account for NIH's Real Property Inventory by providing information online at the desk of each stakeholder involved with real property management.

Office for Civil Rights

OCR's performance plan is organized around two broad goals: 1) to increase nondiscriminatory access and participation in HHS programs and 2) to enhance OCR's operational efficiency. OCR has identified, in conjunction with its stakeholders, six performance objectives that address its high priority issues – adoption, managed care, services for limited English proficient persons, welfare reform, nondiscriminatory quality health care, and services in the most integrated setting possible for individuals with disabilities. In carrying out its enforcement program, OCR processes and resolves discrimination complaints, conducts reviews and investigations, monitors corrective action plans, and conducts voluntary compliance, outreach and technical assistance activities.

Several of the specific performance measures included in the 2001 performance plan illustrate OCR's activities:

- Increase to 33 percent and/or 297 closures focused on high priority issues.
- Decrease to 241 days the average age of all priority case closures.
- Increase to 30 the number of corrective actions and no violation findings in managed care cases.
- Increase to 29 the number of corrective actions and no violation findings in TANF cases.
- Increase to 151 the number of corrective actions and no violation findings in cases involving access to services for persons with limited English proficiency.

Program Support Center

The PSC was created to provide administrative services on a competitive, service-for-fee basis to HHS customers as well as other federal agencies. The agency does not actually implement programs; rather, its major functions and operations are all focused on management support activities. Its mission is to provide high quality, innovative and cost-effective services to its customers through its three major areas: human resources, financial management, and administrative operations. As such, the performance measures included in its performance plan are all management activities. Several of the specific performance measures included in the 2001 performance plan illustrate these areas:

- Improve the timeliness of personnel action processing so that 90 percent of actions are completed within seven working days
- Review and negotiate 95 percent of all indirect cost rate proposals and process 85 percent of statewide cost allocation plans within twelve months of receipt.

- Increase customer satisfaction with the indirect cost rate process.

- Improve the quality and timeliness of payment management system operations by increasing the number of recipient organizations to 15,000 and resolve 100 percent of assigned audit findings within five months.

- Increase the yield of debt management services by 10 percent and refer 100 percent of verified delinquent debts to the Treasury Offset Program within 75 days after the end of each quarter.

- Reduce the unit cost per telecommunication line to $24.50.

Substance Abuse and Mental Health Services Administration

SAMHSA's mission is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society. Its performance plan emphasizes three long term policy goals: 1) to support and contribute to the improvement of community-based systems of care for adults and children with serious mental illnesses or disturbances; 2) to educate and enable America's youth to reject illegal drugs as well as underage use of alcohol; and 3) to assist States and communities by supporting and helping to improve their substance abuse prevention and treatment efforts. The agency emphasizes several strategies: bridging the gap between knowledge and practice; promoting the adoption of best practices; assuring services availability and meeting targeted needs; and investing in data for quality improvement and accountability. Both mental health and substance abuse issues involve a broad array of partners and stakeholders who play an important role in the determination of agency priorities. Their role is especially critical in the implementation of two of the agency's largest programs: the mental health and substance abuse block grants to states. Several of the specific performance measures involving management objectives that are included in the 2001 performance plan include:

- Eight months after the close of data collection, data will be available in the National Household Survey on Drug Use.

- Increase to 9,000 the number of complaints of abuse that will be addressed by the Protection and Advocacy program of CMHS.

- Less than 20 months after the close of data collection, data will be available from the Drug Abuse Services Information System.

- Increase by 10 percent the number of requests for materials, connects to the web, and telephone inquiries related to the Knowledge Exchange Network of the CMHS.

- Increase by 15 percent over baseline the number of information requests from the CSAP Clearinghouse Program.

- Increase to 38 States the number of States that incorporate needs assessment data into block grant applications for CSAP.

Performance Measurement for Generic Management Functions

In addition to the program-related management issues covered under the performance plans of the individual HHS Operating Divisions, there are a number of Department-wide management functions represented particularly in the HHS submission for the General Departmental Management account. The performance objectives and measures included for these functions are consistent with ones that have been developed for other Federal agencies, and they have been implemented on a Departmental basis. As the performance progress statements below indicate, HHS has included Departmental management measures in its performance plans since 1999, and can now report positive results for its management functions in its first performance report.

It should be noted that HHS does not limit Departmental performance measurement to the measures included in the formal GPRA performance plans and reports. The HHS FY 1999 Financial Management Status Report and Five Year Plan identifies strategic financial management goals and annual targets through 2004. This annual document reflects the commitments of the Chief Financial Officer (CFO) of HHS for cross-cutting financial management activities and selected other commitments of the individual Operating Divisions as well. In addition, performance progress on the CFO's plan, plus key program performance results will be presented in the FY 1999 HHS Accountability Report to be released by March 31, 2000. HHS is also in the process of redefining its long-term goals and performance measurement principals and processes for information technology functions, has developed generic "balanced scorecard" methods that are being adopted for acquisition and grants management operations across the Department, and has instituted a Departmental process and approach for addressing the workforce planning challenges that confront virtually all Federal agencies.

The following summarizes HHS performance progress for selected Departmental management measures included in the HHS performance plan for major management functions.

Financial Services

Goal: All HHS Operating Divisions will submit audited financial statements in accordance with Departmental guidance.

Actual Performance: Timely audited financial statements were prepared for 8 of 8 audited Operating Divisions, plus HHS as a whole.

Goal: Entity audit opinions are clean.

Actual Performance: Two of 8 audited financial statements were unqualified in the FY 1999 audit of HHS's FY 1998 financial statements. By 2001 all agencies will have clean audit opinions.

Goal: Maximize the use of electronic payments.

Actual Performance: In FY 1999 100 percent of grant payments were electronic, 99 percent of salaries, 85 percent of vendor payments and 93 percent of travel payments were electronic.

Information Resources Management Services

Goal: Ensure that all HHS information systems functioning properly in Year 2000.

Actual Performance: All HHS information systems have functioned properly in Year 2000.

Goal: 100 percent of information technology investments approved by the Information Technology Investment Review Board meet review criteria.

Actual Performance: All approved investments met the review criteria.

Grants, Acquisition and Logistics Management Services

Goal: Increase the effectiveness of HHS-wide policies for grants, procurement, and logistics.

Actual Performance: An initial survey on policy effectiveness for FY 98 was 3.4 on a scale of 0 to 5.

Goal: Ensure that 85 percent of HHS grant administrative policies are current in FY 1999.

Actual Performance: 86 percent were current in FY 1999.

Goal: Increase the location accuracy of capitalized property records to 94 percent in FY 01.

Actual Performance: 92 percent were accurate in FY 1999.

Special Management Challenges

During the past year, the Department has been asked to respond to several inquiries about its ability to improve its performance and resolve long-standing fraud, abuse, and management problems. In a letter to HHS Secretary Donna Shalala, Senator Fred Thompson, Chairman of the Senate Committee on Governmental Affairs, reviewed reports from GAO and the HHS Inspector General that identified a number of management challenges. While he emphasized some problems, he noted that the Department's FY 2000 Performance plan contained performance goals for 12 of the 14 high risk and other most serious management problems confronting the Department. The following summarizes the highlights of how HHS has addressed these and other special management challenges in the GPRA performance plans.

Issue: Y2K Compliance in Medicare.

Response: HHS included Departmental and HCFA performance goals for Y2K compliance. HCFA and HHS have achieved its Y2K performance goals.

Issue: HCFA Information Security.
Response: HCFA has strengthened central security, corrected material weaknesses, developed security plans, and improved oversight of Medicare contractor information security. The HCFA performance plans for FY 2000 and 2001 include performance goals for improving systems security.

Issue: Medicare Payment Errors.
Response: In cooperation with the HHS Office of Inspector General, HCFA has reduced payment errors from 14 percent in 1996 to 7.1 percent in 1998. The 1998 achievement exceeded HCFA's GPRA performance goal for FY 1999 of 9 percent. HCFA seeks to reduce the error rate to 6 percent in 2001.

Issue: Improper Medicare Payments for Mental Health Services.
Response: A defined "point" in HCFA's 10-point Comprehensive Plan for Program Integrity is: "Addressing Service Specific Vulnerabilities: Community Mental Health Center Care." The successful implementation of this plan appears as new performance goal in HCFA's FY 2001 performance plan.

Issue: Inadequate control over Medicare managed care.
Response: HCFA has included seven ongoing performance goals that address various aspects of managed care program activities. These include goals to improve administration of the appeals process by managed care plans and the development of new payment systems for Medicare+Choice.

Issue: Inadequate Controls over Medicare Home Health Benefits.
Response: HCFA met its FY 1999 performance goal to reduce erroneous payments in four states where the HHS Office of Inspector General had identified significant payment errors, and has targeted further reductions for FY 2000.

Issue: Implementation of payment reforms for nursing facilities.
Response: Skilled nursing facility prospective payment systems have been implemented. HCFA's performance plans include goals for the development of new payment systems for fee-for-service and Medicare+Choice.

Issue: Implementation of Other Balanced Budget Act Provisions.
Response: In addition to the GPRA goal to develop new Medicare payment systems, HCFA has performance goals that relate to other Balanced Budget Act provisions. These include goals for: managed care enrollment, health plan choices, improper payments to Home Health Agencies, and the State Children's Health Insurance Program.

Issue: HCFA should institute standardized integrated accounting systems for its Medicare contractors.

Response: HCFA has pursued a course of action that will result in improvements in payment controls and financial management. These are reflected in several prominent HCFA performance goals that address the reduction of payment errors, Medicare contractor oversight, and other program integrity and financial management improvements.

Issue: Modifications in the Child Support Enforcement program.
Response: ACF has established measurable performance indicators related to increased paternity establishment, increased support orders, and improved collection.

Issue: Improve the effectiveness of FDA's foreign inspection program.
Response: FD has a program requirement to follow up cases involving serious deficiencies and documents corrections or necessary compliance action.

Issue: Assess the impact of Head Start programs.
Response: ACF has convened an advisory committee of 32 national experts which has issued a report on recommendations for a study or studies of the impact of Head Start services. The ACF performance plans include specific performance goals related to measurable improvements in the learning readiness of children.

Issue: Scope and Complexity of HHS Programs Create Performance Measurement Challenges.
Response: This Summary and the performance plans of HHS components identify for all HHS strategic goals, and for all HHS program activities, how HHS and its performance partners are confronting its performance measurement challenges. Prominent among HHS's processes for coordinating Departmental activity to address program improvements and initiatives is the HHS budget process. In the Section II of this Summary, HHS addresses HHS progress toward the achievement of its strategic goals, through its budget initiatives, as indicated in performance measures for its program activities.

DATA CHALLENGES

HHS long ago resolved that performance data must be credible to be useful to decision-making. As a result, the Department seeks continuous improvement in the quality of the data it will use for performance measurement and in its assurances that performance data is credible. HHS also continues to address significant data challenges, two of which are prominent at this stage of GPRA implementation. The first is the timely collection of data, particularly among program activities that are administered by states, localities or other partners. The second is the determination of the appropriate level and form of data assurance for activities that rely upon well established, but complex data systems that are difficult to describe within the context of a performance plan and report.

The performance plans and reports developed by the HHS Operating Divisions reflect a commitment to providing useful information to support and explain program decisions. Program units have diverse functions and data needs; consequently, they vary widely in how they collect, verify and validate timely performance data. All parts of the Department have focused on the fundamentals of data verification and validation, and have addressed other factors that affect data collection and quality. These include: reliance on achieving agreement by program partners; the timeliness of data; the resource-intensive nature of data collection; the diversity of data sources; and the suitability of data systems.

The commitment of HHS and its components is apparent in the innovative approaches the programs and the Department have taken to resolving specific data challenges. For example, the Maternal and Child Health Program achieved agreement with its state partners on a set of performance measures to used in State applications for the MCH block grant that are reported through an electronic reporting system. This was achieved over several years, beginning with work in a number of pilot States. In addition, HHS has worked to disseminate best practices in data collection through the HHS Data Council that coordinates Department-wide data collection efforts. Venues such as the Data Council provide a setting for program units to share experience and information that will assist others address data issues.

Overall, HHS has a large number of administrative and survey data systems to draw upon that provide high quality information. To obtain data on outcome measures, for example, the Department relies upon major national surveys such as the National Health Interview Survey, the National Household Survey on Drug Use, the Behavioral Risk Factor Surveillance System and many others. To obtain data on process measures (i.e., services provided to clients) and capacity measures (i.e., activities designed to improve program quality), the Department depends on an even larger number of administrative data systems. Although these data sources were originally developed for other management and research purposes, HHS confidently relies on many of them to support performance measurement functions.

Programs with well-established systems for collecting data continue to address the challenge of assuring the public that their performance data is credible. The performance reports that have been developed by HHS program units indicate that different levels of accuracy are needed in different circumstances for performance information to be meaningful and useful for decision-

makers. As GAO has noted, data is not an absolute factor; professional judgment plays an important role in this determination. In HHS, the range of program types calls for a tailored approach to verification and validation, and programs do, in fact, differ in their approaches to the documentation of data assurance. Nevertheless, as GAO has noted, "Determining the most appropriate validation and verification approaches for each type of program is a matter for individual agency diagnosis, analysis, and choice, taking into account stakeholder views, the relevant professional standards, and technical advice.[1]

Other Data Issues

Despite HHS's commitment to improving data quality and our assurance of its reliability, there are common challenges that we face in using data to assess performance. To illustrate this phenomenon, the factors described below all contribute to the challenge of collecting timely data and providing assurances that the data is credible. While the extent to which each issue impacts data collection or credibility varies across program area, these issues are present across the Department.

Reliance on achieving agreement by partners. A significant number of HHS programs rely on data that are collected by the external organizations in the implementation process. Data that emerge from these groups are constrained by the agreement of those partners to the data definitions as well as the burden of collection and reporting. The process of achieving agreement from the Department's intergovernmental partners is often time consuming and requires significant staff investment. In addition, efforts to collect information are affected by the Paperwork Reduction Act processes, which prohibits agencies from collecting data from outside entities without public notice and comment and approval by the Office of Management and Budget. Although an important form of public protection from excess Federal burden, the process is time consuming. Even after the process is complete, approval is often granted only on a voluntary basis, which allows outside entities to choose not to report. This happens with some frequency for State-administered programs, and limits the ability of some agencies to develop national performance goals for their programs.

Timeliness of data. Many of the data sources that have been utilized in the GPRA process do not provide current fiscal year performance data in time to be included in the performance report for that year. Time lags can occur for two primary reasons. First, major surveys such as the Behavioral Risk Factor Surveillance Survey are not collected annually. Other surveys must track special population groups and are not collected regularly. Second, data that are collected annually from states, localities or other partners are not submitted to federal agencies until they have been evaluated and validated, which must occur after the fiscal year has ended. Timeliness of reporting will limit our analysis of performance in the early years of performance reporting. However, once the performance measures mature and performance trends emerge, the timeliness of current year data will be a less significant factor. The most recent fiscal year data will become

[1] GAO/GGD-99-139 Verification and Validation of Performance Data, p. 14.

one aspect of a larger performance story, and decision-makers will be able to make inferences about a program's recent performance based on its performance over the last several years.

Resource-Intensive Nature of Data Collection. Data collection requires a significant investment in staff resources and data systems. Non-federal partners often do not have the staff or fiscal resources to collect the data required by program units. Consequently, programs that collect data from non-federal partners often must make difficult tradeoffs between data collection and service provision. While data collection has the potential to greatly improve program decision-making, it should not compromise the provision of necessary services. HHS, its programs, and their partners must carefully weigh the various costs of data collection against its value for decision-making.

Diversity of data sources. The data that are being used by HHS programs in the GPRA process have been drawn from many different sources and reflect different information needs. Some of the data are produced as a result of internal tracking for management purposes; this type of data often focuses on program outputs and was originally designed to provide information to program managers for internal control purposes. Other data that have been included in the performance plans were collected as a part of evaluation activities; both AoA and FDA have utilized this kind of information. Still other programs have used customer satisfaction surveys and household surveys to establish measures of performance. In a few instances, programs have utilized non-governmental data sources to assess achievement, relying on the validity of those sources. While programs may use these multiple data sources, program managers are working to ensure that limitations in data sources do not negatively impact the program's assessment of program performance and achievement of outcomes.

Suitability of data systems. Several HHS programs have acknowledged that the data collected for a few selected measures are not conducive to measuring the desired outputs or outcomes. For example, some data collected by programs in such organizations as AoA and SAMHSA focused on counting service units rather than on the number of individuals served. Although attempts are being made to "clean up" such data and produce "unduplicated counts," that process is a lengthy one. Similarly, other program data may contain some elements of miscoding or duplication that can affect the accuracy of program measurement. Agencies such as AoA and SAMHSA continue to improve their data collection, and expect that these problems will diminish over time.

Working with Our Partners on Solutions

The development of robust systems for measuring the performance of HHS' programs is an iterative process that will require continuous review and refinement as the systems mature. As we begin to use the data to inform decision-making and gain more experience in working with various data systems, current measures may be revised or discarded, and new measures will be developed as replacement measures or to fill gaps in coverage. Much of this work will require the full participation and agreement of HHS' partners in other Federal agencies, the States, and local organizations who participate in the implementation of HHS programs. For example, to adapt data developed for a variety of management purposes to measure program performance, HHS programs and partners are working to resolve data consistency issues common to comprehensive data systems, including the following:

- definitions used across agencies and across reporting jurisdictions within the same survey or other data collection;
- collection methodology across surveys and/or across jurisdictions, e.g.: in-person interviews vs. telephone surveys, sampling frames, and periodicity;
- reporting periods, especially in the case of national surveys;
- time lag between actual data submission and data compilation; and
- number of jurisdictions who participate in administrative reporting systems, as well as surveys that the Department undertakes in cooperation with states and localities.

HHS programs may need to develop new data systems to supplement currently available data or support more accurate, informative indicators of performance. This will require the Department to assess carefully where to invest new resources, as well as determine what current data collection can be reduced or eliminated in order to free up resources to collect new data. As agencies look to develop new data while reducing data collection for secondary measures, the Department will look for opportunities for sharing data sources where outcomes cut across programs. In searching for additional data relevant to outcomes, agencies will also need to consider using data from non-traditional sources, for example, from other agencies involved in the delivery of similar services.

Several HHS components are exploring opportunities to share existing data and to collaborate on the development of measures where several programs, or funding sources, contribute to common outcomes. For example, HHS has funded a small demonstration and evaluation project to expand on work underway in the ACF Office of Community Services (OCS) to learn how performance management can be used to achieve local, community development goals. HRSA is also evaluating the potential for collaborating with other Federal, State, and local entities funding and delivering community health services on the development of community level health measures.

HHS components are considering incorporating measures developed by states in their performance plans. Doing so requires resolving vast differences in data collection and reporting vehicles, but in the long run working with available state data may reduce administrative burden and build greater credibility and confidence in Federal/state "partnerships."

HHS is committed to working creatively with our Federal, state and local partners to address the challenges we jointly face in measuring performance for health and human service programs.

PROGRAM EVALUATION AND PERFORMANCE MEASUREMENT

The Government Performance and Results Act (GPRA) and OMB Circular A-11, Part 2, require Federal agencies to include a summary of the findings and recommendations of Agency program evaluations in the GPRA performance report. The HHS evaluations that were completed during Fiscal Year 1999 are reported in the Department's annual report to Congress titled: *Performance Improvement 2000: Evaluation Activities of the U.S. Department of Health and Human Services.* For purposes of complying with the GPRA requirement, HHS is incorporating this evaluation report by reference into this HHS Performance Report and Performance Plan Summary. The HHS report on program evaluations provides Congress with evaluative information on the Department's programs, policies, activities, and strategies.

In the era of results-oriented management, evaluations are playing an increasingly important role in strategic planning, performance management, and program improvement. To this end, HHS is committed to ensuring its evaluations yield valuable knowledge, and that knowledge is used to complement annual performance planning and reporting. Evaluations conducted by HHS agencies generally serve one or more of the following purposes: evaluate program effectiveness; develop performance measurements; assess environmental impacts on health and human services (i.e., external factors affecting program performance); and improve program management. The results of these evaluations are increasingly being used by HHS program managers to inform the annual performance planning process and the interpretation and reporting of annual performance data.

Program effectiveness provides a way to determine the impact of HHS programs on achieving intended goals and objectives. For example, the Substance Abuse and Mental Health Services Administration performed a cost/benefit study of substance abuse treatment. Using data from the National Treatment Improvement Evaluation Study (NTIES), estimates of treatment costs, crime-related and health care costs, and the income of 5,264 substance abusers in the periods before and after treatment were analyzed The study found dramatic reductions in crime-related costs, modest reductions in health-care costs, and modest increases in the earnings of substance abusers in the period after treatment.

Performance measurement is the primary mechanism used to monitor annual progress in achieving departmental strategic and annual performance goals. To support performance measurement, we are investing evaluation funds to develop and improve performance measurement systems and the quality of the data that supports those systems. For example, the Office of the Assistant Secretary for Planning and Evaluation assessed the "state-of-the-art" in performance measurement for the Department's public health, substance abuse, and mental health block grant programs. The results are being used to develop analytical frameworks for HHS and its partners in the states to measure service outcomes, processes, and capacity and address issues of data and information system requirements.

Environmental assessment is the way we monitor and forecast changes in the health and human services environment that will influence the success of our programs and the achievement of our goals and objectives. In turn, this understanding allows us to adjust our strategies and continue to deliver effective health and human services. For example, The Health Resources and Services Administration conducted a study of mandatory Medicaid managed care enrollment systems to assess the effects enrollment policies on federally qualified health centers (FQHC) and their ability to adapt to managed care systems. The study results are being used to better identify policy implications for "access and quality" to health care for the underserved.

Program management reflects the need of program managers to obtain information or data helpful for effectively designing and managing a program. These evaluations generally focus on developmental or operational aspects of program activities and provide understanding of services delivered and populations served. For example, the Office of HIV/AIDS at the Centers for Disease Control and Prevention conducted an evaluation of its five-year demonstration of social marketing techniques for HIV/STD prevention programs targeted to young people under 26 years of age. The results are being used to assess the implementation phase of the program and inform collaborative national partners who provided technical assistance to the local demonstration sites.

Performance Improvement 2000 is available electronically from the HHS Policy Information Center (PIC) website at: <http://aspe.os.dhhs.gov/PIC/gate2pic.htm>. The PIC project database, a centralized source of information on more than 6,000 studies sponsored by HHS, other Federal agencies and private-sector entities, serves as an information source for individual evaluations (either completed or in progress). For additional information about using the PIC database or accessing copies of evaluation reports, please contact the Policy Information Center at (202) 690-6445.

SECTION III:

FY 2001 PERFORMANCE GOAL SUMMARY

LINKAGE TO
DEPARTMENTAL INITIATIVES
and
THE HHS STRATEGIC PLAN

FY 2001 DEPARTMENTAL INITIATIVES AND REPRESENTATIVE PERFORMANCE GOALS

The FY 2001 HHS budget has been organized around priorities that emphasize important national needs. These priorities cut across program components within the Department and support the Department's efforts to achieve the goals and objectives of the HHS Strategic Plan. While HHS is a large, complex organization that is responsible for implementation of more than 300 programs, these priorities provide the Office of the Secretary with a means of coordinating efforts to improve HHS programs. HHS also seeks to use the GPRA process to enhance program coordination, and has incorporated annual reporting required by the GPRA into the HHS budget process to facilitate the achievement of that objective. This section of the HHS Summary provides information to illustrate the linkages of the HHS budget and annual performance planning process to the HHS strategic plan.

The HHS Strategic Plan emphasizes six overarching goals that inform the budget process, other Departmental planning activities, and program planning across the Department. These goals have provided a broad framework for Annual Performance Plans, for budget initiatives and new program directions for the Department, reflecting both the President's and the Secretary's priorities.

HHS Strategic Goals

- ★ Reduce the major threats to the health and productivity of all Americans.
- ★ Improve the economic and social well-being of communities, families, and individuals in the United States.
- ★ Improve access to health services and assure the integrity of the nation's health entitlement and safety net programs.
- ★ Improve the quality of health care and human services.
- ★ Improve public health systems.
- ★ Strengthen the nation's health sciences research enterprise and enhance its productivity.

Specific programs, strategies and activities that contribute to the achievement of HHS's strategic goals and objectives are identified in the detailed sections of this Summary that follow. That presentation also identifies numerous performance measures for FY 1999, 2000 and 2001 related to the achievement of each of the 39 strategic objectives in the HHS Strategic Plan. All of the performance goals and measures included in this summary and in the performance plans of HHS components are HHS performance goals. Although vast majority of measures necessarily focus on individual program activities, they support Departmental goals and the mission of HHS as do the very program activities that they will serve to assess.

Immediately following is a summary of the cross-cutting, Departmental budget initiatives included in the FY 2001 President's Budget for HHS. To illustrate and reflect HHS's commitment as a

Department to the success of its initiatives, we have also identified FY 2001 performance goals that are representative of efforts across the Department to improve programs through these initiatives.

Improve Health Care Coverage, Access and Quality

The Administration proposes a health insurance initiative to expand access to quality health care for more Americans. Over 44 million Americans lack health insurance. This generally results from lack of insurance affordability and/or limited access to coverage. The consequences of the lack of health insurance is devastating. The uninsured are three times as likely to not receive needed medical care, 50 to 70 percent more likely to need hospitalization for avoidable hospital conditions, and four times more likely to rely on an emergency room or have no regular source of care than the privately insured.

This initiative includes augmenting Medicare coverage and benefits for older and displaced workers, expanding health insurance access and outreach to children and parents of low-income children, and meeting the needs of other under-served populations, such as Native Americans.

The FY 2001 budget contains a number of proposals that address the problems of health care access, affordability, and quality. They include a proposal called *Family Care* that would cover parents of children covered by the State Children's Health Insurance Program (SCHIP) and Medicaid. This proposal would provide higher Federal matching payments for state coverage of parents of children eligible for Medicaid or SCHIP. The budget also includes a proposal to give states needed tools to increase enrollment in SCHIP.

Other program initiatives are also included in this area. The Administration proposes that people aged 62 through 65 and displaced workers aged 55 to 65 be allowed to pay premiums to buy into Medicare. It includes a proposal to give states the option of covering legal immigrants, regardless of when they came to the US. It would expand the FY 2000 initiative that will improve access to health care for uninsured workers. It proposes a comprehensive reform plan to modernize and strengthen the Medicare program in two ways: 1) to meet the health, demographic and financing challenges of the 21st century, and 2) to modernize the administrative infrastructure to prevent and detect health care fraud and abuse.

Efforts are also targeted on continuation and expansion of the 1998 President's Nursing Home Initiative, expansion of long-term care, and program initiatives that will provide a national family caregiver support system.

HHS performance goals that are representative of HHS efforts under this initiative are:

Increase the number of children who are enrolled in Medicaid or the State Children's Health Insurance Program by one million children. *HCFA Plan*

Through the Maternal and Child Health Block Grant, increase the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program to 80 percent. *HRSA Plan*

Improve child and family health by increasing the proportion of American Indian and Alaskan Native children receiving a minimum of four well child visits by 27 months of age by 3 percent over the FY 2000 target (3 percent over the FY 1999 baseline of XX). *IHS Plan*

Reduce the percentage of improper payments made under the Medicare fee-for-service program to 6%. *HCFA Plan*

Support Children and Families

The FY 2001 HHS budget strengthens the family by helping Americans better balance the demands of work and parenthood. This will be achieved by providing access to safe, affordable child care, increasing child support collections, getting more resources to families, and directing support to family caregivers.

This initiative includes a variety of program proposals. The child care initiative attempts to make affordable, high quality child care even more accessible for working families. Under current funding levels, the program reaches only 10 percent of the eligible population. This is done by increasing the Child Care and Development Fund as well as creating the Early Learning Fund.

The FY 2001 budget includes a proposal to build on the success of the child support enforcement program and increase child support collections. It will direct funds to low income families by giving states the option to adopt simplified rules that govern distribution of child support collections. It also proposes to provide limited Federal matching funds for child support collections that states pass-through to families on assistance.

Two proposals are focused on low income children: an increase in funds for Head Start and an initiative that would provide demonstration grants to States to test innovative asthma disease management techniques for children enrolled in Medicaid. The FY 2001 budget also includes an increase in the level of support for the Children's Hospitals Graduate Medical Education and an increase in the funds available to expand the capacity to treat individuals who use and are addicted to illegal drugs.

HHS performance goals for FY 2001 that are representative of HHS efforts under this initiative are:

Increase the percentage of Head Start children who receive necessary medical treatment to 92 percent. *ACF Plan*

Increase the Child Support Enforcement Program collection rate for current support due to 71%. *ACF Plan*

Create a Healthier America

The FY 2001 budget for HHS promotes healthy living and provides health services for more Americans. It addresses many of our greatest public health challenges, including ensuring a safe food supply, and tracking emerging infectious diseases and bioterrorist threats. It focuses on prevention of HIV/AIDS and unwanted pregnancies, provides treatment for substance abuse and mental health, and eliminates health disparities among racial and ethnic minorities.

Proposals included in this budget involve a HIV prevention initiative and investment of additional funds in the Ryan White Program. It responds to the recently released Surgeon General's Report on Mental Health by increasing funds for the Mental Health Block Grant as well as funds for Youth Violence Prevention activities.

The budget proposes an increase in funds to prevent emerging infectious diseases and bioterrorism. These dollars will further develop a national disease surveillance system that can rapidly detect the infectious disease cases that signal the beginning of an outbreak and to respond to medical and public health consequences of a bioterrorist event.

Proposals are included for additional funds for family planning and to make significant investments in the public health infrastructure. The latter includes funds for construction of laboratory facilities. In addition, the FY 2001 budget highlights the elimination and reduction of health disparities among racial and ethnic minorities and expansion of efforts to provide quality care to Native Americans. This initiative proposes an increase in funds for environmental health research in CDC.

HHS performance goals for FY 2001 that are representative of HHS efforts under this initiative are:

Decrease the number of newly reported AIDS cases in children as a result of perinatal transmission to 193. *CDC and HRSA Plan*

Measure trends in rates of HIV transmission. (Placeholder) *CDC Plan*

Measure trends in long-term HIV/AIDS survival rates. (Placeholder) *CDC Plan*

Assure access to preventive and primary care through the Health Centers for minority (65%), low income (86%), and uninsured (45%) individuals. *HRSA Plan*

Decrease proportion of Health Center users who are hospitalized for potentially avoidable conditions to 13 per 1000. *HRSA Plan*

Increase the percentage of children receiving mental health services through the Comprehensive Community Mental Health Services for Children and Their Families program who attend school most of the time to 95 percent. *SAMHSA Plan*

Through a Departmental initiative led by CDC, FDA, SAMHSA and OPHS, reduce tobacco use among minors to 35.9 percent in FY 2001. *CDC Plan*

Increase to between 63 and 68 the number of state and major city health departments with expanded epidemiology and surveillance capacity to investigate and mitigate health threats by bioterrorism. *CDC Plan*

Advance Scientific Research

Future scientific advancements depend on a commitment to strategic investments made today. The FY 2001 budget continues the Administration's commitment to protect public health and promote scientific expertise by investing in biomedical science and health care quality research.

Three program proposals are included in the HHS 2001 budget that relate to this initiative area. It calls for an increase of funding for research at the National Institutes of Health to develop treatments and new prevention strategies for the many diseases and disabilities that affect the Nation's health. This proposal will also place renewed emphasis on research to address domestic and international health disparities that may be associated with race, ethnicity, gender, or socioeconomic status.

The FY 2001 budget includes an increase of funds for the Food and Drug Administration to reduce medical errors and adverse events and for funds for the Agency for Healthcare Research Quality to conduct research directed toward reduction of medical errors. It also emphasizes the importance of efforts to ensure a safer national food supply and to reduce the number of deaths and sicknesses from foodborne illnesses. These efforts involve the FDA, the Centers for Disease Control and Prevention, and the US Department of Agriculture.

HHS performance goals for FY 2001 that are representative of HHS efforts under this initiative are:

Develop new or improved approaches for preventing or delaying the onset or progression of disease and disability. *NIH Plan*

Funding a minimum of 20 projects in: 1) reducing medical errors and enhancing patient safety; 2) informatics applications in health care; and 3) worker safety and health care for workers. *AHRQ Plan*

Increase to 55 percent the proportion of reported foodborne outbreaks in which the food that caused the outbreak is identified. *CDC Plan*

FY 2001 PROGRAMS, INITIATIVES, STRATEGIES, AND PERFORMANCE GOALS THAT SUPPORT THE HHS STRATEGIC PLAN

The HHS Strategic Plan identifies six long-range strategic goals that support HHS' mission to enhance the well-being and health of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services. Each strategic goal is supported by strategic objectives that focus on the strategies that HHS will utilize to achieve the strategic goal. These long-range, strategic goals and objectives serve as the performance management framework of the Department.

This section of the HHS Performance Plan Summary illustrates how the strategies, goals, and measures in the FY 2001 Performance Plans and Budgets of the HHS Operating Divisions link together to support the achievement of HHS' long-range strategic goals and objectives. For each HHS strategic objective, this section provides key performance strategies for FY 2001, selected FY 2001 goals and measures that will indicate progress towards achieving the objective, and a list of all HHS programs that support the objective.

Please note that this is a summary document: The HHS Operating Divisions' FY 2001 Performance Plans and Budgets, both of which are important to understand performance planning in HHS, contain detailed performance information for HHS' approximately 300 program activities as required under GPRA. These documents contain a complete listing of HHS' goals and measures, detailed discussions of program performance, information on the means and strategies that will be used to achieve the goals, linkage to the operating division's budget, data verification and validation, and discussions of cross-cutting programs.

HHS Goal 1: REDUCE THE MAJOR THREATS TO THE HEALTH AND PRODUCTIVITY OF ALL AMERICANS

From the HHS Strategic Plan, September 1997. Good health lies at the heart of the nation's well-being. A healthy work force is more productive; a healthy student body is ready to learn; and a healthy people is able to build a better society. Individual behavior, education, equality of opportunity, social and physical surroundings, the economy, and access to health care are all elements crucial to health, and therefore offer opportunities to promote good health.

Research has established that the major behavioral factors contributing to premature death are tobacco, diet and activity patterns, alcohol, injuries, sexual behavior, and illicit drug use. Collectively, these account for 50 percent of all premature deaths each year in the United States. In addition, unintentional injuries, suicides, and homicides account for 30 percent of all years of potential life lost under the age of 65.

Investments in programs that are effective in reducing or eliminating these behavioral threats pay off heavily in improved health and productivity of the American people. The results—better health for individuals and longer life spans—are highly valued by the public. Of the strategies developed by the Department of Health and Human Services (HHS) for reducing behavioral threats to health, most employ a combination of research, prevention, public education, and regulation. All involve multiple components of the Department and rely heavily on partnerships with other levels of government and the private sector, including academic institutions, voluntary associations, and advocacy groups. To reflect our growing understanding of the importance of social and environmental factors for health status, the Department strives to create partnerships with organizations from those sectors. Special efforts are made to target vulnerable populations, including youth, the elderly, women, minorities, and individuals with disabilities. To integrate our activities, the Department has established a conceptual model for the nation—*Healthy People*—that sets an agenda for prevention programs in the public and private sectors and guides our selection of ten-year targets. The objectives and strategies described below, based on research findings and developed in partnership with national health organizations, will contribute to achieving specific Healthy People objectives in the year 2000 and will build a foundation for achieving a new set of Healthy People objectives in the year 2010.

HHS 1.1: Reduce Tobacco Use, Especially Among Youth

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

FDA – Tobacco. FDA will increase the number of compliance checks performed at retail outlets to ensure that retailers are complying with the rule not to allow children and teenagers to purchase cigarettes and smokeless tobacco products. Full implementation of FDA's rule will eliminate certain forms of advertising that are especially appealing to young people. The outreach efforts will increase the number of retailers who receive information from FDA. This information is targeted to help retailers understand their responsibilities under FDA's tobacco rule and ultimately comply with the requirements that prohibit sales to children and teenagers. The U.S. Supreme Court is reviewing FDA's rule. The age and identification provisions of the rule are the only provisions in effect pending the Supreme Court's final decision, expected by the summer of 2000.

SAMHSA – Through its **Substance Abuse Prevention and Treatment (SAPT) Block Grant**, SAMHSA administers the **Synar Amendment** which requires State legislative and enforcement efforts to reduce the sale of tobacco products to minors. SAMHSA provides assistance to States in enforcing their laws and inspecting outlets to measure the level of retailer compliance with tobacco sales reduction.

HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports prenatal care programs that encourage healthy maternal behaviors, including risk reduction behaviors, especially for alcohol, tobacco, and substance abuse.

HRSA – Health Centers and the National Health Service Corps (NHSC). HRSA will reduce racial disparity for patients in communities with the highest morbidity and mortality rates for minority populations. Activities will focus on preventive services and reduction of risk factors contributing to the conditions, including provision of smoking cessation counseling.

CDC – **Heart Disease and Health Promotion, Preventing Tobacco Use**. CDC will expand upon the current infrastructure of state-based tobacco control, by expanding resources available to localities to prevent tobacco use. State-of-the-art training and technical assistance will also be expanded nationwide to further empower local governments, schools, coalitions, and national organizations to develop effective initiatives and programs.

IHS – Prevention, Health Education. IHS assists its local partners to engage in community-based prevention initiatives which address HIV/AIDS risk behavior, violence, child abuse, physical inactivity, nutrition, alcohol and substance abuse and tobacco use and cessation.

NIH – Nicotine Research. Nicotine addiction is the root cause of one of the deadliest and most costly public health problems–use of tobacco products. NIH will continue to provide

scientific leadership in combating nicotine addiction. NIH will support research on the treatment of nicotine addiction by focusing on the development of nicotine and non-nicotine replacement medications in combination with behavioral strategies. NIH will expand its initiative to develop trans-disciplinary research centers focusing on prevention, development and treatment of nicotine addiction and tobacco related cancers. NIH has also launched an Adolescent Tobacco Treatment Research Clinic. Nicotine replacement therapy, using the patch and gum, has been shown to be effective in assisting adult smoking cessation, but only one study to date has been reported for nicotine replacement therapy in adolescents.

OPHS – To prevent the abuse of tobacco, alcohol and other drugs by youth, OPHS promotes partnerships with parents and other caregivers, teachers, coaches, clergy, health professionals, and business and community leaders. Through the Smoke-Free Kids partnership with US Soccer, OPHS coordinates the dissemination of a national program promoting participation of adolescents in soccer as a way to reduce risk of tobacco use. Also, OPHS assists in the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use, supports and disseminates scientific research and data on the consequences of legalizing drugs, and promotes other similar activities. Girl Power activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

OPHS – In 1999, the Surgeon General will issue a report on Reducing Tobacco Use, which describes effective community-based tobacco control programs. A second report on Women and Tobacco will be issued during 2000. This report will provide an update of the 1980 first Surgeon General's report on women and tobacco including issues related to maternal smoking.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Reduce the percentage of teenagers (in grades 9-12) who smoke by conducting an educational campaign, providing funding and technical assistance to state programs, and working with non-governmental entities. *CDC Plan*	FY 01: 35.9% FY 99: 36.4%	FY 01: FY 99: 2000 FY 97: 36.4% FY 95: 34.8% FY 93: 30.5% FY 91: 27.5%
Proportion of mothers who smoke during pregnancy. *OPHS Plan*	FY 01: 9% FY 00: 10% FY 99: 12%	FY 01: FY 00: FY 99: FY 98: FY 97: 13.2%

Performance Goals	Targets	Actual Performance
Increase the number of compliance checks conducted and select certain sites to target for intensified enforcement efforts to determine the effectiveness of different levels of effort. *FDA Plan*	FY 01: 228,000 FY 00: 200,000 FY 99: Enter into contracts with all 50 states to conduct an average of 16,500 unannounced compliance checks each month of retail establishments that sell tobacco products.	FY 01: FY 00: FY 99: Exceeded contracting goals by signing contracts for compliance checks in all 50 States and 3 Territories in FY 2000. Conducted on average approximately 9,000 compliance checks per month, approximately 107,200 in FY 99. FY 98: FDA contracted with 43 states and territories for 188,894 compliance checks. The states and territories conducted 40,234 compliance checks in FY 98. FY 97: Under a pilot program, FDA contracted with 10 states and conducted 6,464 compliance checks.
Increase number of States whose rate of tobacco sales to minors violations is at or below 20%. *SAMHSA Plan*	(FY 03: All States) FY 01: 30 States FY 00: 12 States FY 99: 8 States	FY 01: 6/01 FY 00: 6/00 FY 99: 21 States FY 98: 12 States FY 97: 4 States (baseline)
Develop at least five regional tobacco control centers to assist AI/AN health facilities and organizations with tobacco prevention and cessation activities. *IHS Plan*	FY 01: Establish five tobacco control centers FY 00: establish baseline rates for tobacco usage	FY 01: FY 00:

PROGRAMS SUPPORTING THIS OBJECTIVE

CDC
Heart Disease and Health Promotion
FDA
Tobacco
HRSA
Primary Care
Maternal and Child Health Block Grant
IHS
Prevention

NIH
Research Program
OPHS
Healthy People 2000
Office on Women's Health
SAMHSA
Knowledge Development and Application
Targeted Capacity Expansion
High Risk Youth
National Data Collection State Infrastructure
Substance Abuse Block Grant

HHS 1.2: Reduce the Number and Impact of Injuries

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

SAMHSA - The **School Violence Prevention Initiative** is designed to increase opportunities for a range of communities, and in particular ethnic and cultural minority communities, to implement comprehensive school and community violence prevention plans and services. With increased funding in 2001, the Center for Mental Health Services will support 18-25 additional school districts through the Safe Schools/Healthy Students program. This program is based on six core, mandatory activities: school safety; prevention of, and early intervention, violent behavior and alcohol and drug use; school and community mental health preventive and treatment intervention services; early childhood psychosocial and emotional development programs; educational reform; and safe school policies. Through this initiative, SAMHSA hopes to decrease the rate of violence in the schools and increase the percentage of mental health activities actually implemented in schools.

CDC – Injury Prevention and Control. The National Center for Injury Prevention and Control (NCIPC) works to prevent premature death and disability through: extramural and intramural research, developing, evaluation, and implementing prevention programs, assisting State and local health jurisdictions in their efforts to reduce injuries, and conducting prevention activities in partnership with other Federal and private-sector agencies. Evaluation of intervention programs is a key component of CDC's overall strategy to discover what works and determine how best to deliver programs to the American people. Priority areas for FY 2001 include:

Traumatic Brain Injury (TBI). CDC will continue working toward effective prevention programs for TBI by developing a uniform reporting system; funding research; supporting State health department prevention projects; promoting public awareness of TBI; and evaluating the use of registries to improve the quality of life for persons with TBI.

Youth Violence Prevention. CDC funds projects to evaluate effective interventions for preventing and reducing aggressive behavior among youth. The majority of the projects emphasize primary prevention and are cooperative efforts among schools, health departments and community partners. Several projects have been funded across the country which have looked at a broad range of promising interventions including peer mediation, conflict resolution training, mentoring, role playing, and efforts to improve parenting skills. These interventions will serve as the framework for developing performance measures aimed at reducing the incidence of youth violence.

Intimate Partner Violence. CDC funds projects to determine how effective specific prevention or intervention programs, or combinations of these programs, are in preventing intimate partner violence and sexual assault. The expansion of this program will broaden the population-base receiving the interventions which will lead to greater knowledge of modifiable

risk factors and consequences associated with the development of effective prevention and intervention strategies for intimate partner violence and sexual assault.

Bicycle Helmet Usage and Head Injury Prevention. CDC works to prevent these injuries and deaths by developing and disseminating injury control recommendations on bicycle helmets; collaborating with the National Highway Traffic Safety Administration, other federal agencies, private and voluntary agencies to promote helmet use and bicycle safety; and providing grants to state health departments to implement and evaluate programs that promote helmet use. In 1994, CDC began funding programs to promote helmet use within funded communities.

Fire-Related Injury Prevention. CDC works to prevent these needless deaths by conducting, coordinating, and funding fire and burn prevention research and interventions at the state, local, and community levels, and collaborating with the Consumer Product Safety Commission, U.S. Fire Administration, other federal agencies, private and voluntary agencies on developing recommendations for conducting and evaluating smoke detector programs.

IHS – Prevention, Injury Prevention. IHS collaborates with tribes and other Federal, State, and local agencies in efforts to reduce the incidence of severe injuries, with special emphasis on primary prevention, developing programs on sound epidemiological bases, and funding community-based prevention projects. IHS has developed injury prevention training programs specifically for the community-based practitioner. IHS will also assist tribes in building their capacity and local tribal health infrastructure to develop effective programs to prevent traumatic injuries and death and increase the number of tribal injury prevention programs by as many as 200 projects. The FY 2001 Budget proposes investing in the development of an environmental health data surveillance system which includes the capacity to track the etiology of injuries so that effective interventions can be employed.

FDA – Injury Reporting Initiative. Reduce injuries and illnesses resulting from consumption and use of FDA-regulated products. One of the FDA's primary objectives is to develop and implement a comprehensive surveillance system to improve the quality of information on adverse events and product defects associated with FDA-regulated products. The system will focus on three areas: surveillance and epidemiology; research; and education and outreach. FDA believes this system will increase the safety of FDA-regulated products because more reports of rare and unexpected adverse events and product problems would be discovered and corrective action taken. Systematic feedback about the problem can then be provided to the healthcare community and the public.

HRSA – Maternal and Child Health, Traumatic Brain Injury Program (TBI). The TBI Demonstration Grant Program is designed to improve health and other services for the assessment and treatment of TBI and to emphasize activities by States that implement State-wide systems that ensure access to comprehensive and coordinated TBI services.

HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports injury prevention and domestic violence reduction programs that reduce both accidental and intended injuries, especially to children.

HRSA – Maternal and Child Health, Poison Control Centers. As part of a joint HRSA/CDC initiative, HRSA will support the development and assessment of uniform patient management guidelines to provide consistent, evidence-based protocols nationally. This builds on funding allocated in FY 1999 by CDC, with support from HRSA, to develop a national toll-free telephone number for poison control and initiate a public education campaign to advertise this number.

ACF- Family Violence Prevention and Services/Battered Women's Shelters. This program provides grants to States and Indian Tribes to assist in supporting programs and projects to prevent incidents of family violence, provide immediate shelter and related assistance for victims of family violence and their dependents, and provide resources to programs that offer prevention services for perpetrators. To address the growing need for counseling and other immediate services to existing and underserved populations and locations, funds for battered women's shelters will be increased through the FY 2001 request.

ACF - The **Domestic Violence Hotline** provides crisis intervention by helping callers identify problems and possible solutions, including making plans for safety in an emergency; information about sources of assistance for those wanting to learn more about domestic violence and related issues; and referrals to battered women's shelters and programs, social service agencies, legal programs, and other groups and organizations willing to help. The FY 2001 request will increase funds for the National Domestic Violence Hotline so that persons needing immediate response can get the help they need.

IHS – Prevention, Health Education, and Treatment. IHS screens the treatment population for indication for abuse or neglect and assists its local partners to engage in community-based prevention initiatives which address HIV/AIDS risk behavior, violence, child abuse, physical inactivity, nutrition, alcohol and substance abuse and tobacco use and cessation.

NIH – Research on Treatment for Traumatic Brain and Spinal Cord Injury. Research to develop effective treatments for traumatic brain and spinal cord injuries and to understand the long-term consequences of head injury, especially in children, is an important strategy to reduce the impact of injuries. For example, the National Institute of Neurological Disorders and Stroke is supporting projects that include a clinical trial to test the safety of systemic hypothermia to slow down metabolism and thereby inhibit the cascade of biochemical events that immediately follows a head injury and results in brain cell death or damage. Another project will assess the impact of traumatic brain injury (TBI) in children and adolescents on the other family members and the extent to which recovery from pediatric TBI is influenced by the family environment. A Traumatic Brain Injury (TBI) Rehabilitation Research Network is being developed to address research needs recently highlighted in NIH's Consensus Development Conference entitled "Rehabilitation of Persons with Traumatic Brain Injury." In addition, a multidisciplinary, collaborative program is being planned to develop and assess therapies specifically targeted to the physical, emotional and social needs of children experiencing trauma, including TBI.

OPHS – The Office on Domestic Violence, within the Office of Women's Health, provides HHS-wide coordination and leadership on domestic violence. In addition, OPHS staffs the Advisory Committee on Violence Against Women, a joint Federal Advisory Committee that advises both HHS and the Department of Justice on the issues and needs to successfully prevent and address domestic violence.

HRSA – Primary Care, Health Centers. HRSA's Health Centers are implementing a Family Violence Initiative and plan to add parenting classes, home visiting and abuse prevention services in high risk areas.

HRSA – Maternal and Child Health, Emergency Medical Services for Children (EMSC). EMSC is designed to ensure that all children and adolescents, no matter where they live or where they travel, can receive appropriate care in a health emergency. It seeks to improve all aspects of children's acute emergency medical care, including pre-hospital care, emergency department care, hospital care, and rehabilitation, and to prevent such emergencies from occurring. HRSA will continue systems improvement grants to States in order to fund evaluation, data improvement, and evidence-based research.

CDC – Occupational Safety & Health. The National Institute for Occupational Safety and Health (NIOSH), in CDC, conducts a national program of biomedical research in occupational safety and health. NIOSH's corps of multi-disciplinary teams comprising engineers, epidemiologists, industrial hygienists, physicians, and toxicologists perform five basic public health functions to improve the safety and health of workers: (1) determines the nature and extent of the occurrence and causes of work injuries and diseases to target research and prevention activities; (2) detects and investigates workplace health and safety problems, identifying their causes and effects; (3) conducts studies and demonstrations to identify effective engineering solutions, personal protective equipment, work organization and practices, and health communications strategies to prevent work injuries and diseases; (4) develops and disseminates recommendations for assuring the safety and health of workers; and (5) provides leadership and training in occupational safety and health, establishing national research agendas to leverage the impact of government and private sector resources, and training professionals and scientists.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Reduce the number of unintentional injuries for AI/AN people. *IHS Plan*	**Hospitalizations** FY 01: 70.0/10,000 FY 00: 71.5/10,000 **Deaths** FY 99: 93/100,000	FY 01: FY 00: FY 99: 12/00 FY 98: 72.5/10,000 FY 96: 74.7/10,000 FY 99: 12/02 FY 94-96: 92.6/100,000 FY 92-94: 95.0/100,000
Increase the use of bicycle helmets by child bicyclists in CDC-funded project areas. *CDC Plan*	FY 01: 25% increase FY 00: 25% increase FY 99: 30% increase	FY 01: FY 00: FY 99: 4/00 FY 98: California + 83%. Colorado + 16% Florida + 3% Oklahoma +214% Rhode Is. + 15%
The incidence of residential fire-related deaths will be reduced. *CDC Plan*	FY 01: 1.1/100,000 FY 00: 1.1/100,000 FY 99: 1.1/100,000	FY 01: FY 00: FY 99: 2000 FY 97: 1.1/100,000 FY 94: 1.4/100,000
Recruit additional hospitals into the MedSun System (Medical Device Surveillance Network) for injury reporting that uses improved data format and collection methods to enhance the validity and reliability of data provided, thus affording a higher level of public health protection. *FDA Plan*	FY 01: Over 200 additional hospitals FY 00: Develop MedSun based on approximately 75 to 90 representative user facilities. FY 99: N/A	FY 01: FY 00: FY 99: Pilot completed FY 98: Recruited 24 pilot facilities

Performance Goals	Targets	Actual Performance
Increase percentage of IHS, Tribal and Urban programs that have implemented a suicide surveillance system to monitor the incidence and prevalence rates of suicidal acts (ideation, attempts, and completions) which assures those at risk receive services, and that appropriate population-based prevention interventions are implemented. *IHS Plan*	FY 01: 50%	FY 01: FY 00: FY 99: FY 98: 25% est.
Proportion of injurious suicide attempts among youth ages 14-17. *OPHS Plan*	FY 01: 1.6 FY 00: 1.8 FY 99: 2.0	FY 01: FY 00: FY 99: FY 98: FY 97: 2.6% FY 94: 2.8%
Violent victimization inflicted by intimate assailant. *OPHS Plan*	**Women** FY 01: FY 00: 7/1,000	FY 01: FY 00: FY 99: FY 98: FY 92: 4.5/1000
Increase the percentage of IHS, Tribal, and Urban medical facilities with Urgent Care or Emergency departments or services that have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (i.e., child, spouse, and/or elderly). *IHS Plan*	FY 01: 80% FY 00: 70% FY 99: 60%	FY 01: FY 00: FY 99: 64% FY 98: 47%
Increase the number of Federally recognized Indian Tribes that have family violence prevention programs. *ACF Plan*	FY 01: 189 FY 00: 174 FY 99: 162	FY 01: FY 00: FY 98: 174 FY 96: 120

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Family Violence Prevention and Services/Battered Women's Shelters
Domestic Violence Hotline
CDC
Injury Prevention and Control
Occupational Safety & Health
FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant

Emergency Medical Services for Children
Traumatic Brain Injury Program
Poison Control Centers

IHS
Prevention

NIH
Research Program

OPHS
Office on Women's Health
Office of the Surgeon General

HHS 1.3: Improve the Diet and the Level of Physical Activity of Americans

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

CDC – Chronic Disease Prevention. CDC is taking a crosscutting approach to address the burden of heart disease and other health risks in the U.S. through the prevention of risk factors (e.g., tobacco use, physical inactivity, and poor nutrition), surveillance, epidemiologic research, and health promotion activities. Cardiovascular disease is the leading cause of death in all states; CDC is implementing this approach to heart disease and stroke prevention by building state-specific capacity for cardiovascular health promotion, first in those states with the greatest heart disease and stroke burden. In subsequent years, efforts will expand to create capacity in all states and territories in order to build a nationwide cardiovascular health program..

CDC – Environmental Disease Prevention. CDC has laid a foundation for a national campaign to encourage folic acid consumption by all women of reproductive age by conducting communication research needed to develop an effective campaign to increase the consumption of supplemental folic acid. The next step is to encourage implementation and evaluation of state and local programs to conduct educational campaigns targeted to local women of reproductive age, and to make folic acid awareness a part of the delivery of preventative health care services to women. Hispanic women will be specifically targeted to reduce their disparate, increased risk for these serious birth defects.

HRSA – Primary Care, Health Centers. Many of HRSA's Health Centers currently provide nutrition and fitness counseling. In FY 2001, HRSA will provide Health Center services to focus on disparity reduction, particularly for those communities with the highest morbidity and mortality rates for minority populations. The disparity reduction package will include counseling of patients regarding tobacco, alcohol, and drug use, oral health, fitness, and nutrition.

AoA – Congregate and Home-Delivered Nutrition Services. AoA supports congregate and home-delivered meal programs to increase the nutritional intake of at-risk seniors. Home-delivered meals enable older adults to avoid or delay costly institutionalization and allow them to stay in their homes and communities. Congregate nutrition services also improve participants' health significantly and prevent more costly interventions. In addition, congregate services allow older people the opportunity to engage in social activities that contribute to their well-being.

FDA – Foods, Nutrition Labeling. FDA establishes regulations, policies, and standards for nutrition labeling, dietary supplements and other special nutritional products such as infant formulas and medical foods. Through science-based nutrition policies, FDA provides information to enable consumers to make better dietary choices. To develop the science base for its nutrition policies, the Agency will continue research studies and analysis of scientific

and epidemiological data, to better understand the relationships between diet and disease. The food label serves as a primary tool for producers to provide information to consumers about the food's nutritive value and its ingredients as part of a healthy diet. The Agency will also continue to respond to safety concerns associated with the rapidly expanding use and misuse of dietary supplement products such as ephedra.

IHS – Prevention, Health Education. IHS assists its local partners to engage in community-based prevention initiatives which address HIV/AIDS risk behavior, violence, child abuse, physical inactivity, nutrition, alcohol and substance abuse and tobacco use and cessation.

NIH – Five-a-Day for Better Health Program. This program is a national public/private partnership nutrition education program which approaches Americans with a simple, positive message–to eat 5 or more servings of fruits and vegetables every day. The National Cancer Institute takes the lead in the program by serving as the credible health source, maintaining scientific integrity, funding research in nutritional behavior change, and organizing and providing technical support to the 55 State and territorial health departments in the Five-a-Day infrastructure.

NIH – Interdisciplinary Research on Nutrition. NIH encourages interdisciplinary interaction between basic and clinical research and stresses the links between nutrition and obesity, diabetes, and other chronic conditions. This effort is supported by NIH through: 1) guidance from the NIH Nutrition Coordinating Committee lead by the National Institute of Diabetes and Digestive and Kidney Diseases, 2) a research portfolio of basic investigations that seek to understand the molecular role of nutrients in health and in the prevention and treatment of disease, and 3) eight Clinical Nutrition Research Units and four Obesity/Nutrition Research Centers. The centers provide core resources to a broad base of research investigators. The NIH also supports Nutrition Academic Awards to stimulate the development and enhancement of medical school education programs so that physicians may learn nutrition principles and clinical practice skills for the prevention of cardiovascular diseases, obesity, diabetes, and other chronic disease risks and improved nutritional management of their patients.

AoA – Grants to Indian Tribes. AoA's American Indian, Alaska Native and Native Hawaiian Program awards grants to provide supportive and nutrition services, including both congregate and home-delivered meals to older Native Americans.

OPHS – To improve health behaviors related to physical activity and diet, OPHS works to engage youth, adults, and the elderly in programs to increase physical activity through coordinated activities related to the Presidential Sports Award (for ages 7 to adult) and the President's Challenge Physical Fitness Awards Program (for school-based achievement). In addition, the office engages in partnership activities with prominent organizations such as the National Task Force on the Prevention and Treatment on Obesity, International Year of the Older Persons Subcommittee, Partnership for Prevention, Women's Sport's Foundation, Sears, United States Olympic Committee, Metropolitan Life Insurance Company (MetLife), and National Football League (NFL)/Gatorade Punt, Pass & Kick.

At the grassroots level, OPHS enlists the active support and assistance of individual citizens, civic groups, private enterprise, voluntary organizations, and others in efforts to promote and improve physical activity and fitness of all Americans. OPHS encourages the development of community recreation, physical fitness and sports participation programs. It develops and distributes a range of publications to inform the general public of the importance of exercise and the link which exists between regular physical activity and good health.

OPHS works closely with industry, government, and labor organizations to establish sound physical activity, fitness initiatives, and partnerships in an effort to reduce the financial and human cost resulting from physical inactivity. OPHS has also assisted educational organizations at the national, state, and local levels in developing high quality, innovative, comprehensive health and physical education programs which emphasize the importance of exercise and good health.

GirlPower activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Percent of people aged 18-74 who engage in light to moderate physical activity for at least 30 minutes per day, five or more times a week. *OPHS Plan*	FY 01: 26% FY 00: 30% FY 99: 29%	FY 01: FY 00: FY 99: FY 98: FY 95: 23%
Increase the number of home-delivered meals. *AoA Plan*	FY 01: 166,000,000 FY 00: 155,000,000 FY 99: 119,000,000	FY 01: FY 00: FY 99: 9/01 FY 98: 9/00 FY 97: 123,455,000 FY 96: 119,110,318 FY 95: 119,000,000
Maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites, as part of an overall assessment of the ongoing childhood obesity prevention project's effectiveness. *IHS Plan*	FY 01: implement program and monitor pilots and comparisons sites FY 00: develop five pilot sites FY 99: develop approach and baselines	FY 01: FY 00: FY 99: accomplished

Performance Goals	Targets	Actual Performance
By 2000, increase the percent of women of reproductive age who will be consuming 400 micrograms of folic acid. *CDC Plan*	FY 01: 45% FY 00: 40% FY 99: 35%	FY 01: FY 00: FY 99: Data not available for 1999 (biennial survey) FY 98: 32% FY 96: 25%
Establish model fitness programs at either IHS Area Offices or the I/T/U level. *IHS Plan*	FY 01: 10 sites	FY 01: FY 00: FY 99: FY 98: one site
Increase the proportion of adults who report changing their decision to buy or use a food product because they read the food label. *FDA Plan*	FY 01: 55% FY 00: N/A FY 99: Increase to at least 77% the proportion of people aged 18 and over who use food labels to make nutritious food decisions.	FY 01: FY 00: FY 99: Collaborated with several Federal agencies to develop educational material for educators and consumers on how to use food labels.

PROGRAMS SUPPORTING THIS OBJECTIVE

AoA
Congregate Meals
Home-Delivered Meals
Grants to Indian Tribes
CDC
Chronic Disease Prevention
Environmental Disease Prevention
HRSA
Primary Care, Health Centers
FDA
Foods
IHS
Prevention
NIH
Research Program
OPHS
Office on Women's Health
President's Council on Physical Fitness and Sports
Healthy People, 2010

HHS 1.4: Curb Alcohol Abuse

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

SAMHSA – It has been estimated that only 37% of those who critically need treatment can be served through existing publicly-funded treatment systems. The FY 2001 request proposes

increases for two programs which focus specifically on reducing the treatment gap: 1) the Substance-Abuse Prevention and Treatment (SAPT) Block Grant, which will provide for nationwide expansion of treatment services and aid in the reduction of treatment waiting lists; and 2) the Targeted Capacity Expansion program, which will provide rapid and strategic responses to the demand for alcohol and drug abuse treatment services that are more regional or local in nature.

SAMHSA – State Incentive Grant Program (SIG). Consistent with the HHS focus on community solutions, the FY 2001 budget request supports the transfer of prevention knowledge from prevention studies to application in the States and local communities. The SIG program assists Governors to implement comprehensive science-based prevention practices directed at reducing youth substance abuse (including alcohol), improving access to needed services and reducing the gap in prevention services.

SAMHSA - Effective Alcohol Prevention Strategies for Youth will replicate proven prevention program models demonstrating effectiveness in reducing alcohol use or its precursors among youth ages 5-18. Extending SAMHSA's FY 2000 cross-cutting initiative to a younger population, this component will ask grantees to replicate one of five identified effective models in diverse settings and with diverse populations. Programs will lead to refinements in models for specific populations, prevention standards and guidelines for best practices, and implementation of effective, science-based strategies by Block Grant and other Federal, State and publicly funded prevention programs.

The second component will build on SAMHSA/CSAP FY 2000 and prior programs by supporting the application, through community programs supported by CSAP's State Incentive Grants, of prevention approaches found effective in its Children of Substance Abusing Parents (COSAP) program which ends in FY 2000. The proposed program will expand the availability of best practices in preventing underage drinking problems among youth with specific vulnerabilities to alcohol-related problems in three age groups: age 6-8; age 9-11; and age 12-14.

HRSA – Primary Care, Health Centers. In FY 2001, HRSA will provide Health Center services to focus on disparity reduction, particularly for those communities with the highest morbidity and mortality rates for minority populations. The disparity reduction package will include expanding the counseling of patients regarding tobacco, alcohol, and drug use, oral health, fitness, and nutrition.

IHS – Prevention, Anti-Drug Abuse Activities. IHS will increase drug-related activities, including treatment, Adolescent Regional Treatment Centers, Community Rehabilitation and Aftercare, Training/Community Education, Health Promotion/Disease Prevention, Navajo Rehabilitation Program Urban Programs, and Contract Health Services.

Program improvements will continue to focus on the needs of alcohol and substance abusers who have a history of sexual abuse and on a redesigned community mobilization effort that will provide innovative treatment dn prevention modules targeting communities that have high

rates of alcoholism and drub abuse. In addition, IHS efforts will be responsive to changing drug use patterns, such as the increase in methamphetamine use in the Billings Area.

OPHS – To prevent the abuse of tobacco, alcohol and other drugs by youth, OPHS promotes partnerships with parents and other caregivers, teachers, coaches, clergy, health professionals, and business and community leaders. Also, OPHS assists in the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use, supports and disseminates scientific research and data on the consequences of legalizing drugs, and promotes other similar activities. Girl Power activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports prenatal care programs that encourage healthy maternal behaviors, including risk reduction behaviors, especially for alcohol, tobacco, and substance abuse.

NIH – Adolescent Alcohol Abuse Research. The prevalence of alcohol abuse among adolescents has increased NIH's emphasis on the development of new prevention and treatment strategies against alcoholism and alcohol abuse. The NIH has identified a variety of initiatives associated with its focus on adolescents and youth. These initiatives include soliciting studies that will provide a scientifically-informed basis for developing effective adolescent treatment strategies, including consideration of different cultural and gender needs. Such studies might, for example, contrast integrated treatment regimens designed to address the gamut of adolescent lifestyle issues with more traditional treatment programs. Other areas of special interest include identifying alcohol-induced physiological and behavioral changes unique to adolescents, implementing recommendations from the College Drinking Subcommittee, studying mechanisms of youth alcohol abuse, identifying strategies for preventing alcohol sales to underage persons and preventing alcohol use among young adolescents.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Proportion of youth not using alcohol or any illicit drugs during the past 30 days. Use of alcohol or any illicit drug among youth ages 12-20. *OPHS Plan*	FY 01: 78.2% FY 00: -- FY 99: -- FY 97: 77%	 FY 97: 77% FY 96: 78% FY 95: 75% FY 94: 76%

Performance Goals	Targets	Actual Performance
Maintain the rates and intensity of follow-up for adolescents discharged from IHS supported Regional Treatment Centers and assure abstinence. *IHS Plan.*	**Abstinence** FY 01: + 3% over FY 00 FY 00: establish baseline **Follow-up Rates** FY 01: FY 00 or higher FY 00: +10% over FY 99 FY 99: establish baseline	FY 01: FY 00: FY 01: FY 00: FY 99: 64.5% 30 days 55.2% 6 months 40.9% 12 months
Increase number of States that incorporate needs assessment data into block grant application. *SAMHSA Plan.*	FY 01: 38 States FY 00: 34 States FY 99: 27 States	FY 01: TBR 6/01 FY 00: TBR 6/00 FY 99: 26 States FY 94: 13 States
Increase in the percent of adults receiving services who: – were currently employed or engaged in productive activities – had no/reduced involvement with the criminal justice system – experienced no/reduced alcohol or illegal drug related health, behavior, or social consequences – had no past month substance abuse (developmental). *SAMHSA Plan*	FY 01: TBD FY 00: New in 2001 FY 99: New in 2001	FY 01: FY 00: Baseline 11/01 FY 99:
Increase in the percent of children under 17 receiving services who: – were attending school – were residing in a stable living environment – had no/reduced involvement in the juvenile justice system – had no past month use of alcohol or illegal drugs – experienced no/reduced substance abuse related health, behavior, or social consequences (developmental). *SAMHSA Plan*	FY 01: FY 00: New in 2001 FY 99: New in 2001	FY 01: FY 00: Baseline 11/01 FY 99: N/A

PROGRAMS SUPPORTING THIS OBJECTIVE

HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
IHS
Treatment
Prevention
NIH
Research Program
OPHS
Healthy People 2000
Girl Power
Office on Women's Health
SAMHSA
Knowledge Development and Application
Targeted Capacity Expansion
High Risk Youth
National Data Collection State Infrastructure
Substance Abuse Prevention and Treatment
Block Grant

HHS 1.5: Reduce the Illicit Use of Drugs

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

SAMHSA – The Targeted Capacity Expansion program. The TCE program supports a two-prong strategy to reduce/eliminate substance abuse and its related problems. First, the State Incentive Grant (SIG) Program extends ability of the Center for Substance Abuse Prevention (CSAP) to help States improve their prevention service capacity. Funding enables States to examine their state prevention systems, and create Statewide networks of public and private organizations to extend the reach of the primary prevention portion of the SAPT Block Grant and optimizing the application of State and Federal substance abuse funding streams. Eighty-five percent of SIG funds are directed toward implementing best practices within local programming to target prevention service needs within their states and reduce the gap in prevention services. In this way, SIG funds not only help improve access to needed services, they also improve the quality of the prevention services provided. Second, the five Centers for the Application of Prevention Technologies (CAPTS) and the U.S.-Mexico Border CAPT support the SIGs, other States and their communities by transferring research-based knowledge and delivering tailored technical assistance, training, and supportive materials to meet the unique needs of communities and States in their respective geographical areas.

HRSA – Primary Care, Health Centers. In FY 2001, HRSA will provide Health Center services to focus on disparity reduction, particularly for those communities with the highest morbidity and mortality rates for minority populations. The disparity reduction package will include counseling of patients regarding tobacco, alcohol, and drug use, oral health, fitness, and nutrition.

IHS – Prevention, Anti-Drug Abuse Activities. IHS will increase drug-related activities, including treatment, Adolescent Regional Treatment Centers, Community Rehabilitation and Aftercare, Training/Community Education, Health Promotion/Disease Prevention, Navajo Rehabilitation Program Urban Programs, and Contract Health Services.

  Program improvements will continue to focus on the needs of alcohol and substance abusers who have a history of sexual abuse and on a redesigned community mobilization effort that will provide innovative treatment dn prevention modules targeting communities that have high rates of alcoholism and drub abuse. In addition, IHS efforts will be responsive to changing drug use patterns, such as the increase in methamphetamine use in the Billings Area.

NIH – Multi-disciplinary Research on Prevention and Treatment of Drug Abuse. NIH's multi-disciplinary research program covers all aspects of drug abuse prevention and treatment. Research is the lynchpin of efforts to educate and enable America's youth to reject drugs and to decrease the health and social cost of drugs to the American public. Although we now understand clearly that drug addiction is a treatable brain disease, there still exists a tremendous gap between what science tells us about the nature of addiction and the

application of these findings by people in a wide variety of communities. To close this gap, we must capitalize on the variety of effective addiction treatments that have been developed as part of NIH-sponsored research. NIH's FY 2001 initiatives related to drug abuse addresses the following areas: prevention, nicotine, methamphetamine and fetal methamphetamine, genetics of addiction, medication and behavioral therapies, neurochemistry of addiction, neuroimaging, and understanding and preventing relapse. In addition, NIDA will continue to expand its Treatment Clinical Trials Network, which improves drug addiction treatment by rapidly and efficiently testing the effectiveness of behavioral and pharmacological treatments in real life settings.

OPHS – To prevent the abuse of tobacco, alcohol and other drugs by youth, OPHS promotes partnerships with parents and other caregivers, teachers, coaches, clergy, health professionals, and business and community leaders. Also, OPHS assists in the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use, supports and disseminates scientific research and data on the consequences of legalizing drugs, and promotes other similar activities. Girl Power activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports prenatal care programs that encourage healthy maternal behaviors, including risk reduction behaviors, especially for alcohol, tobacco, and substance abuse.

CDC – HIV/AIDS Prevention. CDC provides HIV prevention funding to state and local health departments and education agencies, community-based organizations, minority-based organizations, national organizations, universities, and hospitals targeted to populations at high risk for HIV, including injecting drug users. In FY 2000, CDC will be embarking on an aggressive effort to ensure that all persons infected with HIV know their serostatus.

HCFA – Medicare and Medicaid. Various forms of drug abuse treatment are provided for both Medicaid and Medicare beneficiaries. Under Medicaid, States must pay for the inpatient, outpatient, and physician services for eligible persons, and (at the States' option), clinic and rehabilitative services. Medicare-eligible individuals requiring drug abuse treatment can receive all covered hospital and some non-hospital services necessary to treat their condition. Medicare primarily covers inpatient hospital treatment of episodes of alcohol or drug abuse, as well as some medically reasonable and necessary services in outpatient settings for the continued care of these patients.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
The number of AIDS cases related to injecting drug use will be decreased from the 1997 base of 15,700 cases diagnosed.* *CDC Plan* *Note: Changes in baseline data from 1995 (in FY 1999) to 1997 (in FY 2000) reflects adjustments in AIDS case definitions, and availability of more accurate data.	FY 01: Decrease by 10% from FY 2000 target of 14,130 cases diagnosed. FY 00: 10% decrease from the 1997 base of 15,700 cases diagnosed. FY 99: 15% decrease from the 1995 base of 17,800 cases diagnosed.	FY 01: FY 00: FY 99: 5/00 FY 97: 15,700 cases (numbers represent diagnosed cases adjusted for reporting delay with risk redistributed).
Proportion of youth not using alcohol or any illicit drugs during the past 30 days. Use of alcohol or any illicit drug among youth ages 12-20. *OPHS Plan*	FY 01: 78.2% FY 00: -- FY 99: -- FY 97: 77%	FY 97: 77% FY 96: 78% FY 95: 75% FY 94: 76%
Maintain the rates and intensity of follow-up for adolescents discharged from IHS supported Regional Treatment Centers and assure abstinence. *IHS Plan*	**Abstinence** FY 01: + 3% over FY 00 FY 00: establish baseline **Follow-up Rates** FY 01: FY 00 or higher FY 00: +10% over FY 99 FY 99: establish baseline	FY 01: FY 00: FY 01: FY 00: FY 99: 64.5% 30 days 55.2% 6 months 40.9% 12 months
Increase in the percent of adults receiving services who: – were currently employed or engaged in productive activities – had no/reduced involvement with the criminal justice system – experienced no/reduced alcohol or illegal drug related health, behavior, or social consequences – had no past month substance abuse (developmental). *SAMHSA Plan*	FY 01: FY 00: New in 2001 FY 99: New in 2001	FY 01: FY 00: Baseline 11/01 FY 99:

Performance Goals	Targets	Actual Performance
Increase in the percent of children under 17 receiving services who: – were attending school – were residing in a stable living environment – had no/reduced involvement in the juvenile justice system – had no past month use of alcohol or illegal drugs – experienced no/reduced substance abuse related health, behavior, or social consequences (developmental). *SAMHSA Plan*	FY 01: FY 00: New in 2001 FY 99: New in 2001	FY 01: FY 00: Baseline 11/01 FY 99:

CDC
HIV/AIDS Prevention
HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
IHS
Treatment
Prevention
NIH
Research Program

OPHS
Healthy People 2000
Office of Disease Prevention and Health Promotion
Girl Power
Office on Women's Health
SAMHSA
Knowledge Development and Application
Targeted Capacity Expansion
High Risk Youth
National Data Collection State Infrastructure
Substance Abuse Block Grant

HHS 1.6: Reduce Unsafe Sexual Behaviors

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

CDC – HIV/AIDS Prevention. Research has demonstrated that HIV education in schools can be effective in reducing risk behaviors among youth in school. CDC's efforts to help state and local education agencies implement HIV prevention education programs in schools nationwide include teacher training programs, dissemination of model policies and effective prevention programs, and evaluation technical assistance.

CDC – Sexually Transmitted Diseases (STD). CDC provides national and international leadership through research, policy development, and support of effective services to prevent and control the transmission of STDs and their complications. Specific areas where assistance is provided are: monitoring disease trends; behavioral, clinical, and health services research; education and training; building partnerships for STD prevention; conducting the Infertility Prevention and Syphilis Elimination Initiative.

SAMHSA – The Targeted Capacity Expansion program HIV grant to minority community based organizations will target women, children, adolescents, men who have sex with men, and infected IV drug users. The goal of the program is to decrease substance abuse related HIV infection by integrating substance abuse prevention strategies and HIV prevention strategies. Specific substance abuse treatment outreach programs will provide services to address integrating substance abuse and HIV treatment.

HRSA – Primary Care, Health Centers. All of HRSA's Health Centers provide family planning and STD screening; many have special programs in schools and in the community to reduce teen pregnancy and unsafe sexual behavior.

HRSA – Maternal and Child Health Block Grant, Abstinence Education Program. This program provides formula grants to the States for the purpose of providing abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports the Girl Neighborhood Power program to promote the health and well being of female adolescents between the ages of nine and fourteen, and to prevent the onset of health risk behaviors during their adolescence.

HRSA – HIV/AIDS, HIV Pediatric Grants (Women, Children, Youth). HRSA will improve the infrastructure of comprehensive care services in order to increase the access of HIV/AIDS-affected women, infants, children and youth to a comprehensive, community-based, family-centered system of care.

OPHS/HRSA – Family Planning Program. This program supports a nationwide network of 4,600 clinics and provides reproductive health services to approximately 4.5 million persons each year. In addition to contraceptive services, Title X also supports a broad range of prevention-oriented reproductive health care activities, including counseling, routine gynecological care, hypertension screening, reproductive cancer screening, and testing and treatment for sexually transmitted diseases.

IHS – Prevention, Health Education. IHS assists its local partners to engage in community-based prevention initiatives which address HIV/AIDS risk behavior, violence, child abuse, physical inactivity, nutrition, alcohol and substance abuse and tobacco use and cessation.

NIH – AIDS Research Program. The magnitude of the AIDS pandemic is profound. AIDS has significantly lowered the life expectancy in many nations of Africa, the global epicenter of AIDS. There has been a steep increase of new infections in Sub-Saharan Africa, and burgeoning disease rates also threaten the vast populations of India, Southeast Asia, and China. In the United States, new HIV infections and AIDS-related deaths continue to increase in many sub-populations–among women, racial and ethnic minorities, heterosexuals, adolescents, drug users, and people over 50 years of age. NIH research in this area continues to examine the factors contributing to sexual risk among a range of population groups and to develop effective and appropriate interventions to reduce sexual risk.

OPHS – GirlPower activities work to improve the self esteem of girls and young women so that they adopt healthier lifestyles and reduce their risks for smoking, substance abuse and teen pregnancy.

OPHS – The Adolescent Family Life program supports demonstration projects to develop models aimed at promoting abstinence from sexual intercourse as a means of preventing adolescent pregnancy and sexually transmitted diseases, including HIV, and assisting pregnant and parenting adolescents, their children and their families. The program also funds research projects examining the causes and consequences of adolescent premarital relations, adolescent pregnancy and adolescent parenting.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Reduce the percentage of high school students who have ever engaged in sexual intercourse. *CDC Plan*	FY 01: 45% FY 00: 45%	FY 01: FY 00: FY 99: 06/00 FY 97: 48% FY 95: 53%
Reduce the percentage of currently sexually active high school students who engage in sexual intercourse without a condom. *CDC Plan*	FY 01: 37% FY 00: 37%	FY 01: FY 00: Summer/00 FY 95: 46%
The number of heterosexually-acquired AIDS cases will be decreased from the 1997 base of 11,500 AIDS cases diagnosed.* *CDC Plan* *Note: Changes in baseline data from 1995 (in FY 1999) to 1997 (in FY 2000) reflects adjustments in AIDS case definitions, and availability of more accurate data.	FY 01: Decrease 10% from the FY 00 target of 10,350 FY 00: 10% decrease from the 1997 base of 11,500 AIDS cases diagnosed FY 99: 10% decrease from the 1995 base of 9,300 AIDS cases diagnosed	FY 01: FY 00: FY 99: 6/00 FY 97: 11,500 cases* *Numbers represent diagnosed cases adjusted for reporting delay with risk redistributed.
The number of AIDS cases related to male homosexual contact will be decreased from the 1997 base of 21,300 cases diagnosed.* *CDC Plan* *Note: Changes in baseline data from 1995 (in FY 1999) to 1997 (in FY 2000) reflects adjustments in AIDS case definitions, and availability of more accurate data.	FY 01: Decrease 10% from the FY 00 target of 19,170 FY 00: 10% decrease from the 1997 base of 21,300 cases diagnosed. FY 99: 20% decrease from the 1995 base of 28,600 cases diagnosed.	FY 01: FY 00: 5/01 FY 99: 6/00 FY 97: 21,300 cases diagnosed.
Increase the number of enrolled female clients provided comprehensive services through the HIV Pediatric Grant Program, including appropriate services before or during pregnancy, to reduce perinatal transmission. *HRSA Plan*	FY 01: 15,000 FY 00: 14,470 FY 99: 13,900	FY 01: FY 00: FY 99: 1/01 FY 98: 11,000 FY 97: 9,469

Performance Goals	Targets	Actual Performance
The prevalence of *Chlamydia trachomatis* among women under the age of 25 in publicly funded family planning clinics will be reduced. *CDC and OPHS Plans*	FY 01: < 6%* FY 00: < 6% FY 99: < 6% *prevalence rate	FY 01: 6/02 FY 00: 6/01 FY 99: 6/00 FY 98: 5.4%* FY 96: 9% *median all states
The incidence of gonorrhea in women aged 15-44 will be reduced. *CDC and OPHS Plans*	FY 01: <250/100,000 FY 00: <250/100,000 FY 99: <250/100,000	FY 01: 6/02 FY 00: 6/01 FY 99: 6/00 FY 98: 292/100,000 FY 97: 261/100,000
Achieve and maintain the percentage of high school students who have been taught about HIV/AIDS prevention in school at 90% or greater. *CDC Plan*	FY 01: 90% or greater FY 00: 90% or greater FY 99: 90% or greater	FY 01: FY 00: FY 99: Summer/00 FY 95: 86%
Increase the percentage of U.S. counties that will have an incidence of primary and secondary syphilis in the general population of less than or equal to 4 per 100,000. *CDC Plan*	FY 01: >90% FY 00: >90% FY 99: 85%	FY 01: 6/02 FY 00: 6/01 FY 99: 6/00 FY 98: 90% FY 97: 87% FY 96: 90% FY 95: 81%

PROGRAMS SUPPORTING THIS OBJECTIVE

CDC
HIV/AIDS Prevention
Sexually Transmitted Diseases
HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
Abstinence Education Program
Maternal and Child Health Block Grant
HIV/AIDS, HIV Pediatric Grants
IHS
Prevention

NIH
Research Program
OPHS
Office of Disease Prevention and Health Promotion
Office on Women's Health
Office of Population Affairs
Healthy People 2000
OPHS/HRSA
Family Planning
SAMHSA
Knowledge Development and Application

HHS Goal 2: IMPROVE THE ECONOMIC AND SOCIAL WELL-BEING OF INDIVIDUALS, FAMILIES AND COMMUNITIES IN THE UNITED STATES

From the HHS Strategic Plan, September 1997. Achieving a society in which each person, regardless of age, sex, physical ability, or racial/ethnic background, has the opportunity to lead an economically and socially productive life is central to the Department's vision for the future. Realizing this vision requires that we support strategies that create opportunities for individuals, families, and communities—a responsibility that the Department of Health and Human Services (HHS) shares with other federal agencies, state, local, and tribal governments, and the private sector.

Families, Children and Communities. The Department has identified five important areas in which it has developed strategies to foster the healthy development of children and to strengthen the ability of families to care for them. These areas are economic security, family stability, personal responsibility, healthy development of children, and strong communities.

In addressing these five areas, our guiding principle is to maximize opportunities and reduce barriers to independence and self-sufficiency for those on welfare and for the working poor. Children and adults without adequate income are denied the full benefits of living in our society. Sustained unemployment is discouraging and counterproductive to responsible parenting and citizenship. Our emphasis is on moving families from welfare to work, short-term financial aid coupled with education, training, job services and child care; and gainful employment and quality child care for low-income working families.

In addition, sound growth and development are basic needs if children are to become productive adults and citizens. Recent research has documented the importance of early brain development and preschool experiences on later development. Our Early Head Start, Head Start, and quality child care programs for low-income children are essential to health, early development and school readiness; and child care before and after school and youth development services are necessary to sustain positive effects. Our efforts to promote economic independence and to strengthen families and communities also have a bearing on children's development.

Finally, communities provide the context within which families may function well or poorly. Communities are constantly adapting to social and economic challenges. Dramatic changes in progress require special attention for those who are economically disadvantaged and for distressed communities. The Department, along with the Department of Housing and Urban Development (HUD) and others, is committed to economic development and linking comprehensive community development "place" strategies with comprehensive "people" strategies to help communities to function as a positive factor in the lives of community residents.

People with Disabilities. The Department has also identified significant barriers to independence faced by working-age adults with disabilities (those aged 18–64). People with disabilities typically report that they want to work, but need personal assistance services or devices in order to do so.

Others will not risk working because they cannot afford to lose the health and long-term care coverage they have under Medicaid or Medicare. Thus, while a large majority of working-age people with disabilities (90.7 percent of men and 74.4 percent of women) are in the labor force, that is, they are either employed or looking for work, individuals with functional disabilities are far less likely to be in the labor force (67.3 percent and 52.3 percent, respectively). The Department will work to provide access to health coverage and a wide range of supports for daily living activities needed by people with disabilities to facilitate their participation in the work force and full participation in community life. For those unable to work, the Department will provide similar supports necessary for independent living and integration in the community.

The Aging Population. The paradigm of aging as a state of dependency does not fit today's elderly who want to lead active and independent lives. A new paradigm is needed that recognizes the desire and ability of many seniors to remain engaged in economically and socially productive activities. The Department will support this "active aging" by working to eliminate barriers presented by the current health and social service systems. Doing so calls for adequate community-based and long-term care services for a growing number of elderly who need significant help if they are to continue living independently.

The objectives and strategies that follow set forth the Department's approach to supporting economic self-sufficiency for families with children; fostering safe, stable, and prosperous communities; promoting sound developmental foundations for children; and providing needed assistance for the elderly and persons with disabilities. The Department's efforts will be carried out through partnerships with the private sector and with the state, local, and tribal governments that implement most of its programs.

HHS 2.1: Increase the Economic Independence of Families on Welfare

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

ACF – Temporary Assistance for Needy Families. TANF promotes work, responsibility and self-sufficiency and strengthens families through funding of State-designed and -administered programs that provide support to needy children and move their parents into work.

ACF – Child Care. ACF is again requesting funding for the President's five year initiative to address and expand activities related to three key issues: affordability, quality and availability. These funds will help provide support for working families in their effort to access quality care for their children. These new funds, combined with the child care funds provided through welfare reform, will enable the program to serve 2.3 million children by 2004, an increase of over one million since 1997.

HRSA – Primary Care, Health Centers. Many of HRSA's Health Centers hire and train former welfare recipients from the community as outreach and health promotion workers.

ACF – Refugee Resettlement. ACF helps refugees and Cuban and Haitian entrants who are admitted to the United States to become employed and self-sufficient as quickly as possible by providing cash and medical assistance to refugee households that are not eligible for TANF, Medicaid and SSI during their first months in the United States as well as English language training and employment-related services.

HRSA – Healthy Start. HRSA funds communities to reduce barriers to care, improve perinatal systems, and support private sector partnerships that facilitate welfare to work and community job creation, and reduce racial disparity in health status.

OCR – **Preventing Discrimination in Access to HHS Services**. OCR will work in partnership with ACF and the States to ensure that TANF programs are implemented in a nondiscriminatory manner. An interagency guidance letter was sent to state and local agencies, advocacy organizations, and others explaining civil rights requirements and providing examples of potential discrimination. As the restructuring of welfare agencies proceeds, it is essential that either the civil rights compliance components and/or the methods developed over the past three decades for ensuring that civil rights issues were addressed in program delivery are retained as integral aspects of state and local program implementation and oversight.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
All States meet the TANF work participation targets (the targets are statutory) for FY 2001: *ACF Plan*	**All Families** FY 01: 100% FY 00: 100% FY 99: 100% **Two parent families** FY 01: 100% FY 00: 100% FY 99: 100%	FY 01: FY 00: FY 99: 01/01 FY 98: 100% (baseline) FY 01: FY 00: FY 99: 01/01 FY 98: 66% (baseline)
Increase the percentage of adult TANF recipients and former recipients employed in one quarter of the year who continue to be employed in the subsequent quarter. *ACF Plan*	FY 01: 84% FY 00: 83% FY 99: N/A	FY 01: FY 00: FY 99: 1/01 FY 98: 80%
Increase the number of refugees entering employment through ACF-funded refugee employment services by at least 5% annually. *ACF Plan*	FY 01: 56,885 FY 00: 54,176 FY 99: 51,597	FY 01: FY 00: FY 99: 5/00 FY 98: 52,298 FY 97 46,800 (baseline)
Increase the number of children served by CCDF subsidies from the 1998 baseline average of 1.5 million served per month. *ACF Plan*	FY 01: 2.22 FY 00: 1.92 FY 99: N/A	FY 01: FY 00: FY 99: 5/00 FY 98: 1.53
Increase the number of refugee families (cases) that are self-sufficient (not dependent on any cash assistance) within the first 4 months after arrival by at least 4% annually. *ACF Plan*	CY 01: 6,176 CY 00: 5,938 CY 99: 5,710	CY 01: CY 00: CY 99: 5/00 CY 98: 5,194 CY 97: 5,279 baseline
Increase compliance of state and local TANF agencies and service providers with Title VI, Section 504 and ADA. Measure: Increased number of corrective actions and no violation findings. *OCR Plan*	FY 01: 36 FY 00: 29 FY 99: 16	FY 01: FY 00: FY 99: 23 FY 98: 8

Performance Goals	Targets	Actual Performance
In order to increase access to HHS services for limited English proficient (LEP) persons, OCR will increase the number of HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. Measure: Increased number of corrective actions and no violation findings. *OCR Plan*	FY 01: 153 FY 00: 151 FY 99: 125	FY 01: FY 00: FY 99: 146 FY 98: 98

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Temporary Assistance for Needy Families
Refugee Resettlement
Social Services Block Grant
Child Care
ASPE
Policy Research

HRSA
Healthy Start
Primary Care, Health Centers
OCR
Preventing Discrimination in Access to HHS' Services

HHS 2.2: Increase the Financial and Emotional Resources Available to Children From Their Noncustodial Parents

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

ACF – Child Support Enforcement. ACF will continue to provide direction, guidance technical assistance, oversight, and some services to States' CSE Programs to aggressively enforce payment of legally owed child support, to establish paternities, and to promote the involvement of noncustodial fathers in their children's lives.

Early interventions will be sought through expanding in-hospital based paternity establishment programs and partnering with birth record agencies, pre-natal clinics and other entities, encouraging voluntary acknowledgments, in accordance with the requirements of PRWORA. Focus will be placed on improved enforcement techniques with emphasis on automated mechanisms for enforcement, collections and payments to families.

ACF will continue efforts to broaden parental responsibility, especially the involvement of fathers in the lives of their children through several means: first focusing attention on the positive role fathers have in improving their children's well-being; second, ensuring that the HHS research agendas pay adequate attention to the role of fathers in families and the effects of fathering on children's well-being; third, using positive messages and language regarding fathers and fatherhood in publications and announcements; and, finally, ensuring that HHS's own workforce policies encourage and enable fathers to balance work and family life responsibilities.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Increase the paternity establishment percentage among children born out-of-wedlock. *ACF Plan*	FY 01: 96% FY 00: 96% FY 99: 96%	FY 01: FY 00: FY 99: 3/00*
Increase the percentage of IV-D cases having support orders. *ACF Plan*	FY 01: 76% FY 00: 76% FY 99: 74%	FY 01: FY 00: FY 99: 3/00*
Increase the IV-D collection rate for current support due. *ACF Plan*	FY 01: 71% FY 00: 71% FY 99: 70%	FY 01: FY 00: FY 99: 3/00*

Performance Goals	Targets	Actual Performance
Increase the percentage of paying cases among IV-D arrearage cases. *ACF Plan*	FY 01: 50% FY 00: 46% FY 99: 46%	FY 01: FY 00: FY 99: 3/00*

* ACF is recalculating its baseline based on 1999 performance.

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Child Support Enforcement

HHS 2.3: Improve the Healthy Development and Learning Readiness of Preschool Children

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

ACF – Head Start. ACF plans to increase participation by approximately 70,000 preschool children, infants, toddlers, and their families, moving toward the President's goal of serving 1 million children in Head Start and doubling the size of Early Head Start by 2002.

Early Head Start. ACF will increase the number of infants and toddlers and their families in the Early Head Start program, as well as expanding technical assistance, training, and research to support top quality infant and toddler programs nationwide.

Strengthening Families. An essential part of Head Start is the involvement of parents in parent education, program planning, and operating activities. Many parents serve as members of policy councils and committees. Participation in classes and workshops on child development and staff visits to the home allow parents to learn about the needs of their children and about educational activities that can take place at home.

Partnerships. In keeping with the Department's own vision of strong foundations for children's development that cut across programmatic lines, ACF will continue to expand the ability of Head Start programs to work with others in communities and states across the country on an integrated vision of top quality early childhood services. ACF is identifying and disseminating community models of Head Start-child care collaborations; developing new and stronger links with the Department of Education and local school districts; and strengthening the State Collaboration offices, which support linkages between Head Start and state early childhood and related offices in all 50 states.

ACF – Child Care. ACF will continue to work with State administrators, professional groups, service providers, and others to identify elements of quality in child care and appropriate measures; to inform States, professional organizations, and parents about what constitutes quality in child care; to influence the training of child care workers and accreditation; to improve linkages with health care services, Head Start, and Early Head Start.

IHS – Treatment and Prevention. Through an Interagency Agreement with Head Start, IHS health care consultants and providers prioritize Head Start children for essential services and provide training and technical assistance to Head Start staff at the local level.

HRSA – Primary Care, Health Centers. The Health Centers have mounted a major initiative to increase childhood immunization rates in collaboration with CDC. This initiative has already shown significant progress in nine states.

CDC – Immunizations. The National Immunization Program (NIP) focuses on several major programmatic areas to achieve its goals, including childhood immunization, adult

immunization, and global polio eradication. Although NIP has assistance from many partners, State and local health agencies play a primary role in helping NIP carry out its mission in the United States. State and local health agencies use CDC grant funds for a wide range of activities including hiring staff, conducting surveillance, assessing immunization levels, developing immunization registries, conducting education and outreach, and establishing partnerships with community groups and private sector organizations.

HCFA – Childhood Immunization. Childhood immunization is a key element of the healthy development of preschool children, and is recognized as such by the State Children's Health Insurance Program (SCHIP) and Medicaid. Under SCHIP legislation, States that create a separate SCHIP program must include coverage of the complete series of immunizations. States also are prohibited from imposing co-payments or deductibles on immunization services.

FDA – Drugs, Vaccines. FDA has the responsibility for ensuring that vaccines and related products are safe, effective, and adequately labeled. Vaccines against ten diseases (Hepatitis B, polio, Haemophilus influenzae type b, mumps, measles, rubella, diphtheria, tetanus, pertussis, and chicken pox) are recommended for all U.S. children.

For the past decade, the development of an acellular pertussis vaccine for infant immunization has been a major national goal. FDA has played a major role in developing and standardizing these vaccines. Currently, three acellular pertussis vaccines are licensed for infants (one in 1996 and two in 1997), and several additional acellular vaccines are now under review. FDA anticipates that these vaccines, especially when combined with other routine pediatric vaccines, will replace whole cell pertussis vaccines in the United States. Combination vaccines reduce the number of needle sticks to children and the number of visits to health care providers, and are a current FDA priority. The Agency released a guidance document on combination vaccines this year.

HCFA – State Children's Health Insurance Program and Medicaid. Estimates of the insurance coverage of children in the United States suggest that there are approximately 11 million children under the age of 19 who lack insurance. Research shows that children who lack insurance coverage have access to fewer health services. Insured children are more likely than uninsured children to get preventive and primary health care. Insured children are also more likely to have a relationship with a primary care practitioner and to receive basic preventive services, such as immunizations and well-child checkups. Medicaid and the State Children's Health Insurance Program (SCHIP) have the potential to cover many of the children who currently lack insurance.

SAMHSA – The Starting Early Starting Smart program, a collaborative effort of SAMHSA's three Centers and the Casey Family Program, is generating new empirical knowledge about the effectiveness of integrating substance abuse prevention, substance abuse treatment and mental health services for children ages zero to seven who experience multiple risk factors for substance abuse or mental health problems. More importantly, the projects are measuring the processes being used to provide integrated services in order to understand the role played by specific service designs in program success using a common research design and data collection methodologies.

HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports projects to develop health care delivery programs and health care services for children. It provides the framework and support for newborn screening programs. It also supports the development of coordinated care delivery systems and services for children with special health care needs.

HRSA – Maternal and Child Health, Healthy Start. Healthy Start focuses on the need to strengthen and enhance community systems of perinatal health by helping communities to fully address the medical, behavioral and psychosocial needs of women and infants. The FY 2001 program will provide for a continuing opportunity to reduce factors contributing to infant mortality by adaptation of successful Healthy Start models of intervention in urban and rural communities with high rates of infant mortality, especially among racial/ethnic populations, and to share the lessons learned with States, communities, and academic and professional organizations.

CDC – Lead Poisoning. Exposure to lead is a well-recognized cause of serious cognitive, learning, and behavioral problems in children. Progress continues to be made in reducing childhood lead poisoning, but many children nationwide, especially those who live in large central cities in older housing, continue to be heavily exposed to lead from lead-based paint, dust, and soil. Screening and other lead poisoning prevention approaches are being intensified among children in high-risk populations. In order to more effectively focus screening and follow-up efforts on high-risk children, CDC has updated its screening guidelines, based on new scientific and practical information. This will result in better targeting of prevention efforts and enable prevention programs to use their limited resources more cost-effectively.

HRSA – Maternal and Child Health, Universal Newborn Hearing Screening. This partnership with CDC, NIH, and the Department of Education will promote universal newborn hearing screening prior to hospital discharge thereby greatly lowering the age at which children with congenital permanent hearing loss are identified and increasing the ability of these children to perform on school related measures. HRSA will address critical gaps by supporting grants to the States to develop and expand statewide universal newborn hearing screening programs, link screening programs to intervention within the community service system, monitor the impact of early detection and intervention on child, family, and systems, and provide technical assistance.

NIH – Pediatrics Research. Among new pediatric initiatives are: a new pediatric trauma program as well as extensive new research on birth defects, including utilization of animal models like zebrafish and *Xenopus*, with easy-to-visualize embryos, to shed light on the complex processes that regulate embryonic development, with the ultimate goal of finding ways to prevent and treat birth defects. We are also creating multidisciplinary research centers on birth defects, capitalizing on the skills and knowledge of basic researchers and clinicians. Another initiative will target immune system dysfunction in newborns and young infants, seeking to understand how immunological immaturity and delayed or altered immunological development contribute to infectious disease, allergy, and immune deficiency in this age group. Also being developed is a comprehensive, multidisciplinary initiative to enhance our

understanding of why children become aggressive or commit violent acts by identifying the varied roots of child and adolescent violence.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Improve emergent literacy, numeracy and language skills of Head Start children. *ACF Plan* Maintain at the FY 1999 baseline of 10 points the average gain in word knowledge. Maintain at the FY 1999 baseline of 3 points the average gain in mathematical skills. Maintain in FY 2000 and increase in FY 2001 the FY 1999 baseline of 1.5 points the average gain in letter identification. Note: See ACF Plan for description of "point" scales.	**Vocabulary** FY 01: 10 FY 00: 10 FY 99: N/A **Math** FY 01: 3 FY 00: 3 FY 99: N/A **Letter identification** FY 01: 3.4 FY 00: 1.5 FY 99: N/A	FY 01: FY 00: FY 99:10 FY 01: FY 00: FY 99: 3 FY 01: FY 00: FY 99: 1.5
In FY 2000, maintain at the FY 1999 baseline of 1.05 points and increase to 1.24 in FY 2001 the average gain in fine motor skills. *ACF Plan* Note: See ACF Plan for description of "point" scales.	FY 01: 1.24 FY 00: 1.05 FY 99: N/A	FY 01: FY 00: FY 99: 1.05
Maintain at the FY 1999 baseline of 1.4 points the average gain in social skills. *ACF Plan* Note: See ACF Plan for description of "point" scales.	FY 01:1.4 FY 00: 1.4 FY 99: N/A	FY 01: FY 00: FY 99: 1.4
Maintain and then increase the percentage of children rated by parent as being in excellent or very good health. *ACF Plan*	FY 01: 80% FY 00: 77% FY 99: N/A	FY 01: FY 00: FY 99: 77%

Performance Goals	Targets	Actual Performance
Increase the percentage of Head Start classroom teachers with a certificate, a degree, or appropriate training related to early childhood education. *ACF Plan*	FY 01: 100% FY 00: 100% FY 99: 100%	FY 01: FY 00: FY 99: 93% FY 98: 95%
Maintain and then increase the percentage of Head Start children who receive necessary medical treatment after being identified as needing medical treatment. *ACF Plan*	FY 01: 92% FY 00: 90% FY 99: 88%	FY 01: FY 00: FY 99: 87 % FY 98: 88%
Increase the proportion of AI/AN children receiving a minimum of four Well Child Visits by 27 months of age and expand coverage. *IHS Plan*	FY 01: 2% over FY 00 FY 00: 2% over FY 99 FY 99: establish baseline	FY 01: FY 00: FY 99: 4/00
Increase the number of children who are enrolled in the State Children's Health Insurance Program (SCHIP) and Medicaid (less than age 19 for SCHIP; less than age 21 for Medicaid). *HCFA Plan*	FY 01: 1 million over previous year FY 00: 1 million over previous year FY 99: Develop goal; set baselines and targets	FY 01: FY 00: FY 99: Goal Met FY 97: 22.7 million enrolled in Medicaid
Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program. *HRSA Plan*	FY 01: 9.7M FY 00: 9.6M FY 99: 8.9M	FY 01: FY 00: FY 99: 5/00 (9.15)est FY 98: 8.7M FY 97: 8.3M

Performance Goals	Targets	Actual Performance
Achieve or sustain the following immunization coverage of at least 90% among children 19- to 35-months of age for each vaccine: 1. 4 doses of Diphtheria-Tetanus-Pertussis containing vaccine 2. 3 doses of *Haemophilus influenzae* type b vaccine 3. 1 dose of Measles-Mumps-Rubella vaccine* 4. 3 doses of Hepatitis B vaccine 5. 3 doses of Polio vaccine 6. 1 dose of Varicella vaccine.	FY 01: Achieve or sustain immunization coverage of at least 90% among children19- to 35-months of age. FY 00: Achieve or sustain immunization coverage of at least 90% among children19- to 35-months of age. FY 99: Achieve or sustain immunization coverage of at least 90% among children 2 years of age for each vaccine.	FY 01: 8/02 FY 00: 8/01 FY 99: 8/00 FY 97: (7/97-6/98) 90% vaccination coverage for each vaccine. 1. 84% 2. 93% 3. 92% 4. 87% 5. 91% 6. 43%
Increase the percentage of Medicaid two-year old children who are fully immunized. (To be achieved in 3 phases for State groupings.)		
– Group 1 States (baseline: 2000; first report: 2001)	FY 01: First Report FY 00: Set Baseline FY 99: Not Applicable	FY 01: FY 00: FY 99: Not Applicable
– Group 2 States (baseline: 2000-2001; first report: 2002)	FY 01: Set Baseline FY 00: Not Applicable FY 99: Not Applicable	FY 01: FY 00: Not Applicable FY 99: Not Applicable
– Group 3 States (baseline: 2001-2002; first report: 2003)	FY 01: Begin Baseline Activities FY 00: Not Applicable	FY 01: Not Applicable FY 00: Not Applicable
HCFA Plan	FY 99: Not Applicable	FY 99: Not Applicable

Performance Goals	Targets	Actual Performance
Increase the proportion of AI/AN children who have completed all recommended immunizations by the age two. *IHS Plan*	FY 01: 2% over FY 00 FY 00: 2% over FY 99 FY 99: 90%	FY 01: FY 00: FY 99: 87% FY 98: 88%
By 2000, the number of children with elevated blood lead levels will have been reduced by 30% over the 1991-1994 baseline. *CDC Plan*	FY 01: 35% lead level reduced. FY 00: 30% lead level reduced. FY 99: 25% lead level reduced.	FY 01: FY 00: FY 99: No data available. NHANES survey results will next be available 2002/3. FY 91- 94: 890,000 children with blood lead levels greater than 10 micrograms per deciliter.
Decrease the percentage of low birth weight babies born to Healthy Start clients. *HRSA Plan*	FY 01: 11.75%	FY 01: FY 00: FY 99: 9/00 FY 98: 12.09%* *Provisional

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Child Care
Head Start
CDC
Immunizations
Lead Poisoning
FDA
Biologics
HCFA
Medicaid
Children's Health Insurance Program
HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
Healthy Start
Universal Newborn Hearing Screening and Early Intervention
NIH
Research Program
OPHS
Office of Disease Prevention and Health Promotion, Healthy People 2010
SAMHSA
Knowledge Development and Application
Starting Early, Starting Smart

HHS 2.4: Improve the Safety and Security of Children and Youth

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

ACF – Adoption and Safe Families Act Programs. The President has set an Adoption 2002 goal of providing safety, permanency and well-being for at-risk children by doubling the number of adoptions and permanent placements from the public welfare system. ACF will continue the joint effort by Federal, State and local governments, child welfare and adoption professionals, community leaders, and interested citizens to achieve this goal, thereby improving the lives of children who are backlogged, or at risk of being backlogged, in the child welfare system, by creating permanent homes for them.

  In addition, efforts to reduce barriers to the adoption process and strengthen ACF's technical assistance to enable States to increase the numbers of children adopted, especially children with special needs will continue. In addition, ACF proposes an investment from title IV-E funds for monitoring of child welfare and family service programs in the states, including family preservation and support, time-limited reunification services, adoption support services, child protective services, foster care, adoption, and independent living. These reviews are essential to safety, permanency and child and family well-being. In addition, these funds will be targeted to providing technical assistance and monitoring of critical systems development, the system which provides ACF with the information necessary to approve or disapprove state expenditures.

ACF – Independent Living Program. This program will help keep children aging out of the child welfare program from becoming homeless, jobless, or drug addicted.

HRSA – Primary Care, Health Centers. HRSA's Health Centers are implementing a Family Violence Initiative and plan to add parenting classes, home visiting and abuse prevention services in high risk areas.

HRSA – Maternal and Child Health Block Grant. Through Title V of the Social Security Act, this program supports injury prevention and domestic violence reduction programs that reduce both accidental and intended injuries, especially to children.

SAMHSA – The Comprehensive Community Mental Health Services for Children and their Families Program seeks to provide intensive *community-based* services for children with serious emotional disturbances and their families. The program features a broad array of services tailored to meet the needs of the child through an individualized service planning process. In FY 2001, HHS will continue to support and evaluate approximately 50 grants, allowing continued national progress in improving outcomes for a larger number of children with serious emotional disturbances and their families.

IHS – Prevention, Health Education, and Treatment. IHS screens the treatment population for indication for abuse or neglect and assists its local partners to engage in

community-based prevention initiatives which address HIV/AIDS risk behavior, violence, child abuse, physical inactivity, nutrition, alcohol and substance abuse and tobacco use and cessation.

OCR – Preventing Discrimination in Access to HHS Services. During FY 2001, OCR anticipates continuing technical assistance to states and placement agencies, ongoing partnership with ACF and others, reviews or investigations of compliance, and follow-up monitoring of corrective action plans associated with implementation of the strengthened adoption nondiscrimination provisions included in the Small Business Job Protection Act of 1996 (SBJPA) and in guidelines for OCR and ACF implementation.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Make progress towards doubling the number of adoptions for children in the public foster care system between FY 1997 and FY 2002. *ACF Plan*	FY 01: 51,000 FY 00: 46,000 FY 99: 41,000 (Originally 24,000)*	FY 01: FY 00: FY 99: 9/00 FY 98: 36,000 FY 97: 31,000 (baseline) FY 96: 28,000 FY 95: 26,000
Increase the number of State agencies and adoption agencies (local) found to be in compliance with the nondiscrimination provisions of the Small Business Job Protection Act. Measure: Increased number of corrective actions and no violation findings. *OCR Plan*	FY 01: 24 FY 00: 22 FY 99: 30	FY 01: FY 00: FY 99: 20 FY 98: 20
Decrease the percentage of children with substantiated reports of maltreatment who have a repeat substantiated report of maltreatment within 12 months. *ACF Plan*	CY 01: 10% CY 00: 11% CY 99: 21%	CY 01: CY 00: CY 99: 10/01 CY 98: 10/00 CY 97: 12% CY 96: 21% (baseline) CY 95: 20%
Increase the proportion of ACF-supported youth programs that are using community networking and outreach activities to strengthen services. *ACF Plan*	FY 01: 75% FY 00: 75% FY 99: 75%	FY 01: FY 00: FY 99: 51% FY 98: 79% FY 97: 77%

Performance Goals	Targets	Actual Performance
Increase the proportion of youth living in safe and appropriate settings after receiving ACF-funded services. *ACF Plan*	FY 01: 96% FY 00: 95% FY 99: 95%	FY 01: FY 00: FY 99: 86% FY 98: 81% FY 97: 82%
Increase then maintain the proportion of children receiving Comprehensive Community Mental Health Services who are attending school 75% of the time. *SAMHSA Plan.*	FY 01: 95% FY 00: 80% FY 99: 80%	FY 01: 8/01 FY 00: 8/00 FY 99: 88.9% FY 98: 78.8% FY 97: 70% (baseline)
Increase then maintain the proportion of children receiving Comprehensive Community Mental Health Services with law enforcement contacts at entry who have no law enforcement contacts after 6 months. *SAMHSA Plan.*	FY 01: 57 % FY 00: 57 % FY 99: 57%	FY 01: 8/01 FY 00: 8/00 FY 99: 43% FY 98: 54.8% FY 97: 47% (baseline)
Improve the stability of living arrangements of children receiving Comprehensive Community Mental Health Services by decreasing the percentage of participants having more than one living arrangement after 6 months in services. *SAMHSA Plan*	FY 01: 11% FY 00: 51% FY 99: 56%	FY 01: 8/01 FY 00: 8/00 FY 99: 27% FY 98: 23.7% FY 97: 76% (baseline)
Increase the percent of IHS, Tribal, and Urban medical facilities with Urgent Care or Emergency departments or services that have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (child, spouse, elderly). *IHS Plan*	FY 01: 80% FY 00: 70% FY 99: 60%	FY 01: FY 00: FY 99: 64% FY 98: 47%

* The original baseline for the adoption measure was underestimated at 24,000. The revised baseline is 41,000.

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Child Welfare
Youth Programs
Developmental Disabilities
Social Services Block Grant
HRSA
Primary Care, Health Centers
Maternal and Child Health Block Grant
IHS
Prevention and Treatment
OCR
Preventing Discrimination in Access to HHS' Services
SAMHSA
Comprehensive Community Mental Health Services for Children and Their Families

Program

HHS 2.5: Increase Opportunities for Seniors to Have an Active and Healthy Aging Experience

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

AoA–Supportive Services and Senior Centers. AoA's supportive services program funds transportation, information and assistance, case management, personal care services, and a range of services provided in senior centers. These funds provide elders with information, assistance and services which enable them to remain active and in the community.

AoA – Congregate and Home-Delivered Nutrition Services. AoA supports congregate and home-delivered meal programs to increase the nutritional intake of at-risk seniors. Home-delivered meals enable older adults to avoid or delay costly institutionalization and allow them to stay in their homes and communities. Congregate nutrition services also improve participants' health significantly and prevent more costly interventions. In addition, congregate services allow older people the opportunity to engage in social activities that contribute to their well-being.

HRSA – Primary Care, Health Centers. HRSA's Health Centers have a proven record of expertise in the management of chronic conditions such as diabetes and hypertension affecting the elderly. HRSA is undertaking an initiative to measure and improve quality of care for diabetic patients in over 100 individual centers. In addition, HRSA has launched an initiative to increase the number of Medicare beneficiaries served, with emphasis on managed care and geriatric expertise.

IHS – Treatment and Prevention, Elder Health. A proposed increase in the FY 2001 Budget will allow IHS to develop specialized geriatric capacity within the IHS, Tribal, and Urban health care system and provide treatment and medication management unique to the elder patient population.

CDC – Immunizations. The National Immunization Program (NIP) focuses on several major programmatic areas to achieve its goals, including childhood immunization, adult immunization, and global polio eradication. Although NIP has assistance from many partners, State and local health agencies play a primary role in helping NIP carry out its mission in the United States. State and local health agencies use CDC grant funds for a wide range of activities including hiring staff, conducting surveillance, assessing immunization levels, developing immunization registries, conducting education and outreach, and establishing partnerships with community groups and private sector organizations.

CDC – Injury Prevention and Control. CDC provides national leadership for designing programs to prevent premature death and disability and reduce human suffering and medical costs caused by injuries. Work in the area of suicide prevention among our Nation's elderly is ongoing.

HCFA – Supplementing Medicare. One of HCFA's central concerns is that Medicare beneficiaries are able to get the care they need when they need it, and that they are not impeded by factors such as cost, health status, location, or availability of primary care physicians or specialists. This is true not only for beneficiaries as a class, but most especially for vulnerable subgroups such as persons with disabilities and members of minority and economically disadvantaged populations. Although Medicare provides beneficiaries with a basic set of health benefits, they still are required to pay a significant amount out-of-pocket for premiums, deductibles, and co-insurance. This cost can be prohibitive for many beneficiaries, particularly for the approximately 12 percent who do not have private or public supplemental insurance. HCFA's access to care performance goal will target financial barriers to care for these beneficiaries. Emphasis in the initial years of this goal will be on increasing enrollment for the Medicare beneficiaries who are eligible for the Qualified Medicare Beneficiary (QMB) or the Specified Low-Income Medicare Beneficiary (SLMB) programs.

HCFA – Managed Care. Medicare has provided access for beneficiaries to mainstream health care. The health care system is changing with growth in health maintenance organizations and other forms of managed care as well as new delivery arrangements. HCFA's goal is to ensure that all Medicare beneficiaries have a choice of a number of high quality health care options in both fee-for-service and managed care. The following strategies will create greater choice of health plans for Medicare beneficiaries. 1) The Balanced Budget Act of 1997 will allow contracting with other than traditional HMOs. It is hoped that some of the applications may come from rural areas that have few or no managed care options. 2) Utilization of a "triage" approach will facilitate processing of managed care applications and service area expansions from plans that will offer products in areas that have little or no managed care penetration. 3) The offering of different plan choices through demonstration projects, such as Choices, Social/HMO, and ESRD capitation demonstration. These allow promotion of managed care in areas that have not had much interest from traditional HMOs. Under the Balanced Budget Refinement Act of 1999, a Bonus Payment Process has been initiated as an incentive for a managed care organization to enter a county where no other managed care plans exist; either because non has ever been there or due to existing plans terminating their Medicare contracts with HCFA and leave the county with no managed care services.

SAMSHA – **Treatment Outcomes Study**. Recognizing that most older adults receive mental health and substance abuse (primarily alcohol related) services in a primary care setting, the three SAMHSA Centers, in collaboration with HRSA, will be working to identify the differences in outcomes between treatment models. The study continues to examine how the location, type of provider, and type of health care financing affects the level of actual use of substance abuse prevention services.

IHS – Prevention, Health Education, and Treatment. IHS screens the treatment population for indication for abuse or neglect and assists its local partners to engage in community-based prevention initiatives which address HIV/AIDS risk behavior, violence, child abuse, physical inactivity, nutrition, alcohol and substance abuse and tobacco use and cessation.

NIH – Research on Applied Gerontology. The National Institute on Aging's Edward R. Roybal Centers of Research on Applied Gerontology conduct research with the goal of keeping people independent, active, and productive in later life. Investigators at these centers focus on translating promising social and behavioral research findings into strategies to help improve the lives of older people and their families in such areas as computer skills, driving, exercise, caregiving, and nursing home care.

SAMHSA - Linkages among Primary Care, Mental Health, Substance Abuse, and HIV Services for Older Americans. This TCE program will focus on developing linkages among primary care, mental health, substance abuse and HIV for older Americans, with the goal of learning how best to deliver services for a diverse group of older Americans (50 and over) living with HIV/AIDS or at risk for HIV. The program model will address the primary and secondary prevention needs of the population as well as the implementation of a continuum of care for older Americans. To achieve this, approximately ten grants will be awarded and a coordinating center will be established.

AoA – Grants to Indian Tribes. AoA's American Indian, Alaskan Native and Native Hawaiian Program awards grants to provide supportive and nutrition services, including both congregate and home-delivered meals to older Native Americans.

AoA– Alzheimer's Disease Demonstration Grants to States. Through research conducted by NIH and other parts of the Department, as well as through demonstration results of this program, new behavioral approaches are rapidly emerging that encourage greater independence and reduce disturbing behavior. The Alzheimer Demonstration Grant Program provides an important mechanism for the systematic application of these research findings to the development and implementation of models of care for persons with Alzheimer's Disease.

OPHS – Activities and initiatives on cardiovascular disease, the prevention of osteoporosis, a new older women's exercise and fitness initiative, and related activities are targeted at health promotion and disease prevention for women.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
The rate of vaccination among persons ≥65 years will be increased for influenza and pneumococcal pneumonia.***** *CDC Plan* *****Influenza and pneumococcal vaccination coverage goals for adults aged 65 and older are based on the 90% coverage goals in Healthy People 2010. It is expected that influenza vaccination coverage will increase approximately 2% per year and pneumococcal vaccination will increase about 3% per year to realized the 2010 goals.	FY 01:Influenza: 72%. *Pneumococcal pneumonia:* 63%. FY 00: *Influenza*:70%. *Pneumococcal pneumonia:* 60%. FY 99: The rate of vaccination among non-institutionalized high-risk populations: *Influenza*: 60%; *Pneumococcal pneumonia*: 54%.	FY 01: FY 00: FY 99: 6/00 FY 97: *Influenza*:65%. *Pneumococcal pneumonia*: 43% (preliminary data from NHIS) FY 95: *Influenza*:58%. *Pneumococcal pneumonia*: 34%.
Meet State/Federal national enrollment targets for dually eligible beneficiaries (Medicare and Medicaid). *HCFA Plan*	FY 01: 01/00 FY 00: 01/00 FY 99: Set FY 2000 target	FY 01: FY 00: FY 99: 01/00
Increase the percentage of Medicare beneficiaries who have at least one managed care option/choice. *HCFA Plan*	FY 01: 73% FY 00: 73% FY 99: 80%	FY 01: FY 00: FY 99: 72% FY 98: 72% FY 97: 70%
Increase then maintain the high percentage of Medicare +Choice enrollment transactions processed on a timely basis. *HCFA Plan*	FY 01: 98% FY 00: 98% FY 99: 98%	FY 01: FY 00: FY 99: 98%

Performance Goals	Targets	Actual Performance
Increase overall pneumococcal and influenza vaccination levels among adults aged 65 years and older. *IHS Plan*	FY 01: 2% over FY 00 FY 00: 65% FY 99: N/A	FY 01: FY 00: FY 99: 3/00 FY 98: 63%
Increase the percentage of IHS, Tribal, and Urban medical facilities with Urgent Care or Emergency departments or services that have written policies and procedures for routinely identifying, treating and/or referring victims of family violence, abuse or neglect (child, spouse, elderly). *IHS Plan*	FY 01: 80% FY 00: 70% FY 99: 60%	FY 01: FY 00: FY 99: 64% FY 98: 47%

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Research on Health Costs, Quality, and Outcomes
AoA
Supportive Services & Centers
Congregate Meals
Home-Delivered Meals
Alzheimer's Initiative
Grants to Indian Tribes

CDC
Immunization
Injury Prevention and Control
HCFA
Medicare
Peer Review Organizations
Medicare+Choice
Medicaid

HRSA
Primary Care, Health Centers
IHS
Treatment and Prevention
NIH
Research Program
OPHS
Healthy People 2000
Office on Women's Health

SAMHSA
Knowledge Development and Application
Targeted Capacity Expansion
National Data Collection State Infrastructure
Protection and Advocacy
Mental Health Performance Partnership
Block Grant
Substance Abuse Block Grant

HHS 2.6: Expand Access to Consumer-Directed, Home and Community-Based Long-Term Care and Health Services

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

AoA – Long-Term Care Ombudsman Program. The Long-Term Care Ombudsman Program helps states to investigate and resolve complaints made by, or on behalf of, residents of long-term care facilities related to action, inaction, or decisions that may adversely affect the health, safety, welfare, or rights of residents. There are 52 State Long-term Care Ombudsman Programs which support ombudsman staff and volunteers in 564 local programs. AoA also supports an Ombudsman Resource Center that offers training and technical assistance to ombudsmen throughout the country.

AoA – Supportive Services and Senior Centers. AoA's supportive services program funds transportation, information and assistance, case management, personal care services, and a range of services provided in senior centers. These funds provide elders with information, assistance and services which enable them to remain active and in the community.

AoA – Congregate and Home-Delivered Nutrition Services. AoA supports congregate and home-delivered meal programs to increase the nutritional intake of at-risk seniors. Home-delivered meals enable older adults to avoid or delay costly institutionalization and allow them to stay in their homes and communities. Congregate nutrition services also improve participants' health significantly and prevent more costly interventions. In addition, congregate services allow older people the opportunity to engage in social activities that contribute to their well-being.

AoA – Support for Caregivers. AoA is proposing to provide support for family caregivers as authorized under Title III of the Older Americans Act. AoA will provide information, assistance in access to services, counseling and support groups, and direct services to complement informal care provided by families. Support to informal caregivers significantly benefits them while delaying the need of care recipients for nursing home services.

AoA– Alzheimer's Disease Demonstration Grants to States. Through research conducted by NIH and other parts of the Department, as well as through demonstration results of this program, new behavioral approaches are rapidly emerging that encourage greater independence and reduce disturbing behavior. The Alzheimer Demonstration Grant Program provides an important mechanism for the systematic application of these research findings to the development and implementation of models of care for persons with Alzheimer's Disease.

HCFA – Programs for All-Inclusive Care for the Elderly. States have the option of providing Medicaid coverage for categorically related groups, such as individuals who would be eligible for Medicaid if institutionalized, but who are receiving care under home and community-based services waivers. The Balanced Budget Act made permanent the Programs of All-inclusive Care for the Elderly (PACE), for eligible persons as a State option. PACE

provides an alternative to institutional care for persons aged 55 and over who require a *nursing facility level* of care. The PACE team offers and manages all health, medical, and social services, and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive services. This care is provided in day health centers, homes, hospitals, and nursing homes--while helping the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well as under Medicaid. PACE providers must make available all items and services covered under both Medicare and Medicaid without amount, duration, or scope limitations, and without application of any deductibles, copayments, or other cost sharing.

HCFA – Nursing Home Initiative. HCFA continues to play a significant role in the President's Nursing Home Initiative announced in July, 1998. In FY 1999, HHS began phasing-in key provisions of the initiative. Continued funding will be provided primarily for State surveys of nursing homes, Federal surveyor oversight and developing a national criminal abuse registry to screen potential nursing home employees. Continued efforts will also ensure legal resources for the Office of the General Counsel and the Departmental Appeals Board to provide judicial hearings and handle administrative and court litigation in a timely manner.

IHS – Division of Facilities and Environmental Engineering. IHS provides access to health services through construction of health care and sanitation facilities.

SAMHSA - The Center for Mental Health Services, working in partnership with other Federal agencies, State and local mental health authorities, service providers, consumers of services, and their families, is providing a key function in guiding a system of care for community based, consumer focused services. An example is the recently funded knowledge development program on School Violence.

OCR – **Preventing Discrimination in Access to HHS' Services**. Following the decision by the Supreme Court in the *Olmstead* case regarding the most integrated setting requirements of the Americans with Disabilities Act (ADA), OCR has begun to determine how best to inform beneficiaries of their rights and recipients of their responsibilities under the ADA with respect to providing services in most integrated settings. OCR expects a significant increase in complaint filings related to the Olmstead decision and in requests for technical assistance from both providers and the disability community. OCR will take a two-pronged approach to resolve these complaints. There first will focus on developing a model for collaboration and cooperation among state Medicaid programs, complainants, advocacy organizations, and HCFA to achieve voluntary resolution. The second is to conduct formal investigations, as necessary, to determine if the requirements of the Olmstead decision are being followed by the states.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Decrease then sustain the reduced prevalence of the use of physical restraints in nursing homes. *HCFA Plan*	FY 01: 10% FY 00: 10% FY 99: 14%	FY 01: FY 00: FY 99: 12% FY 98: 12% FY 96: 17%
Reduce the prevalence of pressure ulcers (bed sores) among patients of long-term care facilities. *HCFA Plan*	FY 01: 01/01 FY 00: Set baseline and target FY 99: New in FY 2000	FY 01: FY 00: FY 99: N.A.
Provide sanitation facilities to new or like-new homes and existing Indian homes. *IHS Plan*	FY 01: 6,350 New/Like 13,080 Existing FY 00: 3,740New/Like 11,035 Existing FY 99: 5,900 New/Like 9,330 Existing	FY 01: FY 00: FY 99: 3,557 New/Like 13,014 Existing
Improve access to health care by construction of the approved new health care facilities. *IHS Plan*	FY 01: complete scheduled phase of construction of appropriated facilities FY 00: complete scheduled phase of construction of appropriated facilities FY 99: complete scheduled phase of construction of appropriated facilities	FY 01: FY 00: FY 99: Accomplished

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Research on Health Costs, Quality, and Outcomes
AoA
Supportive Services & Centers
Congregate Meals
Home-Delivered Meals
National Family Caregiver Support Program
Alzheimer's Initiative
Long-Term Care Ombudsman
Grants to Indian Tribes
HCFA
Medicaid
Medicare
OCR
Preventing Discrimination in Access to HHS' Services
SAMHSA
Knowledge Development and Application

HHS 2.7: Improve the Economic and Social Development of Distressed Communities

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

Comprehensive, Coordinated Community Services. HHS' community service programs, such as ACF's Family Violence Prevention Program, Community Services Block Grant, Healthy Start, SAMHSA's Mental Health Services for Children, and AoA's Aging Network are encouraged to build coordinated service networks.

ACF – The Empowerment Zone/Enterprise Community Initiative. The EZ/EC initiative, in cooperation with the Department of Housing and Urban Development, provides substantial funding and technical assistance for community development corporations and other organizations to create new business and employment opportunities.

SAMHSA - Targeted Capacity Expansion (TCE). The Center for Substance Abuse Treatment's TCE will focus on vulnerable populations which include minority communities, women, and youth. As part of a "Strengthening Communities" initiative, services will be targeted to certain geographic areas, including rural areas, small towns, and metropolitan areas experiencing particularly acute substance abuse problems where appropriate linkages will be made with Empowerment Zones. The program will continue to be responsive to emerging drug trends, notably those identified in State-level data which will be available from the National Household Survey on Drug Abuse. Programs in all areas will be based on sound, scientifically-based evidence of effectiveness.

ACF – Temporary Assistance for Needy Families. TANF promotes work, responsibility and self-sufficiency and strengthens families through funding of State-designed and -administered programs that provide support to needy children and move their parents into work.

ACF – Community Services Block Grant. CSBG provides a range of services and activities having a measurable and potentially major impact on causes of poverty in the community.

ACF – Social Services Block Grant. SSBG supports a variety of social services tailored to supplement State investments in the self-sufficiency and well-being of low income populations through State grants. SSBG funds also help improve and integrate services, create community-based partnerships, and stimulate innovations.

ACF – Native American Programs. ACF's Social and Economic Development Strategies program is based on the premise that local communities have the primary responsibility for determining its own needs, planning and implementing its own programs, and for use of its own natural and human resources. Through a direct grant funding relationship, Tribes and Native communities have created administrative systems to operate their own social and economic programs, much in the same way as State and local governments. Support for the

unique, government to government relationship that exists between Tribal governments and the Federal government is reflected in this approach. Additional priority funding areas include native languages preservation and enhancement, environmental regulatory enhancement, and environmental mitigation.

HRSA – Primary Care, Health Centers. HRSA's Health Centers provide economic development in the communities they serve, providing jobs for neighborhood residents and business for local enterprises. Many are participating in the Empowerment Zone/Enterprise Community program through ACF and the Department of Housing and Urban Development.

HRSA – Healthy Start. HRSA funds communities to reduce barriers to care, improve perinatal systems, and support private sector partnerships that facilitate welfare to work and community job creation, and reduce racial disparity in health status.

ACF – Low-Income Home Energy Assistance Program. LIHEAP block grants provide funds to States, Indian Tribes/Tribal organizations and Insular areas to assist low-income households in meeting the costs of home energy.

CDC – HIV/AIDS Prevention. The largest portion of CDC's HIV prevention resources is awarded to state, local, and territorial health departments. Priorities for these resources are determined through the HIV prevention community planning process. This process brings together representatives of affected communities and HIV-infected populations with health department officials, scientists, and service providers to analyze the epidemic in their jurisdiction, assess prevention needs, develop resource inventories, identify priority needs in terms of populations and the most effective interventions to reach each population, and develop a comprehensive plan for HIV prevention in the jurisdiction that reflects the established priorities.

SAMHSA – CSAP's State Incentive Grant (SIG) Program will enable Governors/States to examine their State Prevention Systems and redirect resources to critical targeted prevention services within their states. Eighty-five percent of the SIG funds will be directed toward the community level for implementing best prevention practices and improving the access/quality of services.

OPHS – Through its staffing of the Departmental Minority Initiatives Coordinating Committee (DMICC), OPHS will guide and coordinate the formulation of action plans for the implementation of the four minority-specific initiatives, which encompass Blacks/African Americans, Hispanic/Latinos, American Indians/Alaska Natives, and Asian Americans/Pacific Islanders. While necessarily diverse in their scope and goals, these initiatives share common aims at improving institutional infrastructure and educational outcomes for disadvantaged minorities.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Increase the number of volunteer hours contributed by CSBG consumers in one or more community groups by 3 percent over the previous year (expressed in millions of hours). *ACF Plan*	FY 01: 29.22 FY 00: 28.93 FY 99: 28.64	FY 01: FY 00: FY 99: FY 97: 27 (baseline) FY 96: 28.06
Increase the amount of non-Federal resources brought into low-income communities by the Community Services Network (non-Federal funds mobilized). *ACF Plan*	FY 01: 1.39 FY 00: 1.38 FY 99: 1.36	FY 01: FY 00: FY 99: FY 97: 1.26 (baseline) FY 96: 1.20

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Community Services Block Grant
Family Violence Prevention Programs
Low-Income Home Energy Assistance
Native American Programs
Social Services Block Grant
CDC
HIV/AIDS Prevention
HCFA
Medicaid
Medicare
HRSA
Primary Care, Health Centers
Healthy Start
IHS
Division of Facilities and Environmental Engineering
OPHS
SAMHSA
State Incentive Grants
Targeted Capacity Expansion

HHS Goal 3: IMPROVE ACCESS TO HEALTH SERVICES AND ENSURE THE INTEGRITY OF THE NATION'S HEALTH ENTITLEMENT AND SAFETY NET PROGRAMS

From the HHS Strategic Plan, September 1997. The estimated 44 million Americans who lack any health insurance coverage, and the even larger number who are without insurance for behavioral health care services, are at serious risk of going without essential health care. It is a matter of grave concern that these already large numbers are rising, and that employment-based insurance—the bedrock of coverage for working Americans—is declining. The percentage of the nonelderly population with employment-based health insurance coverage shrank from 69.2 percent in 1987 to 63.8 percent in 1995. Without insurance, access to health services, particularly primary and preventive services, is severely compromised. Other barriers to access include the absence of health care facilities or professionals; discrimination on grounds of race, national origin, age, or disability; and language or cultural obstacles that impede the delivery of care.

The major federal programs are the mechanisms through which the Department provides access to care: Medicare and Medicaid, the new State Children's Health Insurance Program, the Indian Health Service (IHS), and the safety net programs (Community Health Centers, Ryan White Care Program, Substance Abuse and Mental Health Block grants, Maternal and Child Health Program). All are undergoing changes that affect access. The agents of change include the emergence of managed care, demographic trends, changes in the relations among the country's levels of government, and the expanding numbers of uninsured individuals who depend on the safety net programs.

The Department is equally committed to the sound and fiscally prudent management of all of these programs. Because of their size and scope, the Medicare and Medicaid programs are particular targets for fraud and abuse and accordingly receive the highest-priority attention. A coordinated enforcement effort—modeled on the highly successful Operation Restore Trust and involving multiple components of the Department of Health and Human Services (HHS), as well as the Department of Justice (DOJ)—is expected to curb strictly and severely fraud and abuse in these programs. Areas of concern encompass fraud perpetrated by providers and beneficiaries as well as program payment policies that may reimburse excessively for certain types of services, and management practices that are wasteful or inefficient. The Department's program strategy targets all of these.

The Department's strategy has three components. First, HHS will work with the Congress and the states to broaden access to services by enlarging the percentage of children and adults who have health insurance coverage. Second, the Department will maximize the number of low-income or special-needs populations served through its programs, consistent with the level of appropriations to those programs. Emphasis will be on integrating specialized safety net

programs with Medicare and Medicaid. Third, HHS will expand its efforts to prevent waste, fraud, and abuse in all of its programs—but particularly in Medicare and Medicaid because of their size and their impact on the total health care system.

HHS 3.1: Increase the Percentage of the Nation's Children and Adults Who Have Health Insurance Coverage

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

HCFA – States' Children's Health Insurance Program. The Balanced Budget Act of 1997 created the States' Children's Health Insurance Program (SCHIP) under Title XXI if the Social Security Act. For FY 2001, the statute appropriates $4,275,000,000 for allotments to States and territories for this program. HCFA continues to work with the States, other parts of HHS, other Federal agencies, and the private sector on a broad array of outreach activities to reach uninsured children. These activities include educating Federal workers, State workers and grantees about children's health outreach, and educating families about their potential eligibility for health insurance. It also includes coordinating efforts across States, community-based organizations, advocacy groups, Government grantees, such as Information, Counseling, and Assistance Agencies (ICAs), and private sector groups to identify or establish networks, coalitions and partnerships that can play an instrumental role in the development and implementation of outreach and enrollment strategies for both Medicaid and SCHIP populations.

HCFA – The Health Insurance Portability and Accountability Act (HIPAA). HIPAA was enacted to promote access to health insurance coverage to people who had lost their insurance, often through job dislocation, or who were previously uninsurable because of their health status. HHS, through HCFA, is responsible for ensuring that States enforce HIPAA provisions with respect to issuers of coverage in the group and individual markets. If States do not have similar protections in place, do not pass appropriate laws, or do not substantially enforce them, HCFA is required to take enforcement actions. Since HCFA has now assumed enforcement authority in three States, we must take on certain responsibilities which were previously conducted by the State. This reflects a significant new role for HCFA.

HCFA – Qualified Medicare Beneficiary (QMB) or the Specified Low-Income Medicare Beneficiary (SLMB) programs. A central concern of HCFA is that Medicare beneficiaries are able to get the care they need when they need it, and that they are not impeded by factors such as cost, health status, location, or availability of primary care physicians or specialists. This is true not only for beneficiaries as a class, but most especially for vulnerable subgroups such as persons with disabilities and members of minority and economically disadvantaged populations. HCFA's goal with regard to this concerns is to improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance. In the initial years of its endeavor toward this goal, HCFA will concentrate on enrollment of individuals who are eligible for the Qualified Medicare Beneficiary (QMB) or the Specified Low-Income Medicare Beneficiary (SLMB) programs. These programs were enacted to help low-income Medicare beneficiaries with their Medicare cost-sharing expenses. States are required to pay for the premiums, deductibles, and cost sharing for QMBs, and the Part B premium for SLMBs. Despite the existence of these programs, it has been documented that a substantial

proportion of individuals eligible for these programs are not enrolled. (For example, two studies estimated non-participation rates for QMB to range from 40 to 60 percent.)

HCFA – Medicare/Medicaid Linked Data Files. As evident in the previous initiative, individuals who are dually eligible for Medicare and Medicaid are an important and growing segment of beneficiaries. Through continued innovation and reform in the Medicare and Medicaid programs, HCFA fosters a service delivery system that is better integrated and more flexible in meeting the needs of dually eligible beneficiaries. The joint Federal and State interest in dual eligibles has resulted in an examination of the data that are available to obtain knowledge about the demographic characteristics, health status, disease episodes, support services, health services utilization, and expenditures of this population. HCFA is providing the States with the Medicare utilization data for dual eligibles and enabling the States to do their own linking with their Medicaid files. This will respond to States' needs and provide them with flexibility to perform State-specific data projects.

HRSA – Primary Care, Health Centers. HRSA's Health Centers will undertake outreach incentives and enrollment assistance to the uninsured who are eligible for coverage under the State Child Health Insurance Program or Medicaid. Centers in a significant number of States are already participating in an Outstationed Eligibility Demonstration in collaboration with HCFA. These and other outreach efforts will be extended in FY 2000.

HRSA – Maternal and Child Health Block Grant. Title V and CSHCN program directors work with the Medicaid and SCHIP program directors in their state to identify and enroll Medicaid and SCHIP eligible children. This has been a major priority and the subject of many national meetings and communications since the passage of SCHIP legislation.

HRSA – Maternal and Child Health, Healthy Start. HRSA, in collaboration with States, will intensify its technical assistance to the Healthy Start projects to facilitate training of project staff and community residents on outreach, education, eligibility assessment, and enrollment activities. In addition, the Healthy Start projects will support the monitoring of quality of services provided under CHIP and serve as advocates in breaking down barriers to care for families.

OCR – Preventing Discrimination in Access to HHS' Services. OCR will continue to provide technical assistance and training to HCFA and HRSA staff in reviewing state CHIP plans, noting civil rights concerns/problems. OCR will follow up with state agencies, providing technical assistance and outreach as they implement and modify their plans to ensure that they incorporate methods of program administration that guarantee effective civil rights protection for program participants.

OPHS – OPHS provides policy analysis and OPHS' perspective on a wide-variety of issues associated with the implementation of the State Child Health Insurance Program and Child Health Initiative.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Decrease the percent of children without health insurance. *HRSA Plan*	FY 01: 10%	FY 01: FY 00: FY 99: 01/01 FY 98: 04/00 FY 97: 14% FY 96: FY 95: 14%
Increase the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program. *HRSA Plan*	FY 01: 80%	FY 01: FY 00: FY 99: 01/01 FY 98: 04/00 FY 97: 70%
Increase the number of uninsured and underserved persons served by Health Centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program. *HRSA Plan*	FY 01: 9.7M FY 00: 9.6M FY 99: 8.9M	FY 01: FY 00: FY 99: 5/00 (9.15 est) FY 98: 8.7M FY 97: 8.3M
Increase enrollment of eligible Medicare beneficiaries in programs for dually eligible beneficiaries, such as the QMB and SLMB programs. *HCFA Plan*	FY 01: Will set target during FY 2000 FY 00: Increase enrollment by 4% FY 99: Establish a target	FY 01: FY 00: FY 99: Goal Met
Ensure compliance with HIPAA requirements in direct enforcement States (California, Missouri, and Rhode Island) by increasing the use of policy form reviews. *HCFA Plan*	FY 01: 60% FY 00: 30% FY 99: New In 2000	FY 01: FY 00: FY 99: New In 2000

PROGRAMS SUPPORTING THIS OBJECTIVE

HCFA
Medicare
Medicaid
Children's Health Insurance Program
Health Insurance Portability and Accountability Program
Maternal and Child Health, Healthy Start
Community Health Centers

OPHS
Office of Disease Prevention and Health Promotion

OCR
Preventing Discrimination in Access to HHS' Services

HHS 3.2: Increase the Availability of Primary Health Care Services

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

HRSA – **Primary Care, Health Centers and the National Health Service Corps**. HRSA's Health Centers and the National Health Service Corps form a cost-effective, integrated safety net for underserved and uninsured children, adults, migrant workers, homeless individuals, public housing and U.S./Mexico border residents in approximately 4,000 communities across the country and will serve over 11.0 million persons in FY 2000 who would otherwise lack access to primary care clinicians. This community-based network delivers preventive and primary care services for the neediest, poorest, and sickest patients in rural and inner city areas, through a Federal, State, and community partnership approach. Health Centers and the NHSC contribute to decreases in racial and income disparities by providing preventive services and risk reduction to a population that is largely minority (64%) and low income (86%) and disproportionately uninsured (41%).

HRSA – Maternal and Child Health Block Grant (MCHBG). State Title V programs use appropriated formula grant funds for capacity and systems building, public information and education, knowledge development, outreach and program linkage, technical assistance, provider training, evaluation, support for newborn screening, lead poisoning and injury prevention, additional support services for children with special health care needs, and promotion of health and safety in child care settings. Special efforts are made to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling. Where no services are available, States also use Title V to subsidize or provide categorical direct care.

  MCHBG also provides assistance and care for some of the new children and critical new needs identified by SCHIP and Medicaid outreach that cannot be met by Medicaid or State Child Health plans, such as additional translation, case management, transportation, special public health, disability, and gap filling services (frequently referred to as "enabling services") needed to make Medicaid effective for low-income children.

HRSA – Maternal and Child Health, Healthy Start. Healthy Start focuses on the need to strengthen and enhance community systems of perinatal health by helping communities to fully address the medical, behavioral and psychosocial needs of women and infants. The FY 2001 program will provide for a continuing opportunity to reduce factors contributing to infant mortality by adaptation of successful Healthy Start models of intervention in urban and rural communities with high rates of infant mortality, especially among racial/ethnic populations, and to share the lessons learned with States, communities, and academic and professional organizations.
OPHS/HRSA – Family Planning Program. This program supports a nationwide network of 4,600 clinics and provides reproductive health services to approximately 4.5 million persons each year. In addition to contraceptive services, Title X also supports a broad range of

prevention-oriented reproductive health care activities, including counseling, routine gynecological care, HIV and STD prevention education, hypertension screening, reproductive cancer screening, and testing and treatment for sexually transmitted diseases.

HRSA – Maternal and Child Health, Universal Newborn Hearing Screening. This partnership with CDC, NIH, and the Department of Education will promote universal newborn hearing screening prior to hospital discharge thereby greatly lowering the age at which children with congenital permanent hearing loss are identified and increasing the ability of these children to perform on school related measures. HRSA will address critical gaps by supporting grants to the States to develop and expand statewide universal newborn hearing screening programs, link screening programs to intervention within the community service system, monitor the impact of early detection and intervention on child, family, and systems, and provide technical assistance.

HRSA – Maternal and Child Health, Emergency Medical Services for Children (EMSC). A joint effort of HRSA and the National Highway Safety Administration, EMSC is designed to ensure that all children and adolescents, no matter where they live or where they travel, can receive appropriate care in a health emergency. It seeks to improve all aspects of children's acute emergency medical care, including pre-hospital care, emergency department care, hospital care, and rehabilitation, and to prevent such emergencies from occurring. FY 2001 funds will enable the States to continue to promote the regionalization of care and to make system improvements to ensure that all components of an effective EMSC system are in place.

CDC – Immunizations. The National Immunization Program (NIP) focuses on several major programmatic areas to achieve its goals, including childhood immunization, adult immunization, and global polio eradication. Although NIP has assistance from many partners, state and local health agencies play a primary role in helping NIP carry out its mission in the United States. NIP ensures quality immunization services by awarding grants to states and large local health departments; offering technical, epidemiologic, and scientific assistance to state and local areas; monitoring immunization coverage; ensuring an adequate supply of vaccine by overseeing vaccine purchases made through CDC contracts and managing the Vaccines for Children program; developing immunization registries; and conducting operational research to develop new and improved delivery strategies.

HCFA – Childhood Immunization. Immunization in children with the complete series of vaccinations in the first two years of life is a widely accepted health care strategy. It is a highly effective intervention to prevent a number of diseases in children and to prevent serious outbreaks of illness. The Medicaid program covers vaccines for children as a basic mandatory covered service. The central importance of childhood immunization is also recognized by the States' Children's Health Insurance Program (SCHIP). Under the legislation, States that create a separate SCHIP program must include coverage of the complete series of immunizations. States also are prohibited from imposing co-payments or deductibles on immunization services.

HCFA – Peer Review Organizations. Appropriate use of effective medical services is a critical component of HCFA's focus on Medicare beneficiaries. HCFA's efforts to improve

medical treatment through its collaboration with Peer Review Organizations is the basis for its performance goals to: 1) increase influenza vaccination, 2) increase the use of mammograms, 3) increase heart attack survival, and 4) increase diabetic eye exams. PROs, which serve under contract with HCFA, conduct cooperative improvement projects in which they use data to identify opportunities to improve care, and then work to develop interventions that will bring improvement for subject quality indicators. Pertinent to the HCFA performance plan, HCFA and the PROs are working with providers, health plans, and others on influenza vaccination projects, and are networking with local project collaborators to provide education and reminders to improve mammography rates.

ACF - Head Start emphasizes the importance of the early identification of health problems. Every child is involved in a comprehensive health program, which includes immunizations, medical, dental, and mental health, and nutritional services.

CDC – Tuberculosis. CDC has developed a national plan to eliminate TB from our country. To achieve this goal, CDC works with local, state, national, and international partners to improve the prevention, diagnosis, and treatment of TB disease. In addition to promoting the more effective use of existing tools for combating TB, CDC is working to develop new diagnostic and treatment tools.

CDC – Breast and Cervical Cancer Prevention. Through CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP), CDC supports activities at the state and national level in the areas of screening, referral and follow-up services, quality assurance, public and provider education, surveillance, collaboration, and partnership development. The screening program ensures that eligible women have access to these preventive services, and that state programs: inform all women of the value of early detection, educate physicians about recommended screening guidelines, ensure the quality of mammograms and Pap tests, monitor program effectiveness through appropriate surveillance and evaluation activities, and build effective community-based partnerships for early detection and follow-up.

CDC – Diabetes and Other Chronic Diseases. In order to prevent or significantly ameliorate the disabling and costly complications of diabetes, CDC's Diabetes Control Programs emphasize ensuring that persons with diabetes have access to quality diabetes care and services. In FY 1999, CDC provided support to 16 states at the comprehensive level. Comprehensive programs include core program activities and emphasize implementation of public health strategies throughout the entire state, with an expected improvement in access to affordable, high quality diabetes care and services.

IHS – Restoring Access to Health Care Initiative. In FY 2000, IHS began an initiative to restore access to basic health services, including assuring that there are adequate facilities and equipment for the provision of health services and providing adequate support services to the tribal health delivery system.

HRSA – Rural Health Outreach Grants. The Rural Health Outreach and Rural Network Development Grant Programs support the delivery of basic health services to hundreds of thousands of Americans living in underserved rural areas of the country. A wide range of

services including primary care, mental health, dental care, health education, specialty care, hospice care are provided through the Outreach Grant Program to small rural communities in almost every state. A few other communities are receiving Network Development Grants to help them develop fully integrated systems of care. These systems usually involve efforts by the local hospital, physicians groups, long-term facilities and even public health agencies to better organize and manage scarce health care resources in rural communities.

HRSA – Telehealth. HRSA will continue its current rural telehealth activities and anticipates supporting exploratory activities in urban underserved communities. HRSA will support projects to examine the role of telecommunications in improving the ability of rural communities to improve the quality of care services and educational opportunities for health professionals. HRSA will also provide support for an assessment of the practical value of telehealth technologies for reaching the underserved, isolated populations in urban settings. Further funds will be provided to support two regional technical assistance centers that will provide technical advice to local communities and providers on the development of telehealth programs.

HRSA – Health Professions – FY 2001 strategies for improving access to health care include increasing the number of health care and public health providers from minority and disadvantaged backgrounds; fostering community-based education and training especially in underserved areas; supporting training that is directed at the special needs of vulnerable, underserved populations; and enhancing service to underserved communities.

OCR – **Preventing Discrimination in Access to HHS' Services**. Recent studies by HHS, various non-profit organizations, universities and other public agencies have shed light on serious disparities in the health status of race and ethnic minorities and in practitioner referrals of minorities for specific diagnostic and therapeutic procedures. OCR is taking steps to determine whether violations of Title VI and other laws enforced by OCR are contributing factors to these disparities. OCR has begun the process of studying the issue by conducting research, meeting with community-based organizations, medial providers, public officials, and concerned individuals. In addition, OCR will continue to work with health care and social services providers, state and local agencies and HHS partners, to ensure that persons of limited English proficiency are not discriminated against on the basis of national origin.

OCR will concentrate its resources on the critical civil rights issues surrounding changes in health care coverage and services, including increased use of managed care, that are undertaken in the states. OCR will focus on assessing the effects of managed care on services to minority and disability communities. It will expand the number of reviews concentrating on ensuring that, as both Medicare and Medicaid expand the sue of managed care, racial and national minority individuals and persons with disabilities are treated in a nondiscriminatory manner.

OPHS – The Bilingual/Bicultural Service Demonstration Grant Program will continue to support community-based projects to improve access to health care services for limited-English-proficient (LEP) populations. All projects focus on improving the ability of health care

providers and other health care professionals to deliver linguistically and culturally competent health care services to LEP populations.

OPHS – The Office on Women's Health proposes to establish a mechanism by which the National Centers of Excellence in Women's Health can compete for funds to carry out activities in three specific areas, modeled after the Special Interest Projects funded through the CDC Prevention Centers. These three areas are: older women's health, specifically the development of outreach and preventive services to elderly women; the development of cross-disciplinary training programs for health professionals, e.g., nursing and public health with medicine, with a focus on women's health; and the development of programs focused on prevention and clinical services for women at risk of or living with HIV/AIDS.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Assure access to preventive and primary care for low income individuals (i.e., at or below 200 % of poverty) in the Health Centers. *HRSA Plan*	**HC NHSC*** FY 01: 86% 8.26M 2.0M FY 00: 86% 8.26M 2.0M FY 99: 86% 7.65M 1.8M *Health Centers/National Health Service Corps sites	FY 01: FY 00: FY 99: 5/00 HC&NHSC FY 98: 86% HC FY 97: 86% HC
Assure access to preventive and primary care for minority individuals (racial minorities or of Hispanic origin) in the Health Centers. *HRSA Plan*	**HC NHSC** FY 01: 65% 6.24M 1.5M FY 00: 65% 6.24M 1.5M FY 99: 65% 5.79M 1.4M	FY 01: FY 00: FY 99: 5/00 HC&NHSC FY 98: 64% HC FY 97: 65% HC
Assure access to preventive and primary care for uninsured individuals in the Health Centers. *HRSA Plan*	**HC NHSC** FY 01: 45% 4.37M 1.0M FY 00: 43% 4.10M .99M FY 99: 42% 3.80M .88M	FY 01: FY 00: FY 99: 5/00 FY 98: 41% FY 97: 39% (HC)
Decrease proportion of Health Center users who are hospitalized for potentially avoidable conditions. *HRSA Plan*	FY 01: 13 FY 00: 13.5 FY 99: 14	FY 01: FY 00: FY 99: FY 98: 5/00 FY 97: 14.7/1000 **Norm:** 18.9/1000

Performance Goals	Targets	Actual Performance
The percentage of TB patients that will complete a course of curative TB treatment within 12 months of initiation of treatment (some patients require more than 12 months). *CDC Plan*	FY 01: 88% FY 00: 85% FY 99: 85%	FY 01: Mid/03 FY 00: Mid/02 FY 99: Mid/01 FY 97: 72.4% FY 94: 67.6%
A minimum percentage of contacts of infectious cases who are placed on therapy for latent TB infection will complete a treatment regimen. *CDC Plan*	FY 01: 78% FY 00: 75% FY 99: 75%	FY 01: Late/03 FY 00: Late/02 FY 99: Late/00 FY 97: 71.6% FY 93: 68.4%
Increase proportion of Health Center women receiving age-appropriate screening for cervical and breast cancer. *HRSA Plan*	**Up-to-date PAP Tests** FY 01: 94% FY 00: 92% FY 99: 90% **Up-to-date Mammograms** FY 01: 70% FY 00: 67.5% FY 99: 65% **Up-to-date Clinical Breast** FY 01: 85.5% FY 00: 84% FY 99: 82.5%	 FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 88.5% FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 62.5% FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 80.5%
Excluding breast cancers diagnosed on and initial screen in the NBCCEDP, at least 73% of women aged 40 and older will be diagnosed at localized stage. *CDC Plan*	FY 01: 73% FY 00: 72% FY 99: 71%	FY 01: FY 00: FY 99: 3/00 FY 98: 70% FY 95: 70%
Excluding invasive cervical cancers diagnosed on an initial screen in the NBCCEDP, the age adjusted rate of invasive cervical cancer in women aged 20 and older is not more that 24 per 100,000 Pap tests provided. *CDC Plan*	FY 01: No more than 22 per 100,000 FY 00: No more than 22 per 100,000 FY 99: No more than 22 per 100,000	FY 01: FY 00: FY 99: 3/00 FY 98: 23 per 100,000 FY 95: 26 per 100,000

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicare Beneficiaries age 65 and over who receive a mammogram every two years. *HCFA Plan*	FY 01: 51%* FY 00: 60%** FY 99: 59%** *New data source (Medicare Claims Data) will be employed for FY 2001. **Data source: National Health Interview Survey	FY 01: FY 00: FY 99: FY 98: FY 97: 45%* FY 94: 55%**
Increase the percentage of Medicare beneficiaries age 65 years and older who receive vaccinations. – annual influenza vaccination – lifetime pneumococcal vaccination *HCFA Plan*	FY 01: 72%* FY 00: 60%** FY 99: 59%** FY 01: 55%* FY 00: New in 2001 FY 99: New in 2001 *New data source (Medicare Current Beneficiary Survey) will be employed for FY 2001. **Data source: National Health Interview Survey	FY 01: FY 00: FY 99: FY 98: FY 97: 63%** FY 95: 58%** FY 94: 55%** FY 01: FY 00: FY 99: FY 94: 25%*
For all states that receive CDC funding for comprehensive diabetes control programs, increase the percentage of diabetics who receive an annual eye exam and annual foot exam. *CDC Plan*	FY 01: Increase FY 96 baseline by 10% FY 00: Increase FY 96 baseline by 10%>	FY 01: FY 00: FY 99: 10/00 FY 98: Eye 64.7% Foot 56.5% FY 96: Eye 62% Foot 52%
Increase percent of Health Center users with diabetes with up-to-date testing of glycohemoglobin – % adults with diabetes tested at recommend intervals. *HRSA Plan*	FY 01: 90% FY 00: 80% FY 99: 60%* *Diabetes Initiative at 90% for first 100 HCs	FY 01: FY 00: FY 99: 6/00 FY 98: 43% (97 study) **Norm**: 20%

Performance Goals	Targets	Actual Performance
Increase proportion of Health Center adults with hypertension who report their blood pressure is under control. *HRSA Plan*	FY 01: 96% FY 00: 93% FY 99: 92%	FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 90%
Develop and operate collaborative models of health care services in rural areas which will serve underserved populations. *HRSA Plan*	FY01: 854,000* FY00: 764,000 FY99: 680,000 FY98: 616,000 *number of persons served per year	FY 01: FY 00: FY 99: 9/00 FY 98: 630,000
Increase the number of children served by Title V, Maternal and Child Health Block Grant. *HRSA Plan*	FY 01: 24M	FY 01: FY 00: FY 99: 01/01 FY 98: 04/00 FY 97: 20.2 million
Increase annual access to dental services for the AI/AN population. *IHS Plan*	FY 01: 25% FY 00: 23% FY 99: 21%	FY 01: FY 00: FY 99: 23% (provisional) FY 98: 24.5%
Increase the percentage of Medicaid two-year old children who are fully immunized. (To be achieved in 3 phases for State groupings.) – Group 1 States (baseline: 1999-2000; first report: 2001) – Group 2 States (baseline: 2000-2001; first report: 2002) – Group 3 States (baseline: 2001-2002; first report: 2003) *HCFA Plan*	FY 01: First Report FY 00: Set Baseline FY 99: Not Applicable FY 01: Set Baseline FY 00: Not Applicable FY 99: Not Applicable FY 01: Begin baseline activities FY 00: Not Applicable FY 99: Not Applicable	FY 01: FY 00: FY 99: Not Applicable FY 01: FY 00: Not Applicable FY 99: Not Applicable FY 01: Not Applicable FY 00: Not Applicable FY 99: Not Applicable
Increase the percentage of Head Start children who receive necessary medical treatment.	FY 01: 92% FY 00: 90% FY 99: 88%	FY 01: FY 00: FY 99: 87% FY 98: 88%

Performance Goals	Targets	Actual Performance
In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care settings, OCR will increase # managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. Measure: Increased # of corrective actions and no violation findings. *OCR Plan*	FY 01: 33 FY 00: 30 FY 99: 40	FY 01: FY 00 FY 99: 27 FY 98: 10
In order to increase access to HHS services for limited English proficient (LEP) persons, OCR will increase # HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 153 FY 00: 151 FY 99: 125	FY 01: FY 00: FY 99: 146 FY 98: 98

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Head Start
ASPE
Policy Research
CDC
Immunization
Tuberculosis
Breast and Cervical Cancer Prevention
Diabetes and Other Chronic Diseases
HCFA
Medicare
Medicaid
Children's Health Insurance Program
Health Professions and Nursing Training Programs
HRSA
Primary Care
  Health Centers
  National Health Service Corps
Maternal and Child Health
  Maternal and Child Health Block Grant
  Healthy Start Initiative
  Universal Newborn Hearing Screening
  Emergency Medical Services for Children
  Traumatic Brain Injury Program
Rural Health
  Rural Health Outreach Grants
  Rural Health Policy Development
  Telehealth
Workforce Information and Analysis
Health Education and Assistance Loans

IHS
Treatment
  Hospitals & Health Clinics
  Dental Services
  Mental Health
  Alcohol & Substance Abuse
  Contract Health Services
  Urban Health
  Indian Health Professions
Prevention
  Public Health Nursing
  Health Education
  Community Health Representatives
  Environmental Health Support
Capital Programming/Infrastructure
  Health Care Facilities Construction
OCR
Preventing Discrimination in Access to HHS' Services
OPHS
Office of Minority Health
Office of Women's Health
SAMHSA
Knowledge Development and Application
Children's Mental Health Services
Protection and Advocacy
Substance Abuse Block Grant
Mental Health Performance Partnership Block Grant

HHS 3.3: Improve Access to and the Effectiveness of Health Care Services for Persons with Specific Needs

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

HRSA – HIV/AIDS. *HIV Care*. Funds are used to support a wide range of services: home and community-based health care and support services; continuation of health insurance coverage, through a Health Insurance Continuation Program (HICP); pharmaceutical treatments, through the ADAP Program; HIV care consortia that assess needs, organize and deliver HIV services in consultation with service providers, and contract for services; and direct health and support services.

HIV Emergency Relief Grants. These grants are used for community-based outpatient health and support services for low-income persons living with AIDS/HIV, including comprehensive medical care, prescription drugs, counseling, transportation, meals-on-wheels programs, home care and hospice care. Funds may also be used to provide in-patient case management for AIDS/HIV patients to prevent unnecessary hospitalization or to expedite hospital discharge.

HIV Early Intervention Services. This program supports outpatient HIV early intervention services, specifically targeting previously underserved populations, which have had limited access to care, including women, children, adolescents, racial and ethnic minorities, and substance abusers. In FY 2001, HRSA plans to fund new sites, all of which are communities of significant need for Federal support.

HIV Pediatric Grants (Women, Children, Youth). This program focuses on increasing the access of HIV/AIDS-affected women, infants, children, and youth to a comprehensive, community-based, family-centered system of care. The focus of the program has further expanded to develop innovative models that link systems of comprehensive community-based medical and social services for the affected population with the National Institutes of Health and other clinical research trials. Funds support innovative strategies and models to organize, arrange for, and deliver comprehensive services through integration into ongoing systems of care.

Dental Services Program. Through grants, this program reimburses accredited dental schools and other post-doctoral dental education programs for the documented uncompensated costs they have incurred for providing oral health treatment to HIV infected patients.

OPHS – The Office of HIV/AIDS Policy (OHAP) manages the overall HIV/AIDS activities throughout the Department. OHAP's coordination efforts integrate the Department's policies, programs and activities designed to prevent the occurrence of HIV infection and AIDS and promote effective mechanisms to serve those infected with HIV. This includes analyzing and contributing to the design of the Department's priorities to ensure a comprehensive national response to the HIV/AIDS epidemic. OHAP also provides advice and guidance to the

Assistant Secretary for Health and Surgeon General (ASH/SG), the Deputy Secretary and Secretary of the Department on HIV/AIDS programs and policies.

Activities and responsibilities of the office include the management of the Department's 25 member HHS Coordinating Group on HIV/AIDS which serves as the forum for providing advice and guidance to OPDIVs, STAFFDIVs and the Secretary on critical issues concerning HIV/AIDS policy and the Secretary's Advisory Committee on Blood Safety and Availability and the ASH/SG's Blood Safety Committee involving a range of Department-wide initiatives and activities within the purview of these committees.

OPHS – A comprehensive Surgeon General's report on mental health (the first ever on this area of health care) scheduled for release in FY 2000 will include cutting edge information about the status of mental health research and services within the United States. The report is expected to serve as a basis for shaping the Federal government's future mental health program initiatives, as well as providing the public with valuable information about mental health issues impacting the country. As mental health and mental illness become more main stream and less stigmatized, health insurance coverage is likely to become less restrictive.

SAMHSA – The Comprehensive Community Mental Health Services for Children and their Families Program seeks to provide intensive community-based services for children with serious emotional disturbances and their families. The program features a broad array of services tailored to meet the needs of the child through an individualized service planning process. In FY 2001, HHS will continue to support and utilize evaluation findings with approximately 50 grants, allowing continued national progress in improving outcomes for a larger number of children with serious emotional disturbances and their families.

SAMHSA - The new Center for Mental Health Services Targeted Capacity Expansion program has been designed to improve and enhance existing mental health systems at the municipal, county, and tribal government levels to generate new mental health system capacity. It will consist of three major elements: 1) expanding local prevention and early intervention services; 2) addressing gaps in community health care; and 3) engaging federal government partners through program linkages.

NIH – Mental Health Research. NIH will collaborate with SAMHSA to develop a new initiative on mental health in FY 2001. The initiative will integrate research and prevention strategies with action designed to improve the delivery of mental health services. Special emphasis will be placed on public health issues relating to the mental health of adolescents, minorities, and the aged, and of individuals with multiple diagnoses, including drug and mental disorders.

NIH – Mental Health and Health Disparity. Large differences exist across ethnic, racial, and gender groups in access to care for mental illness, in understanding of mental health, in treatment seeking behavior, and in the prevalence of some forms of mental illness. Research on mental illness and mental health will continue to range from the laboratory bench to the treatment clinic, including translating state-of-the-art scientific knowledge to community-based practice. Major areas for study include the effects of culture on mental disorders, the

economic and social barriers to diagnosis and treatment, how gender differences influence the development and course of mental disorders, and the behavioral and cognitive effects of environmental exposures on children.

HRSA – Maternal and Child Health Block Grant. HRSA provides additional funds to States to provide services for the approximately 12 million children who are presently in critical need of multi-disciplinary services and do not have adequate insurance to meet the special needs necessary to develop, function and learn, including optional benefits not provided by some state CHIP plans and urgent treatment and preventive services for children who will continue to be uninsured and under-insured. This program also supports the development of coordinated care delivery systems and services for children with special health care needs.

SAMHSA – A major objective of the National Drug Control Strategy is to close the treatment gap for substance-abuse victims and reduce drug use by 50 percent in the next ten years. To improve program impacts for this special needs population in FY 2001, SAMHSA will expand efforts in two programs that focus on reducing the treatment gap: 1) the Substance Abuse Prevention and Treatment Block Grant, which will provide for nationwide expansion of treatment services and aid in the reduction of treatment waiting lists; and, 2) the Targeted Capacity Expansion Program, which will provide rapid and strategic responses to the demand for alcohol and drug abuse treatment services that are regional or local in nature.

ACF – Developmental Disabilities (DD). In order to improve the health of people with developmental disabilities and increase their access to needed health care services, DD works to ensure that individuals with developmental disabilities and their families have access to the health care information they need to make choices; that health care is available, affordable, accessible, and equitable; and that health care personnel are appropriately qualified to meet the health care needs of people with developmental disabilities.

OPHS/HRSA – The National Hispanic Prenatal Hotline Project funded under the National Coalition of Hispanic Health and Human Services Organizations cooperative agreement establishes a national hotline to provide individualized, culturally/linguistically appropriate information regarding prenatal care to Hispanic consumers in the United States and Puerto Rico. Through a newly established database, individuals can access culturally written information on prenatal care and health care providers are able to access information on how to provide culturally and linguistically appropriate prenatal care services.

FDA – Drugs. FDA's Orphan Products Grant Program encourages clinical development of products used to treat rare diseases or conditions. A product used to treat a disease or condition that affects fewer than 200,000 persons in the United States is called an Orphan product. Companies are often reluctant to invest time and money to develop orphan products because the market is so small. To encourage research and product development for rare diseases and conditions, FDA offers grants, special privileges and marketing incentives to companies under the Orphan Drug Act. Orphan products (drugs, biologics, medical devices, medical foods) are needed to help reduce pain and suffering for persons with diseases such as hemophilia, multiple sclerosis, cystic fibrosis, rare cancers, and as many as 5,000 other known rare disorders that affect as many as 20 million Americans.

FDA – Drugs. FDA is dedicated to combating AIDS and other life threatening conditions by streamlining the development and approval process for new therapies. FDA's broad-based, multi-disciplinary research programs have played a significant role in the development of vaccines, therapeutic agents, and test kits for possible use in AIDS and AIDS-related conditions by defining parameters that must be met regardless of sponsor. FDA continues to enlarge the scope of its AIDS-related activities as new data on HIV, AIDS, and AIDS-related diseases become available and as clinical trials of new therapies, vaccines, and diagnostic tests expand.

FDA – Drugs. FDA is encouraging patients to play an integral part in the decision making process for healthcare. FDA appoints patient representatives to participate on Advisory Committees that consider new drugs for approval. FDA also plans to establish a public registry containing information about clinical trials for experimental drugs and biologics that will be used to treat serious or life threatening diseases and conditions. This registry will provide consumers greater access to information about clinical trials and increase their opportunity to participate in these trials.

HRSA – Primary Care, Health Centers. The FY 2001 budget includes a request for funds to provide comprehensive primary care services to more than 50,000 at-risk school children through school-linked and school-based programs, including mental and dental care, substance abuse and violence prevention services.

HRSA – National Marrow Donor Program. Through the program, volunteer donors are recruited and tissue typed, the national registry of potential donors is maintained, computerized searches of the registry are conducted for patients, marrow is collected and provided for transplants (1,362 in 1998), and a scientific registry of transplant outcomes is published. The program emphasizes the recruitment of minority donors in order to equalize access. The program also provides information and search case management for patients and conducts research to improve the number and effectiveness of marrow transplants using unrelated donors.

HRSA – Organ Procurement and Transportation. The total number of organ transplants increased 60% between 1988 and 1998, but the number of transplant candidates is rising faster than the number of donors. Physicians and health care personnel, as well as the general public, require education to recover all organs lost because donation is not considered. In FY 2001, HRSA plans to sustain and increase its efforts with a variety of additional partners to increase organ donation and provide for increased production and distribution of educational materials. HRSA will also support efforts directed at a better understanding of the consent and referral processes that take place between hospital and referral personnel and families. In 1999, there were more than 66,000 registrants waiting for organs.

ACF - Head Start emphasizes the importance of the early identification of health problems. Every child is involved in a comprehensive health program, which includes immunizations, medical, dental, and mental health, and nutritional services.

SAMHSA - The Projects for Assistance in Transition from Homelessness Program (PATH) provides community support services to individuals who are homeless or at risk of homelessness. Eligible services funded under PATH include: outreach; screening and diagnostic treatment; habilitation and rehabilitation; community mental health services; alcohol or drug treatment (for mentally ill individuals with co-occurring substance use disorders); staff training; case management; supportive and supervisory services in residential settings; and referrals for primary health care, job training, and education. In addition to improving coordination of services and housing for the target population, a limited set of housing services may be funded.

OCR – Preventing Discrimination in Access to HHS' Services. OCR will concentrate its resources on the critical civil rights issues surrounding changes in health care coverage and services, including increased use of managed care, that are undertaken in the states. OCR will focus on assessing the effects of managed care on services to minority and disability communities. It will expand the number of review concentrating on ensuring that, as both Medicare and Medicaid expand the use of managed care, racial and national origin minority individuals and persons with disabilities are treated in a nondiscriminatory manner. In addition, OCR will continue to work with health care and social services providers, state and local agencies and HHS partners to ensure that persons of limited English proficiency are not discriminated against on the basis of national origin.

OPHS – The Center for Linguistic and Cultural Competence in Health Care develops and evaluates models, conducts research, and provides technical assistance to providers to address the cultural and linguistic barriers to health care delivery and increase limited English speaking individuals' access to health care. FY 2000 activities include: disseminating information on current language and cultural competency model programs, techniques, organizational and governmental policies; launching a culturally competence systems change initiative; conducting an evaluation of selected sites to determine the effectiveness of culturally competent programs on ethnically diverse patients; commissioning papers on development of culturally competent training programs for health care providers; developing a research project on cultural competence health delivery programs, and initiating research on impact of culturally competent services on patient treatment protocols and outcomes. All products will be disseminated through the Office of Minority Health Resource Center (OMHRC) and through the OMHRC web-site.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Increase the percent of children with special health care needs in the State with a medical/health home. *HRSA Plan*	FY 01: 80%	FY 01: FY 00: FY 99: 01/01 FY 98: 04/00 FY 97: 69%

Performance Goals	Targets	Actual Performance
Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative and home health) in Title I and II programs to a level that approximates inclusion of new clients. *HRSA Plan*	**HIV Emergency Relief Grants** FY 01: 3.00M visits FY 00: 2.92M FY 99: 2.88M **HIV Care Grants to States** FY 01: 1.57M FY 00: 1.53M FY 99: 1.22M	 FY 01: FY 00: FY 99: 1/01 FY 98: 2.79M FY 97: 2.77M FY 96 : 2.67M visits FY 01: FY 00: FY 99: 1/01 FY 98: 1.45M FY 97: 1.07M visits
Increase the number of AIDS Drug Assistance Programs (ADAP) clients receiving appropriate antiretroviral therapy (consistent with clinical guidelines) through State ADAPs during at least one month of the year. *HRSA Plan*	FY 01: 74,800 clients FY 00: 71,900 FY 99: 78,088	FY 01: FY 00: FY 99: 64,500 FY 98: 55,000 clients
Decrease the number of newly reported AIDS cases in children as a result of perinatal transmission. *HRSA Plan*	FY 01: 193 cases FY 00: 203 FY 99: 214	FY 01: FY 00: FY 99: 01/01 FY 98: 225 FY 97: 310 FY 96: 502 cases
Increase by 20% over two years the number of organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation of Hospitals. (9/98) *HRSA Plan*	FY 01: 7,248 donors FY 00: 6,589 FY 99: 5,990	FY 01: FY 00: FY 99: 5/00 FY 98: 5,799 FY 97: 5,477 donors
Increase by 7.5% the number of unrelated bone marrow donors (national registry of potential donors) over previous year totals. *HRSA Plan*	FY 01: 4.35M donors FY 00: 4.04M FY 99: 2.84M	FY 01: FY 00: FY 99: 3.76 FY 98: 3.36 FY 96: 2.58 M donors

Performance Goals	Targets	Actual Performance
In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care settings, OCR will increase # managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 33 FY 00: 30 FY 99: 40	FY 01: FY 00 FY 99: 27 FY 98: 10
Increase the number of health care providers trained to meet the health needs of people with developmental disabilities as a result of DD program intervention. *ACF Plan*	FY 01: FY 00: FY 99: 4,000	FY 01: FY 00: FY 99: 2/01 FY 98: 2/00 FY 97: 2,922
The proportion of people 18 and over reporting depression in the past 12 months who are receiving treatment. *OPHS Plan*	FY 01: 30%	FY 01: FY 00: FY 99: FY 98: FY 97: 23%
Decrease the annual rate of suicide. *OPHS Plan*	FY 01: 10 FY 00: 10.5	FY 01: FY 00: FY 99: FY 98: 10.8 FY 96: 11.7
In order to increase access to HHS services for limited English proficient (LEP) persons, OCR will increase # HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 153 FY 00: 151 FY 99: 125	FY 01: FY 00: FY 99: 146 FY 98: 98

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Developmental Disabilities
Head Start
AHRQ
Research on Health Costs, Quality, and Outcomes
FDA
Drugs
HRSA
Primary Care
  Health Centers
  National Hansen's Disease Program
  Black Lung Clinics
HIV/AIDS
  HIV Care
  HIV Emergency Relief Grants

HRSA (continued)
HIV Early Intervention Services
  HIV Pediatric Grants
  Education and Training Centers
  Dental Services Program
Maternal and Child Health
  Maternal and Child Health Block Grant
  Universal Newborn Hearing Screening and Early Intervention
  Healthy Start Initiative
  Emergency Medical Services for Children
  Traumatic Brain Injury Program
Health Professions and Nursing Training Programs
National Bone Marrow Donor Program
Organ Procurement and Transplantation

NIH
Research Program

OCR
Preventing Discrimination in Access to HHS' Services

OPHS
Office of HIV/AIDS Policy
Office of the Surgeon General

SAMHSA
Targeted Capacity Expansion
Children's Mental Health Services
Protection and Advocacy
Substance Abuse Block Grant
Mental Health Performance Partnership Block Grant

HHS 3.4: Protect and Improve Beneficiary Health and Satisfaction with Medicare and Medicaid

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

HCFA – National Medicare Education Program (NMEP). The primary intervention designed to improve beneficiary satisfaction with the health care services they receive is the NMEP. The NMEP will provide beneficiaries with accurate, easily understandable information about their health insurance options to assist them in becoming more active participants in their health care decisions. This includes providing comparative information on benefit structures, cost-sharing requirements, and quality and performance indicators. The information is intended to help beneficiaries choose whether they want to be in fee-for-service or managed care; and if they choose managed care, which health plan would be best for them. The NMEP will also provide data when available on other Medicare+Choice options, such as medical savings accounts and private fee-for-service plans.

HCFA – Peer Review Organizations. Central to performance measurement for HCFA is the beneficiary focus that pervades its goals and objectives. A critical component of that focus is the effectiveness of medical treatment that is provided to Medicare beneficiaries. HCFA's efforts to improve medical treatment through its collaboration with Peer Review Organizations is the basis for its performance goals to: 1) improve heart attack survival rates, 2) increase influenza vaccination, 3) increase the use of mammograms, and 4) increase diabetic eye exams. PROs, which serve under contract with HCFA, conduct cooperative improvement projects in which they use data to identify opportunities to improve care, and then work to develop interventions that will bring improvement for subject quality indicators. Pertinent to the HCFA performance plan, HCFA and the PROs are fostering utilization of interventions to treat heart attacks and improve survival rates; are working with providers, health plans and others on influenza vaccination projects; and are networking with local project collaborators to provide education and reminders to improve mammography rates.

HCFA – State Children's Health Insurance Program. The importance of childhood immunization is demonstrated in the State Children's Health Insurance Program (SCHIP). Under the legislation, States that create a separate SCHIP program must include coverage of the complete series of immunizations. States also are prohibited from imposing co-payments or deductibles on immunization services. Almost all of the SCHIP State Plans submitted to HCFA by April 1998 indicated the intention to apply a measure of childhood immunization to their SCHIP population as a basic indicator of quality of care.

  Moreover, highly effective, evidence-based interventions are available to raise childhood immunization coverage levels. A large number of studies have shown that performance measurement through HEDIS®, registries, or other assessment techniques and the use of recall and reminder systems to identify and track children in need of vaccination will substantially raise coverage levels. A major barrier to childhood immunization is the information gap that exists among parents and providers about the immunization status. Research indicates that

over three-fourths of parents of children in need of immunization believe their child is completely vaccinated. Similarly, providers also tend to greatly over-estimate the immunization coverage levels of their patients. This information gap is an important reason why both performance measurement and recall and reminder systems are highly effective, evidence-based intervention strategies that are recommended by both the Centers for Disease Control and the Advisory Committee on Immunization Practices.

HCFA – Nursing Home Initiative. In 1998, the President and the Secretary of HHS announced an initiative to toughen nursing home enforcement tools and strengthen Federal oversight of nursing home quality and safety standards. Key components of FY 2001 activities proposed by HCFA toward achieving the President's objectives include increased direct survey activities and emphasis on nursing home effectiveness in preventing bed sores, dehydration, and malnutrition, investigating complaints alleging actual harm to a resident within 10 days, increased sanctions for deficient nursing homes, staggering the start times of annual surveys with at least ten percent begun on weekends or evenings, increased support contract activities, including review of nursing homes' systems to prevent, identify, and stop physical or verbal abuse, neglect, and misappropriation of resident property; and more frequent inspections of nursing homes with repeated serious violations.

AHRQ – Quality of Care Research. AHRQ's priority for new research is more focused than past efforts to respond directly to the priority needs of Medicare and Medicaid. Change and growth in the Medicare and Medicaid populations will continue to affect health care cost, which, in turn, raises concerns about the assurance of health care quality. Examples of AHRQ activities supporting Medicare and Medicaid beneficiaries include: 1) providing objective, science-based, timely information to health care decision makers-- patients and clinicians, health system leaders, and policy makers; 2) health care cost and utilization surveys, such as CAHPS® and MEPS, that provide information supporting health plan choices and coverage decisions; and 3) tracking the national impact of the State Children's Health Insurance Program on access and cost of care for children.

OCR – Preventing Discrimination in Access to HHS's Services. OCR will concentrate its resources on the critical civil rights issues surrounding changes in health care coverage and services, including increased use of managed care, that are undertaken in the states. OCR will focus on assessing the effects of managed care on services to minority and disability communities. It will expand the number of reviews concentrating on ensuring that, as both Medicare and Medicaid expand the sue of managed care, racial and national minority individuals and persons with disabilities are treated in a nondiscriminatory manner. OCR will work with its HHS Agency partners to improve research and data collection efforts to support target enforcement in this changing arena. In addition OCR will continue to work with health care and social services providers, state and local agencies and HHS partners, to ensure that persons of limited English proficiency are not discriminated against on the basis of national origin.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicare beneficiaries age 65 years and older who receive vaccinations. – annual influenza vaccination	FY 01: 72%* FY 00: 60%** FY 99: 59%**	FY 01: FY 00: FY 99: FY 98: FY 97: 63%** FY 95: 58%** FY 94: 55%**
– lifetime pneumococcal vaccination *HCFA Plan*	FY 01: 55%* FY 00: New in 2001 FY 99: New in 2001 *New data source (Medicare Current Beneficiary Survey) will be employed for FY 2001. **Data source: National Health Interview Survey	FY 01: FY 00: FY 99: FY 94: 25%*
Increase the percentage of Medicare Beneficiaries Age 65 and over who receive a mammogram every two years. *HCFA Plan*	FY 01: 51%* FY 00: 60%** FY 99: 59%** *New data source (Medicare Claims Data) will be employed for FY 2001. **Data source: National Health Interview Survey	FY 01: FY 00: FY 99: FY 98: FY 97: 45%* FY 94: 55%**

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicaid two-year old children who are fully immunized. (To be achieved in 3 phases for State groupings.) – Group 1 States (baseline: 1999-2000; first report:2001) – Group 2 States (baseline: 2000-2001; first report: 2002) – Group 3 States (baseline: 2001-2002; first report: 2003) *HCFA Plan*	FY 01: First report FY 00: Set baseline FY 99: Not Applicable FY 01: Set baseline FY 00: Not Applicable FY 99: Not Applicable FY 01: Begin baseline activities FY 00: Not Applicable FY 99: Not Applicable	FY 01: FY 00: FY 99 :Not Applicable FY 01: FY 00: Not Applicable FY 99: Not Applicable FY 01: Not Applicable FY 00: Not Applicable FY 99: Not Applicable
Decrease one-year mortality among Medicare beneficiaries hospitalized for heart attack. *HCFA Plan*	FY 01: Towards 27.4% in 2002 FY 00: Towards 27.4% in 2002 FY 99:New in FY 2000	FY 01: FY 00: FY 99: FY 95/96: 31.4%
In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care settings, OCR will increase # managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 33 FY 00: 30 FY 99: 40	FY 01: FY 00 FY 99: 27 FY 98: 10
In order to increase access to HHS services for limited English proficient (LEP) persons, OCR will increase # HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 153 FY 00: 151 FY 99: 125	FY 01: FY 00: FY 99: 146 FY 98: 98

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Medical Expenditure Panel Surveys
Research on Health Costs, Quality, and Outcomes
HCFA
Medicare
Medicaid
Medicare+Choice
Peer Review Organizations
OCR
Preventing Discrimination in Access to HHS' Services

HHS 3.5: Enhance the Fiscal Integrity of HCFA Programs and Ensure the Best Value Health Care for Beneficiaries

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

HCFA – Reforming HCFA Management. HCFA administers Medicare, Medicaid, and SCHIP, and oversees State health insurance regulation of individual and small group markets. The agency faces the important challenge of strengthening its management capacity in order to coordinate the work of dozens of contractors as well as State and territorial governments – while providing superior customer service to more than 70 million beneficiaries. HCFA is further reforming its operations in order to adapt to the changing health care market and increase its accountability as a prudent purchaser of health care.

HCFA – Strategies to Fight Fraud and Abuse. HCFA's main focus on preventing and detecting fraud and abuse is through the Medicare Integrity Program (MIP) and the Health Care Fraud and Abuse Control (HCFAC) account. To reduce erroneous Medicare payments, HCFA will continue implementation of initiatives that target program oversight areas and benefit categories. Program oversight initiatives include implementation of the Medicare Integrity Program, medical review and benefit integrity, payment safeguards for BBA provisions, and provider integrity. The benefit initiatives cover the following categories: inpatient hospital, congregate care, managed care, community mental health centers, and nursing home enforcement.

HCFA – Medicare Integrity Program (MIP) Activities. The MIP activity in the HCFAC account covers medical review, benefit integrity, provider and HMO audits, Medicare secondary payer activities, and provider education and training. Medical review activities can be conducted either pre-payment or post-payment, and serve to guard against inappropriate benefit payments by ensuring that the medical care provided is covered by the program, and is reasonable and necessary. Benefit integrity activities deter and detect fraud through the concerted efforts with the Office of Inspector General, the General Accounting Office, the Department of Justice, and other HCFA partners. HCFA identifies patterns of fraud, follows up on beneficiary complaints which indicate fraud, and makes appropriate referrals to law enforcement. Auditing is HCFA's primary instrument to safeguard payments made to institutional providers and HMOs whose costs are settled through cost reports. The Medicare Secondary Payer program makes sure that Medicare only pays those claims where it has the primary responsibility for payment for services. When mistaken payments are identified, recovery actions are undertaken. Through provider education and training, HCFA reinforces appropriate Medicare billing practices and assists providers to avoid and detect waste, fraud and abuse.

HCFA – Payment Error Corrective Action Plan. HCFA continues to carry out a corrective action plan specifically designed to reduce payment errors made under the Medicare fee-for-service program. The corrective action plan focuses planned medical review and other

activities on targeted high-risk areas, such as physician office visits, physician evaluation and management, medical documentation, home health services, durable medical equipment, hospital outpatient services, and laboratory services. HCFA is developing the capacity to project precise error rates which are valid below the national level, to improve their ability to target problem areas, and better manage Medicare contractor performance and the Medicare program as a whole.

HCFA – Strengthening Oversight of Medicare Contractors. HCFA seeks to develop a comprehensive approach to improving performance among our Medicare contractors. Our strategy includes: standardizing and strengthening contractor performance evaluation; building a business-like internal control structure at the contractors, focused on financial management and EDP internal controls; creating a team of over 100 financial management experts at the contractors' sites to help ensure a consistent and coordinated response to suspected instances of fraud and waste; and developing an integrated, dual-entry accounting system that can ensure accurate reporting and recording of financial data.

AoA – Operation Restore Trust. AoA provides support to train National Aging Network staff and retired volunteers on ways to educate Medicaid and Medicare beneficiaries to protect themselves against fraudulent, wasteful and abusive health care practices. AoA tracks, for example, the number of health care anti-fraud cases opened as a result of each project's activity and the amount of money recouped.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Reduce the error rate for all Medicare fee-for-service payments. *HCFA Plan*	FY 01: 6.0% FY 00: 7.0% FY 99: 9.0%	FY 01: FY 00: FY 99: FY 98: 7.1% FY 97: 11.0% FY 96: 14.0%

Performance Goals	Targets	Actual Performance
Improve the Medicare Secondary Payer (MSP) Program:		
– Increase total MSP recovery dollars	FY 01: 5% FY 00: New in 2001 FY 99: New in 2001	FY 01: FY 00: (Baseline to be determined)
– Decrease the time to recoup recoveries	FY 01: To Be Determined FY 00: New in 2001 FY 99: New in 2001	FY 01: FY 00: (Baseline to be determined)
– Increase MSP liability and no-fault recoveries (replaced by total recovery dollars in 2001) *HCFA Plan*	FY 01: Discontinued FY 00: 5% FY 99: New in 2000	FY 00: FY 99: New in 2000
Reduce improper home health service payments in four States (California, Illinois, New York, and Texas). *HCFA Plan*	FY 01: Discontinued FY 00: 10% FY 99: 35%	FY 00: FY 99: 19% FY 95/96: 40% (Baseline)

PROGRAMS SUPPORTING THIS OBJECTIVE

AoA
State and Local Innovations and Projects of National Significance
HCFA
Medicare
Medicaid
Medicare Integrity Program

HHS 3.6: Improve the Health Status of American Indians and Alaska Natives

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

IHS – Treatment, Hospitals and Health Clinics. IHS' Hospitals and Clinics Program provides essential services including inpatient care, routine and emergency ambulatory care; and support services including laboratory, pharmacy, nutrition, health education, medical records, physical therapy, nursing, etc. The program includes initiatives targeting special health conditions that affect AI/ANs such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases (including AIDS and tuberculosis and others), and a continuing emphasis on women's and elder health and epidemiology.

  Other clinical services, (dentistry and community services, e.g., public health nursing) along with a number of health programs operated by the tribes (women, infants, and children's programs and behavioral health services) are often housed in the same facilities. This co-location of services in the hospital and clinic increases access and fosters a truly comprehensive community-oriented program.

IHS – Restoring Access to Health Care Initiative. In FY 2000, IHS began an initiative to restore access to basic health services, including assuring that there are adequate facilities and equipment for the provision of health services and providing adequate support services to the tribal health delivery system.

IHS – Reducing the Gap in Health Disparities Initiative. This initiative targets the health problems identified as highest priority by the I/T/U and responsible for much fo the disparity n health status for the AI/AN population. These include alcoholism and substance abuse, diabetes, cancer, mental health, elder health, heart disease, injuries, dental health, maternal and child health, domestic violence, infectious diseases and sanitation. Support for public health infrastructure is also fundamental to this initiative. This initiative will also support surveillance, prevention, and treatment services and are based on "best practices" defied in the health literature. IHS will also address the need for water and sewer systems for new and existing homes at the community level.

ACF – Native American Programs. ACF's Social and Economic Development Strategies program is based on the premise that local communities have the primary responsibility for determining its own needs, planning and implementing its own programs, and for use of its own natural and human resources. Through a direct grant funding relationship, Tribes and Native communities have created administrative systems to operate their own social and economic programs, much in the same way as State and local governments. Support for the unique, government to government relationship that exists between Tribal governments and the Federal government is reflected in this approach. Additional priority funding areas include native languages preservation and enhancement, environmental regulatory enhancement, and environmental mitigation.

AoA – Grants to Indian Tribes. AoA's American Indian, Alaskan Native and Native Hawaiian Program awards grants to provide supportive and nutrition services, including both congregate and home-delivered meals to older Native Americans.

SAMHSA - The Center for Mental Health Services, in collaboration with IHS, funds the Circles of Care program which supports the development and testing of culturally competent models of mental health services for children in Tribes and urban American Indian organizations. The local communities select the services and outcomes which are important to them.

IHS – Treatment, Indian Health Professions. This program enables AI/AN to enter the health care professions through a carefully designed system of preparatory, professional and continuing educations assistance programs; serves as a catalyst to the development of Indian communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; and develops and maintains American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field.

IHS – Prevention, Public Health Nursing (PHN). The public health nursing role is predominantly one of advocacy, strengthening relationships within the Indian community and providing the framework for broadly based community efforts. This includes therapy, counseling, education, and referral activities often carried out in conjunction with other members of the health care teams such as the community health representative. Other significant PHN activities include coordination and case management activities.

IHS – Prevention, Community Health Representatives (CHR). The CHR program provides an effective bridge between the community and direct health care services to improve and increase access to the health care delivery system. AI/ANs most in need of care are identified and home visits are made to expectant mothers, infants, young children, elderly, and those with chronic diseases. Clinical and preventive appointments are made and transportation is arranged by CHRs to ensure those needing health care services receive the care needed. A full-time national coordinator for community health promotion/disease prevention provides technical assistance to tribal programs and IHS and coordinates activities and resource sharing among the growing number of tribal CHR programs.

IHS – Prevention, Health Education. IHS assists its local partners to engage in community-based prevention initiatives which address HIV/AIDS risk behavior, violence, child abuse, physical inactivity, nutrition, alcohol and substance abuse and tobacco use and cessation.

IHS – Prevention, Anti-Drug Abuse Activities. IHS will increase drug-related activities, including treatment, Adolescent Regional Treatment Centers, Community Rehabilitation and Aftercare, Training/Community Education, Health Promotion/Disease Prevention, Navajo Rehabilitation Program Urban Programs, and Contract Health Services.

Program improvements will continue to focus on the needs of alcohol and substance abusers who have a history of sexual abuse and on a redesigned community mobilization effort that will provide innovative treatment dn prevention modules targeting communities that have high rates of alcoholism and drub abuse. In addition, IHS efforts will be responsive to changing drug use patterns, such as the increase in methamphetamine use in the Billings Area.

IHS – Prevention, Injury Prevention. IHS collaborates with tribes and other Federal, State, and local agencies in efforts to reduce the incidence of severe injuries, with special emphasis on primary prevention, developing programs on sound epidemiological bases, and funding community-based prevention projects. IHS has developed injury prevention training programs specifically for the community-based practitioner. IHS will also assist tribes in building their capacity and local tribal health infrastructure to develop effective programs to prevent traumatic injuries and death and increase the number of tribal injury prevention programs by as many as 200 projects. The FY 2001 Budget proposes investing in the development of an environmental health data surveillance system which includes the capacity to track the etiology of injuries so that effective interventions can be employed.

OPHS – Executive and Secretarial Orders and Proclamations. OPHS plans to continue its key role in coordination, management, and implementation of several important Executive and Secretarial Orders and Proclamations to address the health needs of AI/ANs. Among them is the departmental minority initiative, under Executive Order 13021 issued in October 1996 to support access by Tribal Colleges and Universities to Federal resources. OPHS will also execute a number of cooperative agreements and other formal arrangements with national and community organizations to address AI/AN health needs, including a cooperative agreement to ensure that AI/AN needs are appropriately addressed in the National Diabetes Education and Prevention Plan.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Increase the proportion of I/T/U clients with diagnosed diabetes that have improved their glycemic control. *IHS Plan*	FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 38%	FY 01: FY 00: FY 99: 9/00 FY 98: 35%
Increase the proportion of I/T/U clients with diagnosed diabetes and hypertension that have achieved diabetic blood pressure control standards. *IHS Plan*	FY 01: 3-year average improved FY 00: 3-year average improved FY 99: 30%	FY 01: FY 00: FY 99: 9/00 FY 98: 27%

Performance Goals	Targets	Actual Performance
Increase the proportion of woman who have annual Pap screening. *IHS Plan*	**Pap Screening** FY 01: 3% over FY 00 FY 00: 55% FY 99: establish baseline **Cervical Cancer** FY 99: determine incidence	 FY 01: FY 00: FY 99: 04/00 FY 99: 8-10/100,000 based on 40% of AN/AN
Increase coverage of the AI/AN female population 50-69 years of age who have had annual screening mammography. *IHS Plan*	FY 01: 3% over FY 00 FY 00: 30% or greater FY 99: establish baseline	FY 01: FY 00: FY 99: 04/00
Increase the proportion of AI/AN children receiving a minimum of four Well Child Visits by 27 months of age and expand coverage. *IHS Plan*	FY 01: 3% over FY 00 FY 00: 3% over FY 99 FY 99: establish baseline	FY 01: FY 00: FY 99: 38.5 % (provisional)
Increase the percentage of AI/AN children 6-8 and 14-15 years who have received protective dental sealants on permanent molar teeth. *IHS Plan*	**6-8 Years** FY 01: 2% over FY 00 FY 00: 23% over FY 99 FY 99: 50% **14-15 Years** FY 01: 2% over FY 00 FY 00: 2% over FY 99 FY 99: 58%	 FY 01: FY 00: FY 99: 38.8% FY 91: 40.1% FY 01: FY 00: FY 99: 66.8% FY 91: 66.5%
Increase the proportion of AI/AN children who have completed all recommended immunizations by the age two. *IHS Plan*	FY 01: 2% over FY 00 FY 00: 2% over FY 99 FY 99: 90%	FY 01: FY 00: FY 99: 87% FY 98: 88%
Increase overall pneumococcal and influenza vaccination levels among adults aged 65 years and older. *IHS Plan*	FY 01: 2% over FY 00 FY 00: 65%	FY 01: FY 00: FY 99: FY 98: 63%

Performance Goals	Targets	Actual Performance
Maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites, as part of an overall assessment of the ongoing childhood obesity prevention project's effectiveness. *IHS Plan*	FY 01: implement program and monitor pilots and comparisons sites FY 00: develop five pilot sites FY 99: develop approach and baselines	FY 01: FY 00: FY 99: completed

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Native American Programs
AoA
Grants to Indian Tribes
IHS
Treatment
- Hospitals & Health Clinics
- Dental Services
- Mental Health
- Alcohol & Substance Abuse
- Contract Health Services
- Urban Health
- Indian Health Professions
- Tribal Management
- Self Governance
- Contract Support Costs

Prevention
- Public Health Nursing
- Health Education
- Community Health Representatives
- Environmental Health Support
- OEHE Support

Capital Programming/Infrastructure
- Sanitation Facilities
- Health Care Facilities Construction
- Facilities Support
- Environmental Health Support
- OPHE Support
- Equipment

Consultation, Partnerships, Core Functions, and Advocacy
- Direct Operations
- Facilities Support
- Environmental Health Support
- OEHE Support

OPHS
SAMHSA
Knowledge Development and Application
National Data Collection State Infrastructure
Substance Abuse Block Grant
Mental Health Performance Partnership Block Grant

HHS Goal 4: IMPROVE THE QUALITY OF HEALTH CARE AND HUMAN SERVICES

From the HHS Strategic Plan, September 1997. Together with partners in state, local and tribal governments, the Department of Health and Human Services (HHS) is responsible for delivering an array of health and human services designed to improve the health and economic and social well-being of its citizens. Attendant upon this responsibility is the need to improve the quality of these services continually in order to enhance their effectiveness. The Department accomplishes this through support for a wide range of quality improvement activities designed to provide better ways of addressing the constantly changing problems that confront the health and human service delivery system, from changes in family structures and demographics to innovations in the way health services are organized and financed.

Health Care Services. America is justifiably proud of the quality of care available from its health care system, which over the past fifty years has produced dramatic improvements in the prevention and effective treatment or cure of many diseases and, in turn, longer life spans and more productive lives. These advances were supported in large part by the fee-for-service financing of the health care system. However, a continuing escalation of health care costs in the fee-for-service system set the stage for the transformation that is now occurring in the financing and delivery of care. The demands of purchasers for better value in health care have fostered a variety of strategies and interventions, now often described in the aggregate as managed care, which have brought utilization controls and competitive forces to bear on the industry. Such changes, along with payment reforms in Medicare, have helped curb the rate of growth of health care expenditures.

At the same time, concerns have arisen that cost reductions might compromise the quality of care. Studies have found that many patients do not receive the most appropriate treatment because of underuse or overuse of certain therapies. Assessments are difficult, however, since national baseline information on the quality of health care is at the developmental stage and consumers often erroneously equate restrictions on choice with diminished quality.

In addition, the role of patients in the health care system is changing. In contrast to earlier practice, individuals are being asked to make choices about their health care plans, health providers, and even specific therapies. Many have responded to this change by demanding information about health plans, providers, delivery systems, and treatment options and products. Yet, most consumers have never seen information on quality of care, and when they have seen it, they were not sure how to use it. In addition, wide disparities in access to quality health care persist for certain groups, notably the economically disadvantaged and racial and ethnic minority groups, and contribute to important differences in health status and outcomes.

HHS influences the quality of health care in this country in many ways. Medical research sponsored by the National Institutes of Health (NIH) develops the knowledge base for clinical and population-based health services. From research sponsored by the Agency for Health Care Policy and Research (AHRQ) have come new measures of health outcomes and quality performance, and

studies of the effectiveness of both medical services and of ways to improve and assure quality of care. Multiple agencies—NIH, AHRQ, HCFA, HRSA, IHS, and SAMHSA—develop and disseminate information on how that knowledge can be most effectively applied in various specialized settings. The Department is the largest purchaser of care in the United States through the Medicare and Medicaid programs and through its grant programs to states, tribal governments, and nonprofit entities such as community health centers. The Health Care Financing Administration (HCFA) develops standards and certification of providers, clinical laboratories, and health plans, and has been a leader in the development of performance standards and quality measures for health plans. These standards ensure the basic quality of care for all Americans. Through the Food and Drug Administration's (FDA) regulation of drugs, biologics, and medical devices, and the quality of information disseminated about them, the Department ensures the safety and efficacy of these critical components of medical practice. Also, the Department directly provides health care to Native Americans through the Indian Health Service (IHS). Furthermore, HHS influences practitioners and consumers through the dissemination of health information to these audiences.

Human Services. Human services delivery systems are currently undergoing enormous changes that place new demands on the Department's ability to provide quality services. HHS' role includes assisting states and other partners to develop their data and evaluation capacities and providing extensive technical assistance to help its partners in state and tribal governments and in communities to have access to current information on how to provide high quality and effective social services. The Department will support both research and demonstrations to expand the knowledge base; to identify best practices to help inform states of extant models and approaches to improve the quality of job services, transportation, and child care services; to help identify those who would not otherwise succeed in work without ancillary human services; and to help improve the integration and quality of the services to enable and sustain employment.

Breaking the cycle of dependency depends both on work with parents and early interventions on behalf of children. The Head Start program was established in 1968 to provide comprehensive services to preschool children. In recent years, the program has been expanded to serve more low-income children. Program expansion has heightened awareness of the importance of quality services even further. Recent research in related disciplines is helping to sharpen understanding about early intervention and its effects on early growth and development. The program has had a long history of monitoring and program improvement. But even more is needed to develop effective measures of quality and performance in Head Start, Early Head Start, and child care programs. The Department will continue to work collaboratively with national organizations, researchers, and local programs to develop measures. Rigorous study has commenced to measure Early Head Start outcomes, and child care research partnerships will be expanded to conduct field-initiated studies to examine issues of quality, among other issues.

In related efforts, the National Institute of Child Health and Human Development (NICHD) has conducted a national study of the effects of child care on child development. The increasing demand for child care services for welfare and low-income families has begun to be met with modest increases in funding for subsidized child care. However, little is known about how far the subsidy monies can be extended, the quality of child care that can be purchased with the amounts available, the supply and nature of child care available, utilization patterns, or the extent to which

variations in subsidy and quality child care affect labor force attachment. The Administration for Children and Families (ACF) has initiated activities to improve the Department's understanding of the demands for child care, the child care market, and methods for assessing quality to help inform parents in their choices of care. The quality of license-exempt, unregulated family day care is of particular concern since this is frequently the choice of low-income families. Additional study will soon commence to examine the nature and effects of such care on children and on their parents' ability to enter and sustain employment.

Through these and other interventions, HHS plays an important role in enhancing the development and application of research based on quality standards in the field of human services.

In both health care and human services, the strategies outlined for this goal should be considered partial and preliminary. The Secretary has identified ensuring the quality of health and human services as one of the Department's highest priorities for the next five years, and is leading several planning processes to refine the Department's strategies and translate them into action. Elements of those strategies are described in the objectives that follow. However, they are expected to evolve significantly over the next two years and to be influenced by the recommendations of groups such as the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

HHS 4.1: Promote the Appropriate Use of Effective Health Services

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

FDA – FDA is responsible for ensuring that drugs, biologics, medical devices and food are safe, effective and appropriately labeled. In addition to reviewing new drugs, biologics, medical devices and food additive products, FDA plays a key role in disseminating information about these new products to health professionals and in ensuring the correct use of these products.

FDA continues to collaborate with industry to inform physicians, patients and consumers about new drugs and food items. In FY 2001, FDA will continue to make information about newly approved products, product labels, correct use of medications, and risk information about FDA-regulated products available on the Internet to health professionals, consumers and other interested persons. FDA also has an outreach program for physicians to inform them of new drugs available to their patients. Information is also available on new therapies approved by foreign countries before the FDA approves them.

CDC – Epidemic Services. Epidemic services cover a vast spectrum of activities: preventing and controlling epidemics and protecting the U.S. population from public health crises including biological and chemical emergencies; developing, operating, and maintaining surveillance systems, analyzing data, and responding to public health problems; training public health epidemiologists; developing leadership and management skills of public health officials at the federal, state, and local levels; carrying out the quarantine program as required by regulations; and publishing the *Morbidity and Mortality Weekly Report*, CDC's main channel for communicating public health news about disease outbreaks and trends in health and health behavior.

FDA – Although FDA-regulated products are rigorously tested during the premarket review period, certain rare adverse effects of products are not recognized until after a product is in widespread use. When new health risks related to FDA-regulated products are recognized, FDA ensures that manufacturers, health professionals, and consumers are alerted and corrective actions are taken.

MedWatch, the FDA Medical Products Reporting Program, is an initiative designed both to educate all health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events and problems to FDA and the manufacturer; and to ensure that new safety information is rapidly communicated to the medical community and that patient care improves as a result. FDA uses a variety of means to provide feedback to the health care community about safety issues involving medical products, including "Dear Health Professional" letters, safety notifications, product recalls, and product label changes. These are available on the Internet and in print.

HRSA – Primary Care, Health Centers. HRSA's Health Centers provide psychosocial support and enabling services such as outreach, home visiting, case management, transportation, translation, health education, and eligibility determination. These services, which may not be covered by public or private insurance, are geared to facilitate timely entry into care and appropriate use of the health system.

CDC – To ensure the scientific foundation of public health practices, CDC coordinates the development of the *Guide to Community Preventive Services*. This *Guide* provides public health practitioners, their community partners, and policy makers with evidence-based recommendations for planning and implementing population-based services and policies at the community and state level.

AHRQ - Informatics. AHRQ will undertake a three-part initiative in informatics research to improve health care including (1) the further development of web-based applications for health systems and providers to improve quality; (2) the development and testing of informatics applications and computerized patient records to reduce medical errors, improve patient safety, and promote quality improvement in diverse health care settings; and (3) improving the efficiency, quality, privacy, and security of health care data.

AHRQ - Maximizing Employee Health: the Role of Purchasers and Systems. AHRQ will focus on the quality of the systems through which employees receive, and the quality of the health outcomes and effectiveness of the treatments employees receive, and the quality of the health care workplace. This initiative will address underlying initiatives that are of critical importance to employers, employees, and society at large, such as: interventions or strategies to prevent disability; initiatives to enhance the ability of employees to return to the same job on a long-term basis (not simply return to any job and not return only in the short-term); work force retention (given the high costs of recruitment and training); productivity; and the inter-relationships between health care outcomes, quality of care, safety, and productivity.

AHRQ – Interim outcomes of research can be evaluated on a relatively short-term basis. However, the ultimate outcome of how the research affects people receiving health care or people interacting with the system requires large, expensive retrospective studies. AHRQ is implementing a growing portfolio of evaluations that will show over time the outcomes of the investments of Agency funds. The FY 2001 strategy involves assessing the interim outcomes of four tools created with Agency funds for improving health care quality and evaluating the use and usability of the Medical Expenditures Panel Survey (MEPS) databases for their intended purposes. AHRQ quality improvement strategies that will be subjected to evaluation, and support HHS efforts to promote effective health services include: 1) evidence reports and technology assessments of evidence-based practice centers; and 2) products that advance methods to measure and improve health-care quality, including clinical quality improvement software (CONQUEST), the Consumer Assessment of Health Plans Survey, and the Expansion of Quality of Care Measures project (Q-SPAN).

HCFA – **Childhood Immunization**. The central importance of childhood immunization is recognized by the State Children's Health Insurance Program (SCHIP). Under the legislation, States that create a separate SCHIP program must include coverage of the complete series of

immunizations. States also are prohibited from imposing co-payments or deductibles on immunization services.

Moreover, highly effective, evidence-based interventions are available to raise childhood immunization coverage levels. A large number of studies have shown that performance measurement through HEDIS®, registries, or other assessment techniques and the use of recall and reminder systems to identify and track children in need of vaccination will substantially raise coverage levels. A major barrier to childhood immunization is the information gap that exists among parents and providers about the immunization status. Research indicates that over three-fourths of parents of children in need of immunization believe their child is completely vaccinated. Similarly, providers also tend to greatly over-estimate the immunization coverage levels of their patients. This information gap is an important reason why both performance measurement and recall and reminder systems are highly effective, evidence-based intervention strategies that are recommended by both the Centers for Disease Control and the Advisory Committee on Immunization Practices.

HCFA – Peer Review Organizations. Appropriate use of effective medical services is a critical component of HCFA's focus on Medicare beneficiaries. HCFA's efforts to improve medical treatment through its collaboration with Peer Review Organizations is the basis for its performance goals to: 1) improve heart attack survival rates, 2) increase influenza vaccination, and 3) increase the use of mammograms. PROs, which serve under contract with HCFA, conduct cooperative improvement projects in which they use data to identify opportunities to improve care, and then work to develop interventions that will bring improvement for subject quality indicators. Pertinent to the HCFA performance plan, HCFA and the PROs are fostering utilization of interventions to treat heart attacks and improve survival rates; are working with providers, health plans and others on influenza vaccination projects; and are networking with local project collaborators to provide education and reminders to improve mammography rates.

FDA – FDA is committed to providing clear, up-to-date information to consumers and patients that they need to make health care decisions and to use health products appropriately. The Agency is aware of the growing diversity of consumer health needs and interests. FDA will continue to implement targeted public awareness campaigns such as the *Food Safety Program's BAC!*, *Mammography Awareness Seminars*, and *Over the Counter (OTC) Labeling Changes* and will continue to make information about newly approved products, product labels and a range of health issues available on the Internet in language consumers can understand. The Internet is being used not only to disseminate information to consumers but also to obtain their input on various issues of interest to the Agency. The *FDA Consumer* and other printed materials, many of which are available in several languages, are provided to persons who are without Internet capabilities. A general telephone number and several special interest hotlines are also available to consumers who have specific questions about FDA-regulated products. Public Affairs Specialists in FDA's field offices will continue to play a key role in furnishing up-to-date information about new and emerging products to interested consumers.

CDC – CDC focuses on assuring the public's health through the translation of research into effective community-based action. This goal is oriented towards developing the capacity of public health departments to carry out essential public health programs and services, and involve community institutions and community groups in health promotion and disease prevention.

Also, what people understand about their health and potential risks to their health is of major concern in public health. CDC promotes effective health communication, conveying information to appropriate populations, and facilitating access to health information. The agency seeks to enhance the public's health knowledge through communication that is congruent with the values of diverse communities.

CDC will also continue its efforts in the training of public health leaders in the science of public health practice. Training efforts in this area are critical in addressing future public health issues. For example, the CDC-sponsored Public Health Leadership Institute is an ongoing program that develops the leadership skills of public health officials at the Federal, State, and local levels.

OPHS – A comprehensive Surgeon General's report on mental health (the first ever on this area of health care) scheduled for release in FY 2000 will include cutting edge information about the status of mental health research and services within the United States. The report is expected to serve as a basis for shaping the Federal government's future mental health program initiatives, as well as providing the public with valuable information about mental health issues impacting the country. As mental health and mental illness become more main stream and less stigmatized, health insurance coverage is likely be become less restrictive.

SAMHSA – Bridging the gap between research and practice in mental health services and substance abuse prevention and treatment is one of SAMHSA's goals for pursuit of service effectiveness. Knowledge application activities are intended to further develop and implement results originating in or supported by the National Institutes of Health (NIH) and other organizations. It is the intent of this aspect of SAMHSA's Knowledge Development and Application programs (KDAs) to synthesize knowledge (new or existing) into forms that are useful to practitioners, effectively creating "best practices" that community-based organizations can use.

In FY 2001, knowledge application mechanisms are prominent throughout SAMHSA's programs, as the following examples indicate.

- The Center for Mental Health Services' School and Community Action Grant program requires organizations to employ an exemplary practice to prevent youth violence, promote healthy child development and foster resilience, and to take responsibility for facilitating the adoption of the practice in a specific community.

- The Center for Substance Abuse Prevention's National Strengthening the Family Initiative includes a dissemination research program that is determining cost effective methods for disseminating information and training on science-based family-focused prevention

strategies. The Initiative also includes the Parenting is Prevention Program to strengthen existing anti-drug programs directed by parents, by providing training, technical assistance and resources for parents in initiating youth drug prevention programs.

- The Prevention Enhancement Protocol System collects, synthesizes, translates and disseminates research and practice-based findings in a useable form for application in communities.
- The National Center for the Advancement of Prevention develops, synthesizes, updates and disseminates state-of-the-art prevention knowledge about what works in prevention, for whom, and under what conditions.
- The Center for Substance Abuse Treatment (CSAT) will continue to pursue the application of exemplary treatment models, applying the concepts particularly to women receiving Temporary Assistance to Needy Families, and individuals with co-occurring psychiatric and substance abuse disorders.
- CSAT's Practice/Research Collaborative is designed to bring researchers, providers, and other community leaders together to review available data on substance abuse and substance abuse treatment, to develop plans for improving the services that are available, and to conduct research and evaluation studies that are needed to assure that the improvements are made.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicare Beneficiaries Age 65 and over who receive a mammogram every two years. *HCFA Plan*	FY 01: 51%* FY 00: 60%** FY 99: 59%** *New data source (Medicare Claims Data) will be employed for FY 2001. **Data source: National Health Interview Survey	FY 01: FY 00: FY 99: FY 98: FY 97: 45%* FY 94: 55%**
Decrease one-year mortality among Medicare beneficiaries hospitalized for heart attack. *HCFA Plan*	FY 01: Towards 27.4% in FY 2002 FY 00: Towards 27.4% in FY 2002 FY 99: New in FY 2000	FY 01: FY 00: FY 99: FY 95/96: 31.4%

Performance Goals	Targets	Actual Performance
Increase the percentage of Medicare beneficiaries age 65 years and older who receive vaccinations. – annual influenza vaccination	FY 01: 72%* FY 00: 60%** FY 99: 59%**	FY 01: FY 00: FY 99: FY 98: FY 97: 63%** FY 95: 58%** FY 94: 55%**
– lifetime pneumococcal vaccination *HCFA Plan*	FY 01: 55%* FY 00: New in 2001 FY 99: New in 2001 *New data source (Medicare Current Beneficiary Survey) will be employed for FY 2001. **Data source: National Health Interview Survey	FY 01: FY 00: FY 99: FY 94: 25%*
The proportion of people 18 and over reporting depression in the past 12 months who are receiving treatment. *OPHS Plan*	FY 01: 30%	FY 01: FY 00: FY 99: FY 98: FY 97: 23%
Percentage of CDC-funded state diabetes control programs that will adopt, promote, and implement patient care guidelines for improving the quality of care received by persons with diabetes. *CDC Plan*	FY 01: 100%. FY 00: 100%	FY 01: FY 00: FY 99: 1/00 FY 98: 60%
Based on established criteria, continue to publish the *Morbidity and Mortality Weekly Reports (MMWR)* series of publications including Reports and Recommendations, Surveillance Summaries, and the Annual Summary to communicate major public health events to the media, public policy makers and health professionals through multiple media channels - print, television, radio, interactive World Wide Web. *CDC Plan*	FY 01: 86 issues FY 00: 81 issues FY 99: 77 issues	FY 01: FY 00: FY 99: 77 issues published. Also available on CDC web site.

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Medical Expenditure Panel Surveys
Research on Health Costs, Quality, and Outcomes
CDC
HIV/AIDS Prevention
Sexually Transmitted Diseases
Tuberculosis
Immunization
Diabetes and Other Chronic Diseases
Heart Disease and Health Promotion
Breast and Cervical Cancer Prevention
Prevention Centers
Infectious Diseases
Lead Poisoning
Health Statistics
Prevention Research
Epidemic Services
Environmental Disease Prevention
Occupational Safety and Health
Eliminating Racial and Ethnic Disparities

FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
HCFA
Medicaid
Medicare
Medicare+Choice
Peer Review Organizations
HRSA
Primary Care, Health Centers
NIH
Research Program
OPHS
Office of the Surgeon General
Healthy People 2000
SAMHSA
Knowledge Development and Application

HHS 4.2: Reduce Disparities in the Receipt of Quality Health Care Services

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

HRSA – **Primary Care, Health Centers and the National Health Service Corps** (NHSC). HRSA's Health Centers and the National Health Service Corps form a cost-effective, integrated safety net for underserved and uninsured children, adults, migrant workers, homeless individuals, public housing and U.S./Mexico border residents in approximately 4,000 communities across the country and will serve over 11 million persons in FY 2000 who would otherwise lack access to primary care clinicians. This community-based network delivers preventive and primary care services for the neediest, poorest, and sickest patients in rural and inner city areas, through a Federal, State, and community partnership approach. Health Centers and the NHSC contribute to decreases in racial and income disparities by providing preventive services and risk reduction to a population that is largely minority (64%) and low income (86%) and disproportionately uninsured (41%).

HRSA – Maternal and Child Health Block Grant (MCHBG). MCHBG provides assistance and care for some of the new children and critical new needs identified by CHIP and Medicaid outreach that can not be met by Medicaid or State Child Health plans, such as additional translation, case management, transportation, special public health, disability, and gap filling services (frequently referred to as "enabling services") needed to make Medicaid effective for low-income children.

HRSA – Healthy Start. Healthy Start focuses on the need to strengthen and enhance community systems of perinatal health by helping communities to fully address the medical, behavioral and psychosocial needs of women and infants. The FY 2001 program will provide for a continuing opportunity to reduce factors contributing to infant mortality by adaptation of successful Healthy Start models of intervention in urban and rural communities with high rates of infant mortality, especially among racial/ethnic populations, and to share the lessons learned with States, communities, and academic and professional organizations.

CDC – Eliminating Racial and Ethnic Disparities in Health. CDC efforts will focus on infant mortality, cancer, cardiovascular diseases, diabetes, HIV/AIDS, and adult and child immunization. CDC will also address other areas of preventable health disparities including perinatal conditions, injuries, sexually transmitted diseases, and other infectious diseases. Specific activities include focusing STD and HIV/AIDS prevention efforts in communities of color. The current epidemiology of syphilis, combined with its basic biologic characteristics, make it possible to eliminate this disease in the United States through enhanced surveillance, outbreak response preparedness, efficient delivery of effective behavioral and biomedical interventions, and assessment of both quality and coverage of prevention and control. This multi-system approach to syphilis elimination will also build sustainable prevention capacity for populations at high risk for HIV and other sexually transmitted diseases. In addition, CDC will continue to conduct applied prevention research, expand programs and improve surveillance

aimed at the health problems of racial and ethnic minorities, and improve vaccination coverage levels of adolescents and adults.

HCFA – Horizons. To achieve its performance targets for influenza vaccines and mammograms for elderly individuals, HCFA must address the special needs of minority individuals who receive these services to a lesser degree than the population as a whole. Under Horizons, eight Peer Review Organizations are working with eleven Historically Black Colleges and Universities to formulate statewide interventions with a focus on outreach to the African American Medicare population. HCFA will also target nursing home residents for vaccination against influenza–a population at high risk. In order to address the lower mammography utilization rates for African American and Hispanic American Medicare beneficiaries, six Medicare Peer Review Organizations, also under Horizons, are carrying out community-based projects to increase mammography rates in six major cities for these specific populations.

NIH – Centers of Excellence for Research on Health Disparities. For NIH, the Centers will become a focal point for enhanced support for research, research training, and infrastructure that will accelerate the generation of new knowledge about health disparities. These centers will encompass basic and clinical research focused on addressing health disparities, particularly those affecting minority and disadvantaged socioeconomic groups. Major goals of these centers will be to establish, strengthen, and expand research and training on health disparities; to enhance the academic performance of minority students; to increase the number and quality of minority applicants for research grants; and to improve the capacity to train, recruit, and retain minority faculty.

NIH – Disparity Research Topics. NIH will continue to support a broad range of research, including studies of how socioeconomic and cultural factors contribute to the development of health beliefs and practices, expanded efforts in population genetics, and efforts to gain a more fundamental understanding of the effects of the environment, culture, and economic status on health. Research will also continue to address health disparities with respect to various diseases. The magnitude of the AIDS pandemic is profound. AIDS has significantly lowered the life expectancy in many nations of Africa, the global epicenter of AIDS. There has been a steep increase of new infections in Sub-Saharan Africa, and burgeoning disease rates also threaten the vast populations of India, Southeast Asia, and China. In the United States, new HIV infections and AIDS-related deaths continue to increase in many sub-populations–among women, racial and ethnic minorities, heterosexuals, adolescents, drug users, and people over 50 years of age. NIH research in this area will include examining gender differences in HIH/AIDS, disparities in response to therapy and prevention among minorities, and clinical trials and research infrastructure development to facilitate the conduct of international studies.

IHS – Reducing the Gap in Health Disparities Initiative. This initiative targets the health problems identified as highest priority by the I/T/U and responsible for much fo the disparity n health status for the AI/AN population. These include alcoholism and substance abuse, diabetes, cancer, mental health, elder health, heart disease, injuries, dental health, maternal and child health, domestic violence, infectious diseases and sanitation. Support for public health infrastructure is also fundamental to this initiative. This initiative will also support surveillance, prevention, and treatment services and are based on "best practices" defied in the health

literature. IHS will also address the need for water and sewer systems for new and existing homes at the community level.

HRSA – HIV/AIDS, HIV Care and Emergency Relief Grants. Recent studies have demonstrated that the benefits provided by the new combination drugs (anti-retrovirals/ protease inhibitors) have not uniformly reduced the incidence of AIDS between genders or racial and ethnic minorities. To this end, HRSA has focused priorities to include increasing access to these vulnerable populations.

HRSA – Rural Health Outreach Grants. The Rural Health Outreach and Rural Network Development Grant Programs support the delivery of basic health services to hundreds of thousands of Americans living in underserved rural areas of the country.

SAMHSA – As part of SAMHSA's **Targeted Capacity Expansion** program, an effort has been made to initiate or strengthen the integration of HIV and substance abuse prevention at the local level and increase local capacity to provide integrated services to African American and Hispanic youth and women. In addition, CSAP continues to identify specific interventions tailored for youth and women of color at risk for substance abuse and HIV to develop strategies with emphasis on reducing known risk factors, increasing protective factors, building resiliency, and addressing multiple risks that cross domains.

OCR – **Preventing Discrimination in Access to HHS' Services**. OCR will concentrate its resources on the critical civil rights issues surrounding changes in health care coverage and services, including increased use of managed care, that are undertaken in the states. OCR will focus on assessing the effects of managed care on services to minority and disability communities. It will expand the number of reviews concentrating on ensuring that, as both Medicare and Medicaid expand the sue of managed care, racial and national minority individuals and persons with disabilities are treated in a nondiscriminatory manner. OCR will work with its HHS Agency partners to improve research and data collection efforts to support target enforcement in this changing arena. In addition OCR will continue to work with health care and social services providers, state and local agencies and HHS partners, to ensure that persons of limited English proficiency are not discriminated against on the basis of national origin.

OCR – Discrimination and Racial Disparities. Recent studies by HHS, various non-profit organizations, universities and other public agencies have shed light on serious disparities in the health status of race and ethnic minorities and in practitioner referrals of minorities for specific diagnostic and therapeutic procedures. Racial minorities continue to fall far behind the general population in life expectancy, risk of serious illness, and access to a full range of medical services and specialty care. In addition, it has been found that even when all factors are equal, age, income, job, education and medical insurance, minority patients are less likely to receive the more expensive and sophisticated forms of care for their medical problems. It is essential that OCR take steps to determine whether violations of Title VI and other laws enforced by OCR are contributing factors to these disparities. OCR has begun the process of studying the issue by conducting research, meeting with community-based organizations, medical providers, public officials and concerned individuals.

OCR will also continue its enforcement efforts in the elimination of redlining of health services that may adversely affect people of color or persons with disabilities. Redlining occurs when a service provider refuses to provide services or to provide different services to an individual based on the geographic location where the service is to be provided.

AHRQ - Eliminating Racial and Ethnic Health Disparities. Beginning in FY 2000, AHRQ committed to a long-term investment in activities to make substantial contributions to the Nation's progress in addressing disparities. In fiscal year 2001, AHRQ will support projects to tackle the issue of racial discrimination in health care quality, provide tools and strategies to improve health care for minority Americans, and train a more diverse health research workforce so that we may overcome these issues in the future.

For example, AHRQ will also focus its research to develop and assess strategies focused on improving cardiac care for minority women and the prevention of low birth weight in children of minority women. The impact of cultural differences on outcomes of care will be considered, and effective approaches to better communication will be incorporated into models tested.

OPHS – The Department's Initiative to Eliminate Racial and Ethnic Disparities in Health targets six areas: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and childhood and adult immunizations. The foundation for the initiative is derived from the goals of Healthy People 2000 and is consistent with the proposed goal to eliminate disparities in health in Healthy People 2010.

Healthy People 2010 will be published in FY 2000. OPHS will examine whether and how the actions adopted in the six areas affect implementation and tracking strategies for Healthy People 2010 for those and other focus areas. Funding would be used for analyses that would look more globally at progress and lessons learned in the short term in all six focus areas, drawing on work done by responsible operating divisions in a specific area; for convening federal partners, national organizations, and other State and local stakeholders to review the findings and replicability of specific aspects of the initiative and identify application to Healthy People 2010; and, as appropriate, to engage other interested parties through active outreach into incorporating these findings into actions addressing other Healthy People focus areas.

OPHS will continue to work with NCHS and HHS components to promote the collection and establishment of baseline and comparison data by race and ethnicity using, at a minimum, the OMB Directive 15 standards.

OPHS – The Minority Community Health Coalition Demonstration Program will continue to support 17 demonstration projects focusing on the reduction of health risk factors in minority populations. Emphasis will continue to be on efforts that can demonstrate effective coordination of integrated community-based screening, outreach, and other enabling services to address health problems and needs of minority communities.

OPHS – The Office of Minority Health Resource Center will continue to engage in a wide range of activities to inform and educate racial/ethnic minority communities and those who

serve them regarding the nature and extent of racial/ethnic disparities in health, policies and programs underway to address such disparities, and actions they can take to improve their health care options. Some of these activities include: assistance in the development of Spanish-language radio broadcast messages to Hispanic communities on health promotion and how to use managed care plans appropriately; provision of Spanish-speaking staff to respond to public inquiries for information and recommendations following such radio broadcasts; and provision of information on and referrals to national organizations of minority health care providers and minority health advocacy organizations that, in turn, provide recommendations regarding local providers.

OPHS – The Bilingual/Bicultural Service Demonstration Grant Program will continue to support community-based projects to improve access to health care services for limited-English-proficient (LEP) populations. All projects focus on improving the ability of health care providers and other health care professionals to deliver linguistically and culturally competent health care services to LEP populations.

OPHS –The Center for Linguistic and Cultural Competence in Health develops and evaluates models, conducts research, and provides technical assistance to providers to address the cultural and linguistic barriers to health care delivery and increase limited English speaking individuals' access to health care. FY 2000 activities include: disseminating information on current language and cultural competency model programs, techniques, organizational and governmental policies; launching a culturally competence systems change initiative; conducting an evaluation of selected sites to determine the effectiveness of culturally competent programs on ethnically diverse patients; commissioning papers on development of culturally competent training programs for health care providers; developing a research project on cultural competence health delivery programs, and initiating research on impact of culturally competent services on patient treatment protocols and outcomes. All products will be disseminated through the Office of Minority Health Resource Center (OMHRC) and through the OMHRC web-site.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Decrease proportion of Health Center users who are hospitalized for potentially avoidable conditions. *HRSA Plan*	FY 01: 13 FY 00: 13.5 FY 99: 14	FY 01: FY 00: FY 99: 9/01 FY 98: 9/00 FY 97: 14.7/1000 **Norm:** 18.9/1000

Performance Goals	Targets	Actual Performance
Increase proportion of Health Center women receiving age-appropriate screening for cervical and breast cancer. *HRSA Plan*	**Up-to-date PAP Tests** FY 01: 94% FY 00: 92% FY 99: 90% **Up-to-date Mammograms** FY 01: 70% FY 00: 67.5% FY 99: 65% **Up-to-date Clinical Breast** FY 01: 85.5% FY 00: 84% FY 99: 82.5%	FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 88.5% FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 62.5% FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 80.5%
Increase percent of Health Center users with diabetes with up-to-date testing of glycohemoglobin – % adults with diabetes tested at recommend intervals. *HRSA Plan*	FY 01: 90% FY 00: 80% FY 99: 60%* *Diabetes Initiative at 90% for first 100 HCs	FY 01: FY 00: FY 99: 6/00 FY 98: 43% (97 study) **Norm**: 20%
Increase proportion of Health Center adults with hypertension who report their blood pressure is under control. *HRSA Plan*	FY 01: 96% FY 00: 93% FY 99: 92%	FY 01: FY 00: 4/01 FY 99: 5/00 FY 95: 90%

Performance Goals	Targets	Actual Performance
Serve women and racial and ethnic minorities in Title I and II-funded programs in proportions that exceed their representation in overall AIDS prevalence by a minimum five percentage points (i.e., 16 percent of current overall AIDS cases are among women, 56% are minorities).	**Emergency Relief Grants** FY 01: 32% Women FY 00: 30% FY 99: 30% FY 01: 66% Minorities FY 00: 64% FY 99: 64% **Care Grants to States** FY 01: 28% Women FY 00: 27% FY 99: 27% FY 01: 60% Minorities FY 00: 59% FY 99: 59%	 FY 01: FY 00: FY 99: FY 98: 30.7% FY 97: 30.3% FY 96: 30.7% FY 01: FY 00: FY 99: FY 98: 67.7% FY 97: 67.8% FY 96: 66.5% FY 01: FY 00: FY 99: FY 98: 29.4% FY 97: 30.3% FY 96: 26.3% FY 01: FY 00: FY 99: FY 98: 64.1% FY 97: 63.1% FY 96: 59.9%
Increase the percent of children with special health care needs in the State with a medical/health home. *HRSA Plan*	FY 01: 80%	FY 01: FY 00: FY 99: 01/01 FY 98: 04/00 FY 97: 69%
Decrease the ratio of the black infant mortality rate to the white infant mortality rate. *HRSA Plan*	FY 01: 2.1 to 1	FY 01: FY 00: FY 99: 9/01 FY 98: FY 97: FY 96: 2.4 to 1 FY 95: 2.3 to 1

Performance Goals	Targets	Actual Performance
Increase by 20% over two years the number of minority organ donors nationally from implementation of the final HCFA Rule on Conditions of Participation of Hospitals (9/98). *HRSA Plan*	FY 01: 1,802 donors FY 00: 1,638 FY 99: 1,500	FY 01: FY 00: FY 99: 5/00 FY 98: 1,378 FY 97: 1,342
Increase by 10% the number of unrelated minority bone marrow donors (national registry of potential donors) over previous year totals. *HRSA Plan*	FY 01: 1,100,000 FY 00: 1,000,000 FY 99: 220,000* * New donors: total minority donors estimated at 900,000.	FY 01: FY 00: FY 99: 5/00 FY 98: 800,000 FY 96: 526,000
Collect and establish baseline and comparison data for all measures for 12 racial disparity measures (coronary heart disease and stroke deaths; incidence of lower extremity amputations and end-stage renal disease in persons with diabetes), including relevant racial and ethnic subgroups for which no data are currently available. *OPHS Plan*	FY 01: 12 of 12 FY 00: -- FY 99: 9 of 12	FY 01: FY 00: FY 99: FY 98: 5 of 12
Improve AI/AN consumer satisfaction with the acceptability and accessibility of health care as measured by IHS consumer satisfaction survey. *IHS Plan*	FY 01: 5% over FY 00 FY 00: establish baseline FY 99: develop instrument and protocol	FY 01: FY 00: FY 99: Completed
In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care settings, OCR will increase # managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 33 FY 00: 30 FY 99: 40	FY 01: FY 00 FY 99: 27 FY 98: 10
In order to increase access to HHS services for limited English proficient (LEP) persons, OCR will increase # HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 153 FY 00: 151 FY 99: 125	FY 01: FY 00: FY 99: 146 FY 98: 98

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Research on Health Costs, Quality, and Outcomes
Medical Expenditure Panel Surveys
CDC
HIV/AIDS Prevention
Sexually Transmitted Diseases
Tuberculosis
Immunization
Diabetes and Other Chronic Diseases
Heart Disease and Health Promotion
Breast and Cervical Cancer Prevention
Prevention Centers
Infectious Diseases
Lead Poisoning
Injury Prevention
Health Statistics
Prevention Research
Epidemic Services
Environmental Disease Prevention
Occupational Safety and Health
Eliminating Racial and Ethnic Disparities
HCFA
Children's Health Insurance Program
Medicaid
Peer Review Organizations
HRSA
Primary Care
  Health Centers
  National Health Service Corps
HIV/AIDS
  HIV Care
  HIV Emergency Relief Grants
  HIV Early Intervention Services
  HIV Pediatric Grants
  Education and Training Centers
  Dental Services Program
Maternal and Child Health
  Maternal and Child Health Block Grant
  Universal Newborn Hearing Screening and Early Intervention
  Healthy Start Initiative
  Emergency Medical Services for Children
  Traumatic Brain Injury Program
  Health Professions and Nursing Training Programs
Rural Health
  Rural Health Outreach Grants
  Rural Health Policy Development
  Telehealth
Workforce Information and Analysis
Health Education and Assistance Loans
Organ Procurement and Transplantation
National Bone Marrow Donor Program
IHS
Prevention
Treatment
NIH
Research Program
OCR
Preventing Discrimination in Access to HHS' Services
OPHS
Office of Disease Prevention and Health Promotion
Office of HIV/AIDS Policy
Health People 2000
Office of Minority Health
SAMHSA
Targeted Capacity Expansion

HHS 4.3: Increase Consumers' Understanding of Their Health Care Options

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

HCFA – Increasing Health Plan Choices. The BBA created an array of new managed care and other health plan choices for Medicare beneficiaries and establishes a coordinated open enrollment process. These new choices require HCFA to undertake the most extensive beneficiary education program in the Agency's history. It also requires HCFA to develop and implement new prospective payment systems for many Medicare services to help further restrain the rate of growth of health care spending and foster incentives for more appropriate use of scarce program resources. Furthermore, BBA expands health insurance to many uninsured children through the State Children's Health Insurance Program (SCHIP).

HCFA – National Medicare Education Program. In FY 1999, HCFA began a campaign to educate Medicare beneficiaries so they can make more informed health plan decisions. The initial stages of the campaign focus on increasing access to information about health plan options, as well as increasing awareness among beneficiaries that they now have more health plan options available through Medicare and that they do not have to change from their current option if they do not choose to do so. The campaign also focuses on increasing understanding among beneficiaries regarding differences between the new health plan options and original Medicare.

AHRQ – The Consumer Assessment of Health Plans (CAHPS®) is a tool for surveying members of health plans about their experience with and assessment of the quality of health care they receive, and for reporting the results to other consumers who are choosing a plan. The CAHPS® surveys and reports were developed in the first phase of the project, beginning in September 1995 and continuing until January 1997. In the second phase, CAHPS® will be enhanced to cover individual health care providers and institutions and to allow for cross-market comparisons of data. Demonstrations will be funded to improve the use of quality information by consumers in public and private settings and evaluate impact in terms of the decisions made by consumers, the changes in consumers' behaviors, and any changes in quality and costs of care as a result of this information. AHRQ will also develop partnerships with appropriate health care organizations to assure that CAHPS® products are kept up-to-date and available to both public and private users.

IHS – Office of the Director (OD). OD establishes and coordinates multiple opportunities for American Indian and Alaska Native stakeholders to participate in budget formulation and policy development consistent with the goal of enhancing Indian self-determination.

OPHS – Through Healthfinder™, the Federal government-wide Internet gateway to health information, the National Women's Health Information Center, and the Office of Minority

Health Resource Center, OPHS provides nation-wide access to information and referral services for both health professionals and consumers.

OPHS – The Office of Minority Health Resource Center engages in a wide range of activities to inform and educate racial/ethnic minority communities and those who serve them regarding the nature and extent of racial/ethnic disparities in health, policies and programs underway to address such disparities, and actions they can take to improve their health care options. Some of these activities include: assistance in the development of Spanish-language radio broadcast messages to Hispanic communities on health promotion and how to use managed care plans appropriately; provision of Spanish-speaking staff to respond to public inquiries for information and recommendations following such radio broadcasts; and provision of information on and referrals to national organizations of minority health care providers and minority health advocacy organizations that, in turn, provide recommendations regarding local providers.

OCR – Preventing Discrimination in Access to HHS' Services. OCR will continue to work with state and local health agencies and health care providers to ensure they take steps to provide services and information in languages other than English to ensure that persons of limited English proficiency (LEP) are effectively informed and can effectively participate and benefit from programs.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Increase enrollment of eligible Medicare beneficiaries in programs for dually eligible beneficiaries. *HCFA Plan*	FY 01: Will set target during FY 2000 FY 00: Increase enrollment by 4% FY 99: Establish a target	FY 01: FY 00: FY 99: Goal Met
Increase the percentage of Medicare beneficiaries who have at least one managed care option/choice. *HCFA Plan*	FY 01: 73% FY 00: 73% FY 99: 80%	FY 01: FY 00: FY 99: 76% FY 98: 75% FY 97: 70%
Achieve and maintain the high percentage of Medicare +Choice enrollment transactions processed on a timely basis. *HCFA Plan*	FY 01: 98% FY 00: 98% FY 99: 98%	FY 01: FY 00: FY 99: Spring 2000

Performance Goals	Targets	Actual Performance
Improve the level of I/T/U satisfaction with the processes for consultation and participation provided by the IHS, as measured by a survey of IHS, Tribal, and Urban programs. *IHS Plan*	FY 01: secure OMB clearance FY 00: revise policy and instrument FY 99: establish policy and baseline	FY 01: FY 00: FY 99: policy established but baseline delayed
In order to increase access to HHS services for limited English proficient (LEP) persons, OCR will increase # HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 153 FY 00: 151 FY 99: 125	FY 01: FY 00: FY 99: 146 FY 98: 98

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Research on Health Costs, Quality, and Outcomes
HCFA
Medicaid
Medicare
Medicare+Choice
IHS
Office of the Director
OCR
Preventing Discrimination in Access to HHS' Services
OPHS
Office of Disease Prevention and Health Promotion

HHS 4.4: Improve Consumer Protection

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

HCFA – Medicare Summary Notice (MSN). To enhance beneficiary understanding of Medicare benefits and reduce confusion over which services Medicare covers, HCFA is continuing its nationwide implementation of the Medicare Summary Notice (MSN). The MSN combines information sent to Medicare beneficiaries on benefits received under Medicare Part A and Part B into easy-to-read monthly statements.

HCFA – Medicare Appeals. The appeal process is a critical safeguard available to all Medicare beneficiaries, allowing them to challenge denials of payment or service. The appeal process takes on added significance in managed care and other Medicare Plus Choice plans where there can be pre-service denials of care and, thus, the possibility of restricted access to Medicare covered services. In FY 1999, HCFA initiated development of a comprehensive appeal data system. HCFA will collect internal plan appeal data on several indicators of plan performance during FY 2000 so that the agency will be able to set targets for FY 2002 by the end of FY 2001.

HCFA – Medicare Telephone Service Improvement. Medicare contractors handle in excess of 18 million telephone inquiries annually from beneficiaries and other callers. Beneficiary telephone customer service therefore clearly is a central part of HCFA's customer service function and directly supports the strategic plan goal to promote beneficiary and public understanding of HCFA and its programs. HCFA provides for telephone customer service through a variety of sources. A very large part of the overall volume of calls is handled by Medicare carriers. This goal focuses on improving the telephone customer service of Medicare carriers. A thorough assessment of carrier telephone customer service requires measurement along three dimensions: accessibility of the service, accuracy of response, and caller satisfaction. HCFA intends to adopt a long-term view in measuring and improving carrier telephone customer service.

  HCFA will initiate a number of interventions to promote improved performance, including establishing higher standards through changes to the contractor performance requirements; collecting and sharing information on best practices, through mechanisms such as workshops and regular contractor call center user group conference calls; providing funding increases, if funds are available; and monitoring contractor performance and using our legal authority as appropriate when contractors fail to meet HCFA standards.

HCFA – Provider and Consumer Education. HCFA and other groups have sponsored a large number of provider and consumer education projects to demonstrate ways in which nursing homes may remove residents' restraints. These projects have demonstrated that restraint removal improves quality of life and quality of care and actually decreases the risk of resident injury. HCFA has actively sponsored and participated in education programs consisting of seminars presented locally throughout the country and via satellite to nursing

home providers, care givers and residents' families; interactive video training programs; and written manuals.

One of the main ways in which HCFA can promote reduced use of physical restraints is through the State Survey and Certification Program. State and HCFA surveyors who conduct annual inspections of nursing homes pay close attention to nursing homes' use of restraints and cite nursing homes for deficient practices when they discover that residents are restrained without clear medical reason.

HCFA – Laboratory Proficiency Testing. HCFA is committed to sustaining the current level of accuracy for diagnostic laboratory tests regulated under the Clinical Laboratory Improvement Amendments (CLIA). Specifically, HCFA commits to sustaining the improvements obtained thus far in laboratory scores on proficiency (accuracy) testing (PT) while maintaining the rate of compliance with PT enrollment requirements in CLIA. It is important to measure both enrollment and PT scores so that all laboratories subject to PT under the CLIA rules are both continuing to participate in a PT testing program and continuing to perform well on those PT challenges**.**

Interventions in place from which the improvement has occurred and will continue to be maintained with respect to test accuracy include:

- laboratories reviewing their own findings of PT performance and taking appropriate actions in their laboratory to correct the problem
- State surveyors and HCFA-approved accrediting bodies employing an educational, outcome oriented survey approach and ongoing monitoring of laboratory PT performance
- recommending training and technical assistance for laboratories that fail to meet the standards set for PT performance in lieu of sanctions for the first occurrence
- not allowing laboratories refusing training and technical assistance to conduct the test(s) in question until they have met two PT challenges successfully
- taking enforcement actions or sanctions if a laboratory's accuracy does not improve or is so poor as to pose a threat to the public health and safety
- requesting PT providers to be available to assist laboratories that fail PT to determine why they failed and to prevent recurrence.

AoA – Long-Term Care Ombudsman Program. The Long-Term Care Ombudsman Program helps states to investigate and resolve complaints made by, or on behalf of, residents of long-term care facilities related to action, inaction, or decisions that may adversely affect the health, safety, welfare, or rights of residents. There are 52 State Long-term Care Ombudsman Programs which support ombudsman staff and volunteers in 564 local programs. AoA also supports an Ombudsman Resource Center that offers training and technical assistance to ombudsmen throughout the country.

AHRQ - Enhancing Patient Safety. AHRQ further the nation's understanding of when, how and under what circumstances errors occur, identify the causes of errors, develop the tools, data and researchers needed to foster a national strategy to improve patient safety, and work with public and private partners to apply evidence-based approaches to the improvement of patient safety. The research and training efforts proposed will ensure that efforts for enhancing patient safety will move beyond just describing and defining the problem to providing the knowledge and tools that will be required to address the patient safety challenge. The goal of this research initiative is to provide an evidence base for the nation's approaches to enhancing patient safety.

HRSA – National Practitioner Data Bank. HRSA's National Practitioner Data Bank helps protect the public by assuring that information about medical and dental malpractice payments and other sanctions is available to hospitals and other health care entities, licensing authorities and professional societies.

IHS – Treatment and Prevention. The IHS and its Tribal and Urban Indian Program partners have committed to maintaining excellence in the services provided to consumers through systematic quality assurance processes and benchmarking with the standards of the industry.

SAMHSA - Protection and Advocacy for Individuals with Mental Illness (PAIMI). The goal of this program is through advocacy activities, to reduce incident of abuse, neglect, and civil rights violations of individuals with mental illness who are placed in residential treatment facilities. The protection and advocacy for individuals with mental illness (PAIMI) program makes formula grants to State institutions designated by the Governor, to identify instances of abuse, neglect and rights violations in State hospitals. These State institutions develop and implement education, training and public awareness interventions.

ACF – Developmental Disabilities. ACF and its partners will continue to protect the legal and human rights of individuals with developmental disabilities.

OCR – **Preventing Discrimination in Access to HHS' Services**. OCR will concentrate its resources on the critical civil rights issues surrounding changes in health care coverage and services, including increased use of managed care, that are undertaken in the states. OCR will focus on assessing the effects of managed care on services to minority and disability communities. It will expand the number of reviews concentrating on ensuring that, as both Medicare and Medicaid expand the sue of managed care, racial and national minority individuals and persons with disabilities are treated in a nondiscriminatory manner. OCR will work with its HHS Agency partners to improve research and data collection efforts to support target enforcement in this changing arena. In addition OCR will continue to work with health care and social services providers, state and local agencies and HHS partners, to ensure that persons of limited English proficiency are not discriminated against on the basis of national origin.

OPHS – OPHS will continue to be integrally involved in the work of the Goal 6/Consumer Protection Work Group under the Secretary's Health Care Quality Improvement Initiative and the various work groups under the Quality Initiative Coordination (QuIC) Task Force. OPHS will continue to support the development and implementation of Departmental initiatives that promote cultural competency as a consumer protection for increasingly racially and ethnically diverse populations in the U.S. as well as of HHS efforts to comply with the Consumer Bill of Rights and Responsibilities, per Executive Order. OPHS will also support studies that assess the impact of culturally competent health care services on racial and ethnic minority populations.

OCR – Discrimination and Racial Disparities. Recent studies by HHS, various non-profit organizations, universities and other public agencies have shed light on serious disparities in the health status of race and ethnic minorities and in practitioner referrals of minorities for specific diagnostic and therapeutic procedures. Racial minorities continue to fall far behind the general population in life expectancy, risk of serious illness, and access to a full range of medical services and specialty care. In addition, it has been found that even when all factors are equal, age, income, job, education and medical insurance, minority patients are less likely to receive the more expensive and sophisticated forms of care for their medical problems. It is essential that OCR take steps to determine whether violations of Title VI and other laws enforced by OCR are contributing factors to these disparities. OCR has begun the process of studying the issue by conducting research, meeting with community-based organizations, medical providers, public officials and concerned individuals.

  OCR will also continue its enforcement efforts in the elimination of redlining of health services that may adversely affect people of color or persons with disabilities. Redlining occurs when a service provider refuses to provide services or to provide different services to an individual based on the geographic location where the service is to be provided.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Decrease then sustain the reduced prevalence of the use of physical restraints in nursing homes. *HCFA Plan*	FY 01: 10% FY 00: 10% FY 99: 14%	FY 01: FY 00: FY 99: 12% FY 98: 12% FY 96: 17%
Reduce the prevalence of pressure ulcers (bed sores) among patients of long-term care facilities. *HCFA Plan*	FY 01: 01/01 FY 00: Set baseline and target FY 99: New in FY 2000	FY 01: FY 00: FY 99: N.A.

Performance Goals	Targets	Actual Performance
Improve clinical laboratory testing: – Increase then sustain the percentage of percentage of laboratory scores that demonstrated no failure.	CY 01: 90% CY 00: 90% CY 99: 90%	CY 01: CY 00: CY 99: CY 97: 88.6% CY 96: 87.4% CY 95: 69.4% (Baseline)
– Increase then sustain the percentage of CLIA labs properly enrolled and participating in proficiency testing. *HCFA Plan*	CY 01: 95% CY 00: 95% CY 99: 95%	CY 01: CY 00: CY 99: CY 97: 94.4% CY 96: 93.2% CY 95: 89.6%
Maintain 100% accreditation of all IHS hospitals and outpatient clinics. *IHS Plan*	FY 01: 100% FY 00: 100% FY 99: 100%	FY 01: FY 00: FY 99: 100% FY 98: 100%
Increase the number of complaints of abuse that are addressed under PAIMI. *SAMHSA Plan*	FY 01: 11,100 FY 00: 9000 FY 99: 9000	FY 01: 3/02 FY 00: 3/01 FY 99: 3/00 FY 98: 8,687 FY 97: 8,360 (baseline)
In order to increase access for minorities and persons with disabilities to nondiscriminatory services in managed care settings, OCR will increase # managed care plans found to be in compliance with Title VI, Section 504 and the Americans with Disabilities Act. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 33 FY 00: 30 FY 99: 40	FY 01: FY 00 FY 99: 27 FY 98: 10
In order to increase access to HHS services for limited English proficient (LEP) persons, OCR will increase # HHS grantees and providers found to be in compliance with Title VI in LEP reviews/investigations. Measure: Increased # corrective actions and no violation findings. *OCR Plan*	FY 01: 153 FY 00: 151 FY 99: 125	FY 01: FY 00: FY 99: 146 FY 98: 98

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Developmental Disabilities
AoA
Long-Term Care Ombudsman
ASPE
Policy Research
HCFA
Medicaid
Medicare
Research
HRSA
National Practitioner Data Bank
IHS
Treatment and Prevention
OCR
Preventing Discrimination in Access to HHS' Services
OPHS
SAMHSA
Protection and Advocacy

HHS 4.5: Promote Research That Improves Quality and Develops Knowledge of Effective Human Services Practice

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

ACF – Research. New and continuing studies are underway to evaluate the impact of initial State efforts to implement welfare reform, employment support, and employment retention and advancement strategies for Temporary Assistance of Needy Families (TANF) recipients and other low-income families. These studies examine how TANF is being implemented in local welfare offices, rural communities and in the Tribal TANF program and the impact on the well-being of children, including such issues as school achievement, behavioral problems, and health status. This research is expected to inform state and local program administrators about strategies for moving those who are harder to employ into work situations and methods to improve opportunities for the working poor.

  A major initiative to examine national declines in Medicaid and Food Stamp caseloads that seem to be related to welfare reform is being funded by HHS as well as by the Department of Agriculture and the Robert Wood Johnson Foundation. This initiative will provide technical assistance and grants to states and large counties to improve their enrollment and redetermination processes for Medicaid, the State Children's Health Insurance Program (SCHIP) and Food Stamps.

  Research and evaluation activities in other key areas such as child care, child support enforcement and child welfare studies are planned. Additional research will focus on the development and testing of new ideas for the Head Start program and the continuation of multi-site and longitudinal studies that follow the cognitive, social-emotional and physical development of children over time.

AoA – State and Local Innovations and Projects of National Significance. AoA is proposing for FY 2001 projects relating to: mental health, protection of the older consumer; development and promotion of new roles for successful aging; the demonstration of low-cost interventions for supporting caregivers; and economic security.

SAMHSA - Knowledge Development programs are designed to examine the effectiveness of models of service delivery in actual settings. In addition to targeting specific concerns such as employment, housing, substance abuse, these programs examine how services are delivered including various integrated services and consumer operated models. Application of effective practices is encouraged through the SAPT and Mental Health Block Grant programs.

OPHS – OPHS supports several research and service demonstration grant programs and program evaluations to identify what works, model strategies and approaches, and best practices that address the barriers and health problems of racial and ethnic minorities and identify effective disease and disability prevention and public health approaches. Two major grant programs which will continue to be administered by OPHS are the Bilingual/Bicultural

Service Demonstration Grants Program to improve access to health care by reducing cultural and linguistic barriers, and the Minority Community Health Coalition Demonstration Grants Program to address reduction of racial disparities in targeted health areas.

PROGRAMS SUPPORTING THIS OBJECTIVE

ACF
Temporary Assistance for Needy Families
Child Support Enforcement
Developmental Disabilities
Refugee Resettlement
Child Care
Child Welfare
Youth Programs
Developmental Disabilities
Head Start

AoA
Research, Training and Discretionary
ASPE
Policy Research
OPHS
SAMHSA
Substance Abuse Prevention and Treatment Block Grant
Mental Health Services Block Grant
Knowledge Development and Application Program

HHS Goal 5: IMPROVE PUBLIC HEALTH SYSTEMS

From the HHS Strategic Plan, September 1997. Over the past fifty years, the American medical care system has made remarkable gains in saving lives and ameliorating suffering. Clinical medicine, however, is credited with only five of the thirty years that have been added to life expectancy since the turn of the century. Public health interventions have had a far greater impact and, in concert with clinical medicine, will continue to play an important role in achieving the improvements the Department of Health and Human Services (HHS) seeks. The public health system has provided safe drinking water, reduced and even eliminated major infectious diseases such as smallpox and polio, and decreased contamination of the food supply.

State health agencies are working creatively to stretch their resources and support local partners. Yet today, the majority of local health agencies report that they lack sufficient information systems and trained staff to meet current needs. The technology gap is most evident among local health departments, where many staff lack access to or training about computers and electronic information.

In addition, public health agencies are being affected as Medicaid beneficiaries previously served in public clinics are shifted into managed care networks. This shift deprives health departments of the Medicaid support for overhead costs that have helped to sustain basic public health services. Therefore, the shift to managed care heralds a changing role for health agencies, especially the opportunity to concentrate on providing a full range of essential public health services. Doing so, however, will require staff training in population-based services as opposed to direct care. It also presents a challenge to health agencies to address the loss of resources that support basic public health services.

Challenges also exist in the area of food and drug safety. In the drug area, great progress has been made under the Prescription Drug User Fee Act (PDUFA) in making new drugs and biologics available more quickly to the American people. This has been done without compromising the scientific review process; however, more progress can be made, especially with the extension of PDUFA, which is required for continued progress.

Ensuring the safety of the food supply is one of the government's most enduring and important functions. While the United States has the world's safest food supply, major issues need to be addressed, including emerging pathogens, new and novel food ingredients, hazardous dietary supplements, naturally occurring food-borne toxins, and increasing importation of foods. Sources of contamination are more numerous and more varied than the pathogens themselves, highlighting the importance of adequate research, surveillance, and prevention activities. Currently available diagnostic assays for detection of some pathogens have serious limitations, diminishing the Department's ability to ensure the safety of the food supply.

Preserving and improving the nation's public health systems are critical priorities for the Department. Investments in this area will maintain and improve the foundation for effective programs. HHS must work with state and local governments to secure a workforce that is

appropriately trained, information systems that are adequate and effectively linked, and structures and resources that are sufficient to deliver the essential services of public health. The Department also must work with industry and consumers to implement new approaches in science-based regulation that will allow it to protect the food and drug supply while minimizing costs and intrusiveness.

These activities will be coordinated through the Office of Public Health and Science (OPHS) within the Office of the Secretary (OS) and involve the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Food and Drug Administration (FDA), the Health Care Financing Administration (HCFA), and the Administration for Children and Families (ACF).

HHS 5.1: Improve the Public Health Systems' Capacity to Monitor The Health Status and Identify Threats to the Health of the Nation's Population

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

CDC – CDC provides comprehensive information on health including health status, health risks, the health care system, and health-related outcomes. By maintaining a broad-based monitoring capability, CDC can quickly detect and assess public health threats. CDC's assessment capability, epidemiologic and laboratory surveillance, and response capacity ensure a system that identifies health problems and deploys teams of experts to help resolve the problems promptly. Additionally, the assessment and surveillance capacity ensures data for analysis that can help identify causes of disease early and assist in decisions about appropriate research, policy, and programmatic actions.

  Emphasis is on assuring that CDC's surveillance and health information systems address current health issues and problems and that existing and new CDC data systems are carefully coordinated and integrated. CDC's Health Information and Surveillance Systems Board stimulates and sponsors innovation in health information and surveillance systems supportive of the essential public health services. In addition, epidemiologic and laboratory capacity for surveillance and response will be strengthened. Making health information available to a wide audience is a major CDC priority that requires adjustments to existing data and surveillance systems and modifications of the procedures for accessing information. For FY 2000, this goal is accomplished through many of CDC's program activities, with emphasis on Health Statistics, the Preventive Health and Health Services Block Grant, Epidemic Services, Emerging Infections, Injury Prevention, Environmental and Occupational Health, and Cancer Registries.

CDC – Infectious Diseases. CDC's National Center for Infectious Diseases (NCID) will focus on building a strong and flexible public health infrastructure, recognizing that skilled epidemiologists, strong public health laboratories, and coordinated communications and disease reporting systems are essential for developing sustainable disease prevention strategies and are the best defense against any disease outbreak. This approach emphasizes the need for developing emergency preparedness at all levels of government for an organized, rapid, and effective response in the event of pandemics (global epidemics), such as influenza, and large scale disease outbreaks or natural disasters.

  In addition, NCID will expand activities of the FY 1998-1999 National Food Safety Initiative. Activities carried out under this initiative have focused on building a national early warning system for hazards in the food supply by enhancing capacity for surveillance and outbreak investigations at the state and federal levels, and by linking state health departments and federal agencies together with sophisticated computer and communications systems to coordinate the response to foodborne disease.

CDC – Health Statistics. CDC's National Center for Health Statistics (NCHS) provides statistical information to guide actions and policies to improve health of Americans. CDC will build a broad-based health statistics infrastructure needed to meet new demands for health data from policy-makers, health researchers, public health practitioners, and the public. To assure that these data needs are met, CDC will update current "endangered" systems to assure their utility now and in the future, develop new data systems to address emerging public health issues, invest in technology to improve timeliness and accessibility of data, fill critical gaps in State-level policy information, and fill critical data gaps related to race and ethnicity.

CDC – Developing a Public Health Response to Terrorism Initiative. CDC will improve public health preparedness at the federal, state, and local levels of government to respond to the threat posed by a terrorist event involving biological, chemical or radiological weapons. CDC will build public health emergency response capacity by building public health surveillance for detecting unusual or small covert events; building epidemiologic capacity for minimizing and controlling potential health threats; enhancing public health laboratory capacity for identifying and diagnosing candidate agents for terrorism; and developing communications systems with other government agencies and the general public for rapidly disseminating information.

OPHS – The Office of Emergency Preparedness will continue HHS's integrated plan, begun in FY 1999, to address the complex issues of a health and medical response to bio-terrorism, as well as the continued infrastructure for a medical response to terrorism of any type – nuclear, biological or chemical. The national response to bioterrorism is led by the ASH/SG, through surveillance activities of FDA, CDC, ATSDR and State and local health agencies, with the assistance of all the HHS agencies. The FY 2001 Budget will provide increased support for team training and exercises, Metropolitan Medical Response Team development and research and development relating to small pox and anthrax vaccines.

OPHS – The Office of Emergency Preparedness (OEP) is responsible for coordinating the provision of mental health services in the immediate response phase of natural disasters and domestic terrorism. Working with the Federal Emergency Management Agency and SAMHSA, OEP provides teams of mental health professionals to respond to large-scale declared disasters.

AHRQ - Report to the Nation on the Quality of Health Care. This annual series is intended to provide policymakers with a national perspective on those health care services and the key aspects of the way we organize and deliver those services that most affect the quality and safety of patient care. This information will enable decisionmakers to ensure that the populations they care about are getting the care they need. It should help policymakers to target resources and activities to improve quality where it can and needs to be improved. It will also provide evidence to inform of purchasing decisions in ways that can harness market forces to reward high quality. AHRQ will begin work on enhancing data collection activities in FY 2001 in order to submit the first annual report in FY 2003.

AHRQ - Monitor quality of care through a strengthened **Medical Expenditure Panel Survey (MEPS)**. Additional MEPS investments in FY 2001 will continue the expansions begun in FY

2000 to include in the MEPS household sample a sufficient sample of individuals with certain illnesses of national interest in terms of quality of care and burden of disease. This enhancement will not only permit more focused analyses of the quality of care received for these vulnerable populations; it will also enable analyses of patterns of use, costs, and impact of these services. The FY 2001 investment will also enable the completion of a more extensive module on children, to enable us to understand the impact of changes in health programs.

AHRQ - Healthcare Cost and Utilization Project (HCUP). AHRQ will further expand HCUP to provide state and community decision-makers a powerful set of linked databases they can use to monitor the impact of major system changes on access, quality, outcomes and cost in their states and communities, and to compare these against the progress of other states and communities. Specifically, the expansion will include clinical and financial records from emergency departments and other ambulatory care as well as records from four more States, an increase from an expected 26 states in FY 2000, for a total of 30 States.

CDC–Cancer Registries. Through the National Program of Cancer Registries (NPCR), CDC funds states and territories to enhance existing cancer registries; plan and implement statewide registries where they do not exist; develop model legislation and regulations for states to enhance viability of registry operations; set standards for completeness, timeliness, and quality; and provide training. The NPCR serves as the foundation of a national, comprehensive prevention strategy; it is a basic tool in surveillance efforts that will provide the needed factual basis for appropriate policy decisions and allocations of scarce resources. In FY 1999, CDC supported 45 States, 3 territories, and the District of Columbia for cancer registries.

CDC – Environmental and Occupational Health. CDC is working to develop cost effective environmental interventions that, in conjunction with improved medical management, will reduce the number of asthma exacerbations and improve the quality of life of people with asthma.

FDA – Injury Reporting Initiative. Reduce injuries and illnesses resulting from consumption and use of FDA-regulated products. One of the FDA's primary objectives is to develop and implement a comprehensive surveillance system to improve the quality of information on adverse events and product defects associated with FDA-regulated products. The system will focus on three areas: surveillance and epidemiology; research; and education and outreach. FDA believes this system will increase the safety of FDA-regulated products because more reports of rare and unexpected adverse events and product problems would be discovered and corrective action taken. Systematic feedback about the problem can then be provided to the healthcare community and the public.

FDA – Food Safety Initiative. Surveillance of foodborne illnesses provides critical information to determine the need for preventive interventions. The FoodNet foodborne illness reporting system provides extensive, complete, and reliable information about the occurrences of outbreaks in the U.S. When outbreaks are reported, FDA responds quickly to trace back through the food distribution chain to identify the source of the outbreak and then initiate intervention measures to limit the outbreak.

The National Antimicrobial Resistance Monitoring System (NARMS), which detects potential health hazards through systematic collection, analysis and interpretation of antimicrobial susceptibility surveillance data, is a major part of the surveillance component of FDA's Food Safety Initiative. The NARMS is the basis for regulatory decision making, food animal drug policy, and identifying disease trends in human and animal medicine. The NARMS impacts international policy, federal, state, and local programs.

HRSA – National Practitioner Data Bank. HRSA's National Practitioner Data Bank helps protect the public by assuring that information about medical and dental malpractice payments and other sanctions is available to hospitals and other health care entities, licensing authorities and professional societies.

HRSA – National Center for Workforce Information and Analysis. HRSA's National Center for Workforce Information and Analysis provides essential data for national, State, and local health workforce policy and analysis. The Center builds a network for health workforce research, forecasts health workforce supply and requirements, and maintains the only source of county-level data across the health professions.

IHS – Treatment, Indian Health Professions. This program enables AI/AN to enter the health care professions through a carefully designed system of preparatory, professional and continuing educations assistance programs; serves as a catalyst to the development of Indian communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; and develops and maintains American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field.

IHS – Information and Telecommunications. This initiative is intended to expand the IHS computing and telecommunication/telemedicine capabilities including enhanced patient record systems and improved monitoring capabilities.

SAMHSA – SAMHSA's data infrastructure initiative supports the National Drug Control Strategy, and constitutes an important component of performance measurement efforts of the Office of National Drug Control Policy (ONDCP) in determining the impact of Federal, State and local efforts to reduce drug use. The infrastructure at the State and program level is crucial to the production of data to determine client outcomes and program effectiveness. In addition to providing information the initiative moves the substance-abuse field to the implementation of common tools, targets and measures for assessing program effectiveness.

SAMHSA – Through block grant-related assistance, SAMHSA is working with State substance abuse and mental health agencies to strengthen their ability to collect, analyze and report performance and program data to the Federal government.

NIH – The National Library of Medicine. The National Library of Medicine (NLM) collects, organizes, and makes available biomedical science information to investigators, educators, and practitioners and carries out programs designed to strengthen medical library services in the United States. NIH is currently focusing on improved information generation

and dissemination by the NLM through initiatives in the following four areas: next generation internet, information services for consumers and patients, computational molecular biology, basic library services, and outreach.

OPHS – Healthy People 2010 is scheduled to be released in January 2000 and will provide an agenda for disease prevention and health promotion efforts for the next ten years. To ensure adequate access and to meet the needs of stakeholders for a broad range of information that includes key core indicators, specific content area objectives, and an extensive data tracking mechanism, Healthy People 2010 will be issued as a three-volume set, rather the single volume that comprised Healthy People 2000. The first volume will be designed for policy makers and focus on people, settings, and leading health indicators. It will also be most understandable to consumers. The second volume will contain the national health objectives with supporting references and justification. This volume will be especially useful to national membership organizations, States and communities to use in developing their own sets of performance measurements. The third volume will be a statistical compendium with the data that describes population groups by gender, race and ethnicity, and socio-economic status characteristics. OPHS will also post Healthy People 2010 on the Internet with a complete searchable text database.

OPHS – The US/Mexico Border Health Commission (BHC) is authorized to conduct or support border activities, including a comprehensive needs assessment and investigations, research, or studies designed to identify, study, and monitor, on an on-going basis, health problems affecting the border populations.

The U.S. side of the Commission is expected to be fully operational by FY 2000. Through needs assessments, outreach to border constituencies, and other public interactions, Commissioners will have identified health priorities that could benefit from BHC support and involvement. BHC will provide financial, technical, or administrative assistance to public or private nonprofit entities that act to prevent or resolve such health priority problems. The BHC will also progress toward the conduct or support of a binational, public-private effort to establish a comprehensive and coordinated system for collecting health-related data and monitoring health problems of the U.S.-Mexico border.

OPHS – Office of Minority Health. OMH fosters the development of state infrastructures for addressing minority health issues through the development of a minority health network comprised of Federal, national, state and local organizations. OMH provided assistance through the provision of timely information, conducting of skills-building meetings and conferences (e.g., the use of telecommunications technology), and hands-on technical assistance.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Regional population-based Emerging Infections Programs will conduct early warning investigations of agents of infectious diseases. *CDC Plan*	FY 01: 10 FY 00: 9 FY 99: 9	FY 01: FY 00: FY 99: 9 FY 97: 7
At least 80% of total required data from all programs funded by the Preventive Health and Health Services Block grant will be reported to CDC annually. *CDC Plan*	FY 01: At least 85% FY 00: At least 85% FY 99: At least 80%	FY 01: FY 00: FY 99: 3/00 FY 95: 77%
Ensure safe and healthful working conditions by developing a system for surveillance for major occupational illnesses, injuries, exposures, and health hazards. FY 01 Measure: Complete a comprehensive surveillance planning process and implement recommendations at NIOSH. *CDC Plan*	FY 01: Continue implementation of surveillance recommendations. FY 00: A comprehensive surveillance planning process will be completed and efforts will begin in implementing recommendations for NIOSH. FY 99: Undertake a comprehensive surveillance planning process with NIOSH partners at the State and Federal levels to establish surveillance priorities and define roles for various agencies.	FY 01: FY 00: 1/00 FY 99: Planning process completed; draft surveillance strategic plan developed.

Performance Goals	Targets	Actual Performance
By 2002, a national network will exist that will provide all states with better access to data on disabilities for their use in analyzing the needs of people with disabling conditions. FY 01 Measure: By 2000, the number of states who have begun using the Behavioral Risk Factor Surveillance Survey (BRFSS) disability module will be increased to 16. *CDC Plan*	FY 01: 14 FY 00: 14 FY 99: 15	FY 01: FY 00: FY 99: 16 FY 97: 0
Increase the number of state and major city health departments with expanded epidemiology and surveillance capacity to investigate and mitigate health threats by bioterrorism. *CDC Plan*	FY 01: 63-68 FY 00: 40 FY 99: 40	FY 01: FY 00: FY 99: 34 FY 98: 0
Maintain a national pharmaceutical "stockpile" for deployment to respond to terrorist use of potential biological or chemical agents, including the ability to medically treat 1 million civilians from biological agents of anthrax, plague and tularemia and/or to medically treat 10,000 civilians from chemical attack using nerve or blistering agents. *CDC Plan*	FY 01: Maintain stockpile FY 00: Maintain stockpile FY 99: Create a national pharmaceutical "stockpile" available for deployment to respond to terrorist use of potential biological or chemical agents, including the ability to protect 1-4 million civilians from anthrax attacks.	FY 01: FY 00: FY 99: Created stockpile FY 98: no plan
Number of Metropolitan Medical Response Systems with bioterrorism capabilities. *OPHS Plan*	FY 01: 72 FY 00: 47	FY 01: FY 00: FY 99: 27 FY 98: 0
Recruit additional hospitals into the MedSun System (Medical Device Surveillance Network) for injury reporting that uses improved data format and collection methods to enhance the validity and reliability of data provided, thus affording a higher level of public health protection. *FDA Plan*	FY 01: Over 200 additional hospitals FY 00: Develop MedSun System based on approximately 75 to 90 representative user facilities. FY 99: N/A	FY 01: FY 00: FY 99: Pilot completed FY 98: Recruited 24 pilot facilities.

Performance Goals	Targets	Actual Performance
Expedite processing and evaluation of adverse drug events through implementation of the AERS which allows for electronic periodic data entry and acquisition of fully coded information from drug companies. *FDA Plan*	FY 01: Separate data entry and retrieval functions throughout new drug review divisions. Pilot test advanced analytical techniques. Develop and implement special report module. FY 00: Implement software to make the AERS more compatible with International Conference on Harmonization requirements. Develop next generation of the AERS to enhance functionality. FY 99: Implement AERS for the electronic receipt and review of voluntary and mandatory ADE reports.	FY 01: FY 00: FY 99: Pilot testing of electronic industry submissions ongoing–actual implementation with respect to certain types of periodic industry reports expected by end of FY 99.
Develop the specifications and implementation plan for an automated mutually compatible information system which captures health status and patient care data for Indian Urban health care programs and implement at field urban sites. *IHS Plan*	FY 01: implemented in 30% of urban programs FY 00: test at least 1 site FY 99: develop specs and plan	FY 01: FY 00: FY 99: accomplished
Develop environmental health surveillance system, and complete community environmental assessments in 90% AI/AN communities. *IHS Plan*	FY 01: 90% of communities assessed FY 00: develop surveillance protocol and plan	FY 01: FY 00: FY 99: no reliable baseline

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Research on Health Costs, Quality, and Outcomes
Medical Expenditure Panel Surveys

CDC
Health Statistics
Infectious Diseases
HIV/AIDS Prevention
Chronic Disease Prevention
Prevention Research
Cancer Registries
Epidemic Services
Environmental and Occupational Health
FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
HRSA
National Practitioner Data Bank
National Center for Workforce Information and Analysis
IHS
Treatment
Capital Programming/Infrastructure
NIH
Research Program
OPHS
Office of Disease Prevention and Health Promotion, Healthy People 2000
OPHS (continued)
Office of Emergency Preparedness
US/Mexico Border Health Commission, Office of International and Refugee Health
SAMHSA
Substance Abuse and Mental Health Block Grants

HHS 5.2: Ensure Food and Drug Safety by Increasing the Effectiveness of Science-Based Regulation

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

CDC – Infectious Diseases. CDC's National Center for Infectious Diseases will expand activities of the FY 1998-1999 National Food Safety Initiative. Activities carried out under this initiative focus on building a national early warning system for hazards in the food supply by enhancing capacity for surveillance and outbreak investigations at the state and federal levels and by linking state health departments and federal agencies together with sophisticated computer and communications systems to coordinate the response to foodborne disease.

FDA – Product Safety Assurance Initiative. To assure that FDA-regulated products are being produced and marketed under conditions that will assure their safety, quality and efficacy. FDA intends to meet its domestic statutory requirement by inspecting domestic firms more often with the assistance of our state regulatory counterparts. The Agency will also use multiple strategies of education, technical assistance, targeting higher-risk industry sectors, and enforcement, when necessary, to correct product risk in the market place. A key element of assuring quality and safety, particularly in the food industry, will be to strengthen the ability of industry to develop its own safety and quality monitoring systems. This will be accomplished, in part, by expansion of the Hazard Analysis and Critical Control Point (HACCP) program from seafood to other appropriate industry segments.

To improve safety of imported products, FDA will continue its three coordinated strategies. First, reduce the probability that violative products will be exported to the U.S.; second, at the U.S. border, make rapid and reliable decisions on product entry; and third, target violative products and prevent their entry into the U.S.

FDA – Food Safety Initiative. To increase consumer confidence in the safety of the nation's food supply. At the federal level, FDA has the primary responsibility for ensuring that foods available to the nation's consumers are safe. Food products, which fall under the regulatory purview of FDA, are estimated to represent 70 percent of those found in the marketplace. The remainder of the food supply, primarily meats and poultry, is regulated by USDA.

The rapid growth in the number and complexity of food safety issues increasingly presents major challenges for FDA, including emerging pathogens, hazardous dietary supplements, pesticides and industrial chemical contaminants. Because of the magnitude and complexity of the hazards involved with these and other important food safety issues, strategies to address them must be innovative, based on sound science, and effectively coordinated with the Agency's federal partners, including USDA, CDC and EPA, and the states.

FDA's goal is to reduce foodborne illnesses by expanding the use of preventive control systems; expanding compliance monitoring of domestic and imported products; increasing the

public's understanding and use of safe food handling practices; and developing more effective techniques for detecting, preventing and controlling foodborne hazards.

FDA – International Harmonization of Standards. FDA, other government regulatory bodies, and industry participate in international harmonization activities to help reduce the regulatory burden on industry and to bring products to the market more quickly. Acceptance and use of international safety standards that satisfy U.S. consumer protection goals will improve product safety and public health, reduce FDA's import inspection burden, and help facilitate the importation and exportation of products. By harmonizing international requirements, the industry hopes to reduce the costs of bringing products to market. FDA will continue to participate in international standard setting activities such as General Agreement on Tariffs and Trade (GATT), the North American Free Trade Agreement (NAFTA), and the Codex Alimentarius, to promote development and adoption of science-based international standards and ensure FDA's ability to protect the U.S. public health.

FDA – Science and Research Support for Premarket Reviews. FDA's highest priorities include improving its science base and conducting research, especially to support the review of premarket applications. FDA's goals in conducting research are to develop: 1) in-house scientific experts, especially in emerging technologies; 2) scientific guidance for product sponsors and reviewers; and 3) science-based standards. In-house scientific experts consult with product reviewers on product applications. Scientific guidance benefits both applicants and review staff in developing and reviewing applications. FDA Modernization Act requires FDA to recognize and use standards established by national or internationally recognized standard development organizations in the application review process, especially with medical devices. FDA's scientific efforts will allow the Agency to expand its participation in standards development and harmonization. Since data relating to the aspects of safety and/or efficiency covered by the standards will not be required in the premarket application, the review process can be expedited.

CDC – Epidemic Services. Epidemic services cover a vast spectrum of activities: preventing and controlling epidemics and protecting the U.S. population from public health crises including biological and chemical emergencies; developing, operating, and maintaining surveillance systems, analyzing data, and responding to public health problems; training public health epidemiologists; developing leadership and management skills of public health officials at the federal, state, and local levels; carrying out the quarantine program as required by regulations; and publishing the *Morbidity and Mortality Weekly Report*, CDC's main channel for communicating public health news about disease outbreaks and trends in health and health behavior.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
The proportion of reported foodborne outbreak investigations in which the causative organism or toxin is identified. *CDC Plan*	FY 01: 55% FY 00: 50% FY 99: 45%	FY 01: FY 00: FY 99: 45% FY 98: 40%
The rate of central-line associated bloodstream infections in adult intensive care unit patients will be reduced as measured through the National Nosocomial Infections Surveillance (NNIS) System. *CDC Plan*	FY 01: 4.3 FY 00: 4.4 FY 99: 5.2	FY 01: FY 00: FY 99: 4.4 FY 98: 5.3
Increase the percentage of high-risk domestic food establishments inspected once every year. *FDA Plan*	FY 01: 90-100% once every year FY 00: 90-100% once every one to two years FY 99: N/A	FY 01: FY 00: FY 99: N/A FY 98: Through a combination of FDA and state contract inspections, cover 25% to 33% of the 6,250 high-risk establishments.
Improve inspection coverage by inspecting a greater percentage of registered human drug manufacturers, repackers, relabelers and medical gas repackers. *FDA Plan*	FY 01: 26% FY 00: 22% FY 99: 22%	FY 01: FY 00: FY 99: 26% FY 98: 24% FY 97: 26%
Improve biennial inspection coverage by inspecting 30% of registered animal drug and feed establishments. *FDA Plan*	FY 01: 30% FY 00: 27% FY 99: 27%	FY 01: FY 00: FY 99: 25%
Ensure that at least 97% of mammography facilities meet inspection standards, with less than 3% of facilities with Level 1 (serious) inspection problems. *FDA Plan*	FY 01: 97% FY 00: 97% FY 99: 97%	FY 01: FY 00: FY 99: 97% FY 98: 97% FY 97: 97% FY 96: 95%
50% of the domestic seafood industry will be operating preventative controls for safety as evidenced by functioning HAACP systems. *FDA Plan*	FY 01: N/A FY 00: N/A FY 99: 50%	FY 01: FY 00: FY 99: 3/00

Performance Goals	Targets	Actual Performance
Improve inspection coverage for Class II and Class III domestic medical device manufacturers. *FDA Plan*	FY 01: 25% FY 00: 24% FY 99: 26%	FY 01: FY 00: FY 99: 30% FY 98: 33% FY 97: 40%

PROGRAMS SUPPORTING THIS OBJECTIVE

FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
National Center for Toxicological Research

CDC
Infectious Diseases
Epidemic Services
HCFA
Medicare
Medicaid
Research

HHS Goal 6: STRENGTHEN THE NATION'S HEALTH SCIENCES RESEARCH ENTERPRISE AND ENHANCE ITS PRODUCTIVITY

From the HHS Strategic Plan, September 1997. Improvements in health are grounded on knowledge acquired through research conducted and sponsored by the Department of Health and Human Services (HHS) and other entities, both public and private. In the scope and quality of the science it sponsors, HHS sets the pace for the world in medical, epidemiological, behavioral, and health services research. It does so through strong, sustained public support for health sciences research.

The National Institutes of Health (NIH) plays a vital role in the nation's medical research enterprise. NIH-sponsored research generates knowledge that leads to improvements in the health and quality of life of the American public. It also provides a continually expanding knowledge base for the development of commercial products by the pharmaceutical, medical device, and biotechnology industries and by other key components of the national medical research infrastructure. Through its support of research training, the NIH provides the nation with highly trained scientists who rise to leadership in publicly funded research activities and in the biotechnology and related industries. To a significant degree, future improvements in the health of the American people depend upon sustaining both the research infrastructure that has been developed through NIH support and the basic principles that have enabled NIH research investments to be highly productive.

The Centers for Disease Control and Prevention (CDC) also conducts a strong program of epidemiological and population-based research to protect the public health and prevent and control disease, injury, and disability.

Finally, the Department's health services research plays a critical role by identifying what is most effective and cost-effective in day-to-day practice in community settings and by identifying the most efficient approaches for delivering and financing those services. Expansion in research investments across a broad front of scientific disciplines and operating divisions within the Department will do more than anything else to ensure improvements in health status and in the kinds and quality of services sponsored by the Department.

The Department also enhances the productivity of the nation's research enterprise through such means as international scientific cooperation and regulatory policies that encourage investments in research by the private sector.

Four principles are central to the Department's research investment strategy:

Basic Research. First is the high priority accorded to basic research in the life sciences and fundamental methodological work in health services research. In the area of life sciences, one need look no farther than the history of the biotechnology industry to see the wisdom of this approach. HHS investments in basic research undergird epidemiological, clinical, and health services

research. In the case of the last, they have laid a foundation for better administration and reimbursement in both the public and the private sectors.

Investigator-Initiated Research. The second principle is the high priority accorded to sponsorship of investigator-initiated research. The Department traditionally has eschewed top-down direction for science and instead has relied primarily on individual scientists to propose and carry out specific research projects within the context of broad program goals and policy priorities enunciated by its agencies. As a result, HHS has been uniquely effective in harnessing the creative energies of scientists throughout the nation toward improving human health and well-being.

Peer Review. Third is the reliance upon peer review to assess the quality of research proposals and outcomes. Determining the relative scientific and technical merits of competing research ideas is one of the most difficult tasks facing any research agency. The Department's success year after year in directing investments to the most promising scientific opportunities and the most capable investigators stems largely from its commitment to seeking and heeding the advice of leading experts drawn from the pertinent scientific communities.

Research Capacity/Infrastructure. Fourth is the Department's commitment to sponsoring research in a wide variety of institutional settings and to encouraging a healthy research enterprise in the for-profit sector. Universities, not-for-profit research organizations, hospitals and other practice settings, small and large businesses, and government laboratories—each in its own way has provided a hospitable environment for important scientific initiatives. Also, in view of the unique role played by academic institutions, the Department will continue its efforts to help research-intensive universities remain strong. In particular, it will maintain its policy of paying a fair share of research costs and will collaborate with academic health centers to find ways to counter the destabilizing effects of managed care upon clinical research and the education of health professionals. Finally, the Department will enhance the base of highly qualified scientific investigators.

The Department reaffirms these principles as the core of its strategy to guide new investments to increase the nation's knowledge base about health science and maintain its quality. HHS intends to apply them even more broadly in the years immediately ahead.

HHS 6.1: Improve the Understanding of Normal and Abnormal Biological Processes and Behaviors

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

NIH – The Human Genome Project. The Human Genome Project (HGP) was started in 1990 and has, from its beginning, enjoyed significant success. A major goal of the Human Genome Project is to sequence, or read, each of the approximately 3 billion bases in the human genetic instruction book. Determining the complete genetic blueprint of humans will greatly accelerate the identification of the genes embedded in this genetic code that underlie many human diseases, including complex diseases that represent the greatest health burden to the U.S. population. Identifying those genes is the first step to a more profound understanding of the biological basis of disease and this, in turn, will lead to much more effective and inexpensive ways to diagnosis, treat and prevent disease.

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

  Based on the success of a three-year pilot project, in March 1999, an international consortium, with the U.S. taking the lead, launched the full-scale effort to sequence the human genome. On November 17, 1999, the consortium deposited the one-billionth base pair of the human genome into the public database, GenBank. Achieving this important milestone marks the success of the transition from the pilot to the full-scale production sequencing. The consortium expects to produce at least 90 percent of the human genome sequence in a "working draft" form by the spring of 2000, years earlier than initially expected, and is on track to complete the final, high quality genome sequence by 2003 or earlier.

NIH – Biomedical Research. Much of health care today still involves treating the symptoms of disease without understanding its underlying causes and the precise mechanisms by which disease develops (pathogenesis). In order to effectively and systematically attack the diseases of today, we need a broad base of knowledge about living systems. We need to understand how living systems operate at both a "micro" level–the structure and function of proteins, nucleic acids (DNA and RNA), carbohydrates, and fats–as well as at more "macro" levels–how these molecules organize and function together as living units, i.e., cells, tissues, organs, whole organisms, and even communities. As important, we need to understand how disease, genetic alterations, and environmental factors affect the function of these molecules, cells, tissues, organs, and organisms, and their consequences for human health.

Fortunately, all organisms are made of the same basic materials, and many share similar genetics and physiologic processes, so researchers seeking to understand both normal and disease processes in humans can learn a great deal by studying similar systems in simpler "model organisms" like bacteria, slime molds, yeast, fruit flies, zebrafish, and rodents. Model systems have proven essential tools for understanding a wide array of human conditions, providing critical new insights into mechanisms associated with cardiovascular, gastrointestinal, neurological, structural, and other defects that may have counterparts in human disorders. Animal models can be used for studying the physiological course of a disease, determining the identity and function of the genes and proteins involved in health and human disease, testing new treatments, and developing and testing methods for preventing disease and disability.

At first glance, this goal may appear to focus on laboratory research, but it actually encompasses clinical research as well. The aim is, of course, to be able to put all the parts together to understand normal biological activities and how they malfunction in disease and disability. This, in turn, will provide the fundamental theories and concepts for more disease-oriented investigations that lead to new methods for diagnosing, treating, and preventing disease and disability. It may take years, however, after a new discovery is made for the potential health applications to become clear. Thus, just as no one can predict what researchers will discover in the future, neither can the eventual clinical applications of today's results be known. As productive as the past has been, the future promises to be still more exciting as researchers gain an even greater understanding of living systems and apply that understanding to questions of health and disease.

OPHS contributes to the strengthening of the health sciences research by promoting the responsible conduct of research and the effective handling of scientific misconduct. In making and publicizing approximately 100 findings of scientific misconduct since its establishment in 1992, the Office of Research Integrity (ORI) actions serve as a deterrent to misconduct and educate the scientific community regarding the importance of research integrity.

OPHS ensures that all applicant and awardee institutions have an administrative process available for handling allegations of scientific misconduct in PHS supported research and are taking steps to promote a research environment that emphasizes integrity. ORI has requested institutional policies for responding to scientific misconduct allegations from 1200 institutions for review to date. In addition, ORI has received funding to conduct a study of the guidelines medical schools have adopted for the conduct of research.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Add to the body of knowledge about normal and abnormal biological functions. (Criteria defined in NIH Plan) *NIH Plan*	FY 01:Meet or Exceed FY 00:Meet or Exceed FY 99:Meet or Exceed	FY 01: FY 00: FY 99:Exceeded
Develop new or improved instruments and technologies for use in research and medicine. (Criteria defined in NIH Plan) *NIH Plan*	FY 01:Meet or Exceed FY 00:Meet or Exceed FY 99:Meet or Exceed	FY 01: FY 00: FY 99:Exceeded
Develop critical genomic resources.		
– U.S. annual production rate (base pairs)	FY 01: Not Applicable FY 00: 190 million FY 99: 90 million	FY 01: Not Applicable FY 00: FY 99: 173 million
– Worldwide production:		
▸ Working draft of human genome sequence:	FY 01: 90% complete; 90% accurate.	FY 01:
▸ Final human genome sequence	FY 01: 1/3 complete; 99.99% accurate	FY 01:
▸ Base pairs: annual/aggregate	FY 01: Not Applicable FY 00: 275million/ 675million FY 99: 220 million/ 400 million	FY 01:Not Applicable FY 00: FY 99: 265 million/ 442 million
– Genome sequence of *C. elegans*	FY 99: 100%	FY 99:100%
– Genome sequence of Drosophila melanogaster (excluding heterochromatin)	FY 01: 100%	FY 01:
– Identify human single nucleotide polymorphisms (SNPs) *NIH Plan*	FY 01: 60,000	FY 01:

Performance Goals	Targets	Actual Performance
Number of collaborative activities (workshops, publications and other resource materials produced) that assist institutions to (1) promote integrity in the health science research enterprise, and (2) develop administrative processes that effectively respond to allegations of scientific misconduct. *OPHS Plan*	FY 01: 5 workshops and 2 publications FY 00: 4 workshops and two publications	FY 01: FY 00: FY 99: 6 workshops and one publication
Percent of institutional policies for responding to allegations of scientific misconduct that have been reviewed for compliance with the federal regulation 42 CFR Part 50, Subpart A. *OPHS Plan*	FY 01: 65% FY 00: 60%	FY 01: FY 00: FY 99: 50%

PROGRAMS SUPPORTING THIS OBJECTIVE

NIH
Research Program
OPHS

HHS 6.2: Improve the Prevention, Diagnosis, and Treatment of Disease and Disability

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

NIH – Multi-Disciplinary Research on Disease. The development of preventive, delaying, or disease-halting strategies requires a multi-disciplinary approach. Epidemiologic studies provide a necessary foundation for any disease prevention program by identifying the magnitude, and possibly the variability, of a disease within any given population. The epidemiologic patterns of targeted diseases may identify sub-populations that are at risk for developing specific diseases, as well as provide information about the course of disease development in different environments and in different age, ethnic and socioeconomic groups. Prevention and disease-halting strategies also require a solid understanding of disease mechanisms. For example, it is important to know what causes the disease, how the disease affects specific cells or organs, if there is a genetic basis or predisposition for developing the disease, and whether a person's immune system plays a role in the disease process. A solid understanding of the disease mechanism facilitates the development of effective ways to prevent or delay the disease. Evaluating any new therapies or behavioral approaches requires clinical research and often clinical trials. Behavioral studies are also needed. Effective strategies for prevention or control of a disease may include a new medication, or an alteration in behavior or life-style. Strategies are needed to both educate the public as well as encourage the public to take advantage of these findings.

NIH – Genome Research and Disease. Genomic research is not limited to the human organism. Studies are also underway to characterize the genetic blueprints of a number of disease-causing microbes as well as organisms that are used extensively in research laboratories as model systems. Resources will be used to develop core research centers and to train scientists to relate mouse pathology and physiology to the faulty genes. The end result will be new understanding of mammalian biology as well as new or improved "model systems" for learning about human diseases, genes, and proteins and for testing new treatments.

  Other genetic research focuses not on the entire genome, but on particular complex biological systems, processes, or diseases. The Brain Molecular Anatomy Project, for example, will continue to advance our understanding of the genes involved in brain and nervous system function in normal and disease conditions. Advances from this effort will aid in disease prevention, early detection, diagnosis, and treatment. Other genetic studies will concentrate on complex chronic diseases, such as diabetes and heart disease, and neurodegenerative disorders such as Alzheimer's and Parkinson's disease and retinal disorders. These diseases are particularly challenging because they result from the interactions of a number of genes and environmental factors. New understanding of the identity and interactions of key genes and environmental factors that contribute to disease will provide new targets for the development of therapeutic and prevention strategies.

NIH – AIDS Vaccine Research. In support of the President's goal of developing an AIDS

vaccine, NIH is supporting vaccine research on the prevention of AIDS. A vaccine works by sensitizing the body's immune system to a particular disease-causing bacterium, virus, toxin, or a component of a pathogenic organism. When the infectious agent subsequently invades the body, the immune system recognizes it and mounts an immediate and robust response to destroy the invader before it can cause disease. The many successes of traditional vaccines are well known, but other serious and fatal diseases still have proven stubbornly resistant to vaccines, demanding new approaches.

A safe and effective AIDS vaccine is a global public health imperative. As of December 1998, more than 33 million people were living with HIV/AIDS worldwide, with almost 6 million new infections occurring during 1998 alone. AIDS is now the fourth leading cause of death and is the leading cause of disease burden in the developing world. Without an effective vaccine, the pandemic will continue unchecked. In the U.S., the rate of new infections, approximately 44,000 per year, remains unacceptably high.

To complement the extramural AIDS vaccine effort, the NIH has established an intramural Vaccine Research Center (VRC) to focus on AIDS vaccines. When President Clinton announced the initiation of the VRC in May 1997, he also challenged the NIH and the scientific community to produce an AIDS vaccine within the next 10 years. As part of the effort to meet this challenge, the VRC is a joint venture between two NIH components -- the National Cancer Institute (NCI) and the National Institute of Allergy and Infectious Diseases (NIAID). The primary focus for the VRC is to stimulate multi-disciplinary research, from basic and clinical immunology and virology through to vaccine design and production. Currently, the VRC is a "laboratory without walls," including established intramural labs focused on this area of research. NIH is completing a building on the campus to eventually house scientists recruited for the VRC. In FY 1999, NIH hired a director for the Center.

NIH – Disease Treatment. Research is also paving the way to improve current and, develop new, methods for treating disease and disability. The aim of much of NIH research is the development of new and improved therapeutics. This pathway to our ultimate goal of better health requires a strong foundation of understanding disease mechanisms and normal and abnormal biological functions. Searches for new therapies depend on advances in chemistry, bioengineering, enzymology, structural biology, genetics, immunology, cellular and molecular biology, and pharmacology.

New techniques to rapidly screen chemical compounds are now greatly expanding the pool from which possible therapeutic substances can be drawn. The study of molecular structures by x-ray crystallography has yielded detailed understanding of many molecules critical to health, as well as therapeutic molecules specifically tailored to "fit" the structures and thus alter their chemical activity. In addition, the science of synthetic chemistry has yielded many improved ways to design new therapeutic substances.

NIH – Diagnosis of Disease. Research is paving the way to improve current and, develop new, methods for diagnosing disease and disability. Early diagnosis and detection of disease is often a key requisite for effective treatment and prevention of disease and disability. Some of the most life-threatening diseases and disabilities can only be controlled or cured if they are

diagnosed and treated in the earliest stages. Diagnostic methods include a broad array of biomedical technology, e.g., machines that directly visualize the body, cells, and tissues; instruments that can measure specific body functions; and tests that detect minute quantities of biological and inorganic materials. Despite the extreme variability, diagnostic tools must be accurate and safe. It is also advantageous if they are inexpensive, noninvasive, easy to use and pain-free.

Research to create new diagnostic tools is closely intertwined with basic disease research; diagnostic tools are most commonly developed after the mechanisms of the specific disease process are understood. Studying the efficacy and accuracy of diagnostic tools requires clinical research as well as health services research. It must be shown that a given test is both reliable and effective.

NIH – Clinical Research. New networks for clinical research and clinical trials will be needed to examine innovative therapies for cancer, stroke, diabetes, kidney and urinary tract disorders, and mental health disorders. Additional clinical trials are needed to translate findings from basic science into improved diagnostics and therapeutics. For example, to help speed development of new cancer therapeutics, the Rapid Access to Intervention Development (RAID) program makes available to the academic research community resources–products and information–for the pre-clinical development of drugs and biologics. The goal of RAID is clinical "proof of principle" that a new molecule or approach is a viable candidate for expanded clinical evaluation.

New technologies are enabling production of large numbers of new chemical entities to be evaluated as target-specific candidate therapies. Improved safety evaluation methods are needed to provide preclinical and clinical testing in an efficient and timely fashion. The use of biological markers, or biomarkers, defined as characteristics that can be measured and evaluated as indicators of normal biologic processes, pathogenic processes, or pharmacologic responses to a therapeutic intervention, is one approach to enhance testing of new chemical entities. Biomarker research programs for cancer, Parkinson's disease, stroke, arthritis, and other chronic diseases will help streamline the development and clinical testing of new treatments, thereby enabling patients with these disorders to benefit more quickly from laboratory discoveries.

NIH – Pandemic Flu Research. The NIH has developed a plan to further research in pandemic flu. In addition to supporting a grants and contract program in basic biology, epidemiology, vaccine development and evaluation, drug discovery, development and evaluation, and diagnostics, as related to influenza, funds requested in FY 2001 will allow the initiation of the production of an inactivated, live attenuated, and/or recombinant vaccine against a single avian influenza virus subtype of high pandemic potential.

CDC – The applied techniques of epidemiology, laboratory, behavioral, and social sciences are the primary tools that CDC uses to understand the causes of poor health, identify populations at risk, and develop interventions for disease control and prevention. As research provides more information about the relationships between the physical, mental, and social dimensions of well-being, a broader approach to public health has become important in the quest for

answers to prevent and solve health problems. CDC is committed to expanding its research agenda to help bridge the gap between research and public health practice. Through the integration and communication of scientific information, the most effective public health solutions will be translated into practice in the Nation's communities.

CDC's strategy for assuring a strong science base for public health action requires an agency commitment to support and conduct high quality epidemiologic, laboratory, behavior, and social science research. Through its programs in Environmental Health, Infectious Diseases, Occupational Safety and Health, Epidemic Services, and the Prevention Centers, CDC advances the science base in public health by conducting and supporting both extramural and intramural research on a wide range of public health issues. For FY 2000, research on several major public health issues will be conducted in order to improve decision making, to examine health outcomes, or to prevent disease.

CDC – Breast and Cervical Cancer. CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides cancer screening for under-served women, particularly low-income women, older women, and members of racial/ethnic minorities. Almost all deaths from cervical cancer and an estimated 30 percent of deaths from breast cancer in women over age 50 are preventable though widespread use of Papanicolaou (Pap) testing and screening mammography. CDC's NBCCEDP created the foundation for an aggressive response to breast and cervical cancer and ensures the delivery of successful screening services. CDC supports activities at the state and national levels in the areas of screening referral and follow-up services, quality assurance, public and provider education, surveillance, collaboration, and partnership development.

CDC–Epidemic Services. CDC publishes the *Morbidity and Mortality Weekly Report* (MMWR), which notifies health practitioners and the public of emergencies such as disease outbreaks and threats of bioterrorism, reports changes in health risks and causes of disease among the American public and provides practice recommendations and education programs to guide public health and medical care.

CDC–Infectious Diseases. The challenges posed by new and resurgent infectious disease threats will be addressed within the CDC's Infectious Disease Program. CDC's efforts focus on building epidemiology and laboratory capacity, recognizing that a strong public health infrastructure will lead to improved surveillance, a better understanding of disease determinants, interventions that will prevent and control disease outbreaks, and ultimately, reduced morbidity and mortality.

CDC–Environmental Disease Prevention. CDC's strategy to address the challenge of environmental disease prevention involves a variety of public health approaches that include surveillance and biomonitoring to determine the magnitude of the public health problem; epidemiologic studies to determine the causes, risk and protective factors, and susceptibility for diseases and conditions that have significant public health impact; and finally the development and evaluation of public health intervention programs.

FDA – Scientific Research. FDA's research provides the basis for FDA to evaluate product

safety, estimate human risk, and make sound science-based regulatory decisions; and to promote the health of the American people through enforcement and compliance. The FDA has expedited drug, device and biological approval procedures to provided needed disease diagnostic tests and therapies to consumers more quickly. Research results that improve the ability of FDA reviewers to evaluate and predict rapidly and accurately the adverse effects FDA-regulated products may have on humans, that evaluate new technologies and that revise existing technologies to meet new regulatory challenges are vital to carrying out the Agency's consumer protection mission. Some of the specific aims of FDA's research are to understand the critical biological events that cause some FDA-regulated products to elicit a toxic reaction in humans; to develop methods to better assess human exposure, susceptibility and risk to toxic agents; and to apply these scientific findings to FDA's premarket application review and product safety assurance efforts.

One of FDA's new strategies for predicting product toxicity includes using new test systems that are based on understanding a product's mode of action, refining new and existing tests, as well as conducting studies that help reduce the uncertainty of extrapolating laboratory data to humans. A second strategy focuses on developing computer-based predictive systems that include an accumulation of scientific data and allow a reviewer to predict the toxicity of a drug or chemical in humans and animals based on the drug or chemical's structure and/or activity. This type of system may reduce approval time for estrogen-mimicking drugs used for breast cancer treatment or hormone replacement therapy. Some of FDA's research will also focus on providing data not available from manufacturers in the scientific literature on specific agents, such as anti-estrogens, neurotoxins, food contaminants, and aquaculture therapies. Other Agency research will focus on developing and applying new toxicologic and analytical test methods for more rapid, yet sensitive detection of bacterial pathogens and toxins in food and drugs and decomposition in seafood.

FDA – Interagency Collaboration. Encouraging interagency cooperation allows the substantial expertise of other government scientists to focus their efforts on similar problems. For example, working with other agencies allows the FDA to prevent illness and epidemics. The agency collaborates with the National Institutes of Health to speed drug and vaccine development so that these products can reach consumers more quickly. This inter-agency cooperation also allows the Agency to determine the modes of infection and educate scientists that could lead to new testing methods.

OPHS – OPHS supports several research and service demonstration grant programs and program evaluations to identify what works, model strategies and approaches, and best practices that address the barriers and health problems of racial and ethnic minorities and identify effective disease and disability prevention and public health approaches. Two major grant programs which will continue to be administered by OPHS are the Bilingual/Bicultural Service Demonstration Grants Program to improve access to health care by reducing cultural and linguistic barriers, and the Minority Community Health Coalition Demonstration Grants Program to address reduction of racial disparities in targeted health areas.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Develop new or improved approaches for preventing or delaying the onset or progression of disease and disability. (Criteria defined in NIH Plan) *NIH Plan*	FY 01:Meet or Exceed FY 00:Meet or Exceed FY 99:Meet or Exceed	FY 01: FY 00: FY 99:Met
Develop new or improved methods for diagnosing disease and disability. (Criteria defined in NIH Plan) *NIH Plan*	FY 01:Meet or Exceed FY 00:Meet or Exceed FY 99:Meet or Exceed	FY 01: FY 00: FY 99:Exceeded
Develop new or improved approaches for treating disease and disability. (Criteria defined in NIH Plan) *NIH Plan*	FY 01:Meet or Exceed FY 00:Meet or Exceed FY 99:Meet or Exceed	FY 01: FY 00: FY 99:Exceeded
Develop new or improved instruments and technologies for use in research and medicine. (Criteria defined in NIH Plan) *NIH Plan*	FY 01:Meet or Exceed FY 00:Meet or Exceed FY 99:Meet or Exceed	FY 01: FY 00: FY 99:Exceeded
Reduce morbidity and mortality attributable to behavioral risk factors by building nationwide programs in chronic disease prevention and health promotion and intervening in selected diseases and risk factors. Measure: Reduce the percentage of teenagers (in grades 9-12) who smoke by conducting an educational campaign, providing funding and technical assistance to state programs, and working with non-governmental entities. *CDC Plan*	FY 01: 35.9 % FY 99: 36.4 %	FY 01: FY 00: FY 99: 04/00 FY 97: 36.4 % FY 95: 34.8 % FY 93: 30.5 % FY 91: 27.5 %
Develop and strengthen epidemiologic and laboratory methods for detecting, controlling, and preventing infectious diseases. Measure: 22 extramural awards will continue to be provided to conduct enhanced research investigations to assist in development and improvement of diagnostic tests for use in areas such as antimicrobial resistance, sexually transmitted diseases, malaria, Lyme disease, healthcare-associated infections, and blood safety. *CDC Plan*	FY 01: 45 awards FY 00: 22 awards FY 99: 22 awards	FY 01: FY 00: FY 99: 22 awards FY 97: 17 awards

Performance Goals	Targets	Actual Performance
Strengthen domestic and global epidemiologic and laboratory capacity for surveillance and response to infectious disease. Measure: A surveillance system will be established to collect data on antimalarial drug resistance in sub-Saharan African countries. *CDC Plan*	FY 01: 75% countries FY 00: 50% countries	FY 01: FY 00: FY 99:0% countries
Increase by 20% the number of toxic substances that can be measured by CDC's environmental health laboratory by the year 2002 from a baseline of 200 in 1997, so state-of-the-art laboratory methods can be employed to prevent avoidable environmental disease. Measure: Human exposure to toxic substances will be measured. *CDC Plan*	FY 01:12 new substances. FY 00: 8 new substances. FY 99: 8 new substances.	FY 01: FY 00: FY 99: 8 FY 97: 200 toxic substances
Increase early detection of breast and cervical cancer by building nationwide programs in breast and cervical cancer prevention. Measure: Excluding breast cancers diagnosed on and initial screen in the NBCCEDP, at least 73% of women aged 40 and older will be diagnosed at localized stage.	FY 01: 73% FY 00: 72% FY 99: 71%	FY 01: FY 00: FY 99: 3/00 FY 98: 70% FY 95: 70%
Measure: Excluding invasive cervical cancers diagnosed on an initial screen in the NBCCEDP, the age adjusted rate of invasive cervical cancer in women aged 20 and older is not more that 22 per 100,000 Pap tests provided. *CDC Plan*	FY 01: No more than 22 per 100,000. FY 00: No more than 22 per 100,000. FY 99: No more than 22 per 100,000.	FY 01: FY 00: FY 99: 3/00 FY 98: 23/100,000 FY 95: 26/100,000

Performance Goals	Targets	Actual Performance
Develop, in partnership with industry, academia, and government, gene chip and gene array technology to provide high volume screening of biomarkers for susceptible subpopulations identified in molecular epidemiology.		
– Develop "risk chip" technology to screen large numbers of people for biomarkers simultaneously.	FY 01: Develop technology FY 00: N/A FY 99: N/A	FY 01: FY 00: N/A FY 99: N/A
– Conduct molecular epidemiology studies to identify biomarkers of the most frequently occurring cancers in highly susceptible subpopulations.	FY 01: N/A FY 00: Conduct studies FY 99: N/A	FY 01: N/A FY 00: FY 99: N/A
– Complete biochemical and epidemiology studies to define the basis of susceptibility of humans to the toxicity of regulated compounds. *FDA Plan*	FY 01: N/A FY 00: N/A FY 99: Complete studies	FY 01: N/A FY 00: N/A FY 99: Biochemical studies on pancreatic and colorectal cancer were completed and epidemiology studies on cancer are in the enrollment phase. FY 98: Conducted case control molecular epidemiology studies to assess breast and prostate cancer in African-American women/men. FY 97: Initiated studies to evaluate the use of molecular biomarkers in clinical studies and to identify subpopulations at increased risk.

PROGRAMS SUPPORTING THIS OBJECTIVE

CDC
Breast and Cervical Cancer
Prevention Research
Epidemic Services
Prevention Centers
Infectious Diseases
Environmental Disease Prevention
Sexually Transmitted Disease
Occupational Safety and Health

FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
National Center for Toxicological Research
Tobacco

NIH
Research Program

OPHS

HHS 6.3: Improve the Public Health Prevention Efforts Through Population-Based Research

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

CDC – Prevention Research. Through applied research, CDC identifies emerging problems, tests solutions, and determines how to translate into practice the knowledge that has emerged from biomedical research. CDC's prevention research program can be characterized as problem-solving, population-based research which focuses on preventable risk factors using multidisciplinary, community-based approaches. This type of public health research engages teams of scientists (e.g., epidemiologists, laboratorians, economists, and behavioral scientists) working in cooperation to apply scientific methods to develop and evaluate public health strategies and interventions. Increasingly, CDC is working with extramural researchers as a part of the team to address the complexity of many public health problems.

CDC – Environmental Disease Prevention. CDC examines health outcomes that result from interactions between people's unique biologic, social, and lifestyle factors and their physical, chemical, and developmental environment. CDC's environmental health sciences laboratory develops tests of human exposure to toxicants (biomonitoring); and, when combined with epidemiologic studies, these tests provide vital information about how exposures contribute to serious human disease. In addition to gathering and analyzing human data on environmental exposures and disease, CDC leads efforts to translate scientific data into practical and cost-effective public health actions. This work by the National Center for Environmental Health complements that of the National Institute for Occupational Safety and Health (NIOSH) at CDC, which conducts research and provides national and world leadership in preventing work-related illness, death, and disability.

CDC – Heart Disease and Health Promotion. CDC will conduct cardiovascular disease prevention research to target disadvantaged populations, plan interventions in a variety of settings, and modify policies and the environment for new emerging risk factors, (e.g. homocysteine, antioxidants, genetic factors); secondary prevention of cardiovascular disease (e.g., physician practices, medical records, laboratory, and hospital discharge data; and physical activity and nutrition. In support of its efforts to prevent tobacco use, CDC will conduct prevention research with an emphasis on obesity prevention, improved dietary habits, and increased physical activity.

CDC – Injury Prevention and Control (IPC). IPC is designed to prevent premature death and disability and reduce human suffering and medical costs caused by injuries. IPC accomplishes its mission through: extramural and intramural research, developing, evaluation, and implementing prevention programs, assisting State and local health jurisdictions in their efforts to reduce injuries, and conducting prevention activities in partnership with other Federal and private-sector agencies. Evaluation of intervention programs is a key component of

CDC's overall strategy to discover what works and determine how to deliver programs to the American people.

IHS – Treatment and Prevention. The IHS continues to assist its partners in developing new strategies to prevent communicable diseases through collaboration with the CDC in vaccine research. The IHS also collaborates with CDC and NIH in efforts to prevent and control diabetes in the American Indian and Alaska Native population.

OPHS – OPHS supports several research and service demonstration grant programs and program evaluations to identify what works, model strategies and approaches, and best practices that address the barriers and health problems of racial and ethnic minorities and identify effective disease and disability prevention and public health approaches. Two major grant programs which will continue to be administered by OPHS are the Bilingual/Bicultural Service Demonstration Grants Program to improve access to health care by reducing cultural and linguistic barriers, and the Minority Community Health Coalition Demonstration Grants Program to address reduction of racial disparities in targeted health areas.

OPHS – The national Title X family planning program provides family planning and related gynecological health care services to over 4.5 million individuals each year to assist them in planning the timing and spacing of their children. The program also supports three additional functions: (1) training for all levels of family planning personnel, (2) information dissemination and community-based education and outreach activities, and (3) research to improve the delivery of family planning services.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Maintain ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites, as part of an overall assessment of the ongoing childhood obesity prevention project's effectiveness. *IHS Plan*	FY 01: implement program and monitor pilots and comparisons sites FY 00: develop five pilot sites FY 99: develop approach and baselines	FY 01: FY 00: FY 99: completed

Performance Goals	Targets	Actual Performance
Strengthen the scope and nature of extramural public health research programs. Measure: CDC will increase the number of young investigator and public health research training opportunities. *CDC Plan*	FY 01: 5% increase FY 00: 5% increase	FY 01: FY 00: FY 99: 2 extramural projects and 1 infrastructure project funded to support expanded training activities
Conduct a targeted program of research to reduce morbidity, injuries, and mortality among workers in high priority areas and high-risk sectors. Measure: Annual increases in funding of other federal agencies will be demonstrated. *CDC Plan*	FY 01: Annual increases in funding of other federal agencies will be demonstrated. FY 00: Annual increases in funding of other federal agencies will be demonstrated. FY 99: Current levels of NIOSH and other federal agencies' intramural and extramural research funding in NORA areas will be determined as a baseline and annual increases will be calculated.	FY 01: FY 00: FY 99: A survey in 1998 shows non-NIOSH federal agencies spending $23.4 million on NORA-related activities.
Human exposure to toxic substances will be measured. *CDC Plan*	FY 01: 12 new substances FY 00: 8 new substances FY 99: 8 new substances	FY 01: FY 00: FY 99: 8 FY 97: 200 toxic substances

PROGRAMS SUPPORTING THIS OBJECTIVE

CDC
Prevention Research
Epidemic Services
Prevention Centers
Infectious Diseases
Environmental Disease Prevention
Occupational Safety and Health
Injury Prevention and Control
HCFA
Medicare
IHS
Treatment and Prevention

OPHS

HHS 6.4: Increase the Understanding of and Response to the Major Issues Related to the Quality, Financing, Cost, and Cost-Effectiveness of Health Care Services

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

AHRQ - Report to the Nation on the Quality of Health Care. This annual series is intended to provide policymakers with a national perspective on those health care services and the key aspects of the way we organize and deliver those services that most affect the quality and safety of patient care. This information will enable decisionmakers to ensure that the populations they care about are getting the care they need. It should help policymakers to target resources and activities to improve quality where it can and needs to be improved. It will also provide evidence to inform of purchasing decisions in ways that can harness market forces to reward high quality. AHRQ will begin work on enhancing data collection activities in FY 2001 in order to submit the first annual report in FY 2003.

AHRQ - Monitor quality of care through a strengthened **Medical Expenditure Panel Survey (MEPS)**. Additional MEPS investments in FY 2001 will continue the expansions begun in FY 2000 to include in the MEPS household sample a sufficient sample of individuals with certain illnesses of national interest in terms of quality of care and burden of disease. This enhancement will not only permit more focused analyses of the quality of care received for these vulnerable populations; it will also enable analyses of patterns of use, costs, and impact of these services. The FY 2001 investment will also enable the completion of a more extensive module on children, to enable us to understand the impact of changes in health programs.

AHRQ - *Healthcare Cost and Utilization Project* (HCUP). AHRQ will further expand HCUP to provide state and community decision-makers a powerful set of linked databases they can use to monitor the impact of major system changes on access, quality, outcomes and cost in their states and communities, and to compare these against the progress of other states and communities. Specifically, the expansion will include clinical and financial records from emergency departments and other ambulatory care as well as records from four more States, an increase from an expected 26 states in FY 2000, for a total of 30 States.

HRSA – Rural Health Policy Development. The Rural Health Research Center Program is the only health services research program dedicated entirely to producing rural policy relevant research. It currently supports five research centers that have major studies underway dealing with such diverse topics as rural emergency room use by rural elderly residents, the impact of asthma guidelines on the care of rural pediatric Medicaid recipients, developing an improved definition of "rural", the financial dependence of rural hospitals on Medicare outpatient revenues and implications for outpatient payment reform, and the potential impacts on rural health care providers of the Balanced Budget Act of 1997.

NIH – Impact of Quality and Cost on Health. Research activities are supported across a broad spectrum to increase the understanding of issues related to health care quality, cost and

cost-effectiveness. Included are efforts to better understand the effectiveness of care provided in various health care settings, the outcomes of clinical care which involves patients in treatment decisions, and the assessment of measures designed to evaluate quality-of-life aspects of disease prevention modalities. Other examples include conducting research to examine the characteristics of different health care structures and delivery systems and their impact on health and functioning in old age; the economic aspects of older people's access to and use of health care, and relationship to health; and comparative cross-national analyses of health care needs and services.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Establish future research agenda based on users' needs. *AHRQ Plan.*	Accomplish the following based on consultation with various groups: FY 01: Agency research agenda covering strategic goal areas for FY 2001 priorities (errors, informatics, and worker safety) is documented. FY 00: Agency research agenda covering the 3 strategic research goals and the new FY 2000 closing the gap initiatives are documented. FY 99: Agency research agenda covering the 3 strategic research goals is developed and documented.	 FY 01: FY 00: FY 99: Completed

Performance Goals	Targets	Actual Performance
Make significant contributions to the effective functioning of the U.S. health care system through the creation of new knowledge. *AHRQ Plan.*	FY 01: Funding a minimum of 15 projects to improve health care quality, safety and efficiency. FY 00: Funding a minimum of 10 projects that address gaps in knowledge about the priority problems faced by Medicare and Medicaid. Funding of a minimum of 10 projects to address eliminating disparities in health care, particularly those for racial and ethnic minorities. FY 99: Funding of a minimum of 21 projects in consumers use of information on quality; strengthening value-based purchasing; measuring national health care quality; vulnerable populations; and translating research into practice. FY 99: Funding of a minimum of 17 projects in outcomes for the elderly and chronically ill; clinical preventive services; and children's health.	FY 01: FY 00: FY 99: 54 FY 99: 52

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Research on Health Costs, Quality, and Outcomes
Medical Expenditure Panel Surveys
HCFA
Medicaid
Medicare
Research and Demonstrations
HRSA
Rural Health Policy Development
NIH
Research Program
SAMHSA
Knowledge Development and Application

HHS 6.5: Accelerate Private-Sector Development of New Drugs, Biologic Therapies, and Medical Technology

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

FDA – Premarket Application Review Initiative. The research and development community continues to produce new and often technologically complex health care products. FDA facilitates the availability of these products and is required by the Food, Drug and Cosmetic Act to review new product applications within specific time frames. FDA has dedicated several strategies to help reduce the time required to make important new human drugs, veterinary drugs, blood products, medical devices, vaccines and food additives available to the U.S. public. First, FDA will dedicate additional reviewers to high-priority areas. To use reviewers' time efficiently, FDA has re-engineered to shorten some of its product review processes without sacrificing the quality of the review and the safety of the product. Second, initiatives are underway to reduce the requirements for preapproval of low-risk products and to replace the application review process for these products with a notification process. Third, FDA is encouraging product sponsors to consult the Agency early in the research and development process. Early communication helps product sponsors understand what information is needed by FDA and often leads to a high quality application which can move through the FDA approval process more quickly. And finally, all of FDA's product review centers will continue to improve their application and review tracking systems. Improving these systems should result in faster review times for products, and increased productivity for FDA.

FDA – Injury Reporting Initiative. An estimated 1.3 million Americans are unintentionally injured each year as a result of medical errors. Surveillance of marketed products plays an essential role in increasing the availability of safe and effective medical products for the consumer. One of FDA's primary objectives is to develop and implement a comprehensive surveillance system that improves the quality of information on adverse events and product defects associated with FDA-regulated products. The overall strategy combines elements of surveillance, problem analysis, education, and problem correction by eliminating the conditions that led to the high-risk situation.

  FDA and the industry cannot learn everything about the safety of a product before it is approved, and Americans have chosen to accept this risk in order to have products approved within a reasonable time frame. The tradeoff is that FDA and industry must continue to assess the safety of certain products after their use becomes widespread. For example, postmarket studies of a medical device may provide additional information about long-term uses or the device's effectiveness in a more diverse population. Data that FDA requested for the premarket review can be requested after the product is approved. Making optimal use of postmarket data may reduce the premarket data requirements for some devices. FDA will continue seek ways to minimize the amount of premarket data requested when postmarket studies can provide the appropriate consumer protection.

FDA – International Harmonization of Standards. FDA, other government regulatory bodies, and industry participate in international harmonization activities to help reduce the regulatory burden on industry and to bring products to the market more quickly. Acceptance and use of international safety standards that satisfy U.S. consumer protection goals will improve product safety and public health, reduce FDA's import inspection burden, and help facilitate the importation and exportation of products. By harmonizing international requirements, the industry hopes to reduce the costs of bringing products to market. FDA will continue to participate in international standard setting activities such as General Agreement on Tariffs and Trade (GATT), the North American Free Trade Agreement (NAFTA), and the Codex Alimentarius, to promote development and adoption of science-based international standards and ensure FDA's ability to protect the U.S. public health.

FDA – Science and Research Support for Premarket Reviews. FDA's highest priorities include improving its science base and conducting research, especially to support the review of premarket applications. FDA's goals in conducting research are to develop: 1) in-house scientific experts, especially in emerging technologies; 2) scientific guidance for product sponsors and reviewers; and 3) science-based standards. In-house scientific experts consult with product reviewers on product applications. Scientific guidance benefits both applicants and review staff in developing and reviewing applications FDA Modernization Act requires FDA to recognize and use standards established by national or internationally recognized standard development organizations in the application review process, especially with medical devices. FDA's scientific efforts will allow the Agency to expand its participation in standards development and harmonization. Since data relating to the aspects of safety and/or efficiency covered by the standards will not be required in the premarket application, the review process can be expedited.

NIH – Pharmacogenetics. Genes direct the production of proteins, which are used as important structural components, for movement, in immune defense, and to carry out chemical reactions. Genomic discoveries often lead to new understanding of a protein's structure and function, which can in turn reveal new targets for drug development. Genetic information may also help identify individuals who will respond well or poorly to particular drugs. One of NIH's new pharmacogenetics initiatives is focused on the mechanisms underlying individual variations in drug responses. The ultimate goal is to understand how an individual's genetic makeup determines how effectively a medicine works in their body, as well as what side effects are likely to occur. Knowledge from this research will guide doctors in prescribing types and amounts of medications for a particular patient.

NIH – Bioinformatics. Medical researchers are amassing enormous amounts of information today–from the Human Genome project, clinical trials, statistical studies, population genetics, and imaging research–thereby creating large repositories of information that far surpass all of the information collected previously. As the amount of data grows, the tools to compare and manipulate the data become more important and will be used to form bridges between databases to allow researchers to link disparate information sources. Critical to our efforts to analyze these data is the emerging field of bioinformatics that brings together cross-disciplinary expertise and technologies in biology, computer science, and mathematics. The focus of bioinformatics programs is on management of biological information that enables life science

and novel therapeutic discovery to progress at a much faster pace. For example, the emerging field of pharmacogenetics will rely heavily upon the use of bioinformatics to integrate genomic information about populations and the response to therapeutic agents. Bioinformatic tools will be developed to integrate statistical genetic methods, gene sequence information, genetic variations in the populations, and epidemiologic data.

CDC – Infectious Diseases. CDC is committed to strengthening our Nation's capacity to recognize and respond to infectious disease threats, and our plan, *Addressing Emerging Disease Threats: A Prevention Strategy for the United States*, is being implemented. As we approach the 21st century, many important drug choices for the treatment of common infections are becoming increasingly limited and expensive, and in some cases, nonexistent. This year's performance plan has been updated to include major program efforts for Hepatitis C Virus (HCV) infection, food safety, antimicrobial resistance, and bioterrorism.. In addition, each year CDC is instrumental in accurately tracking influenza strains around the globe, and as a World Health Organization Collaborating Center, using sophisticated techniques to provide scientific data essential for vaccine development.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Review and act on 90% of standard original New Drug Application (NDA), Product License Application (PLA) and Biologic License Application (BLA) submissions within 12 months of receipt (70% within 10 months); and review and act on 90% of priority original NDA/PLA/BLA submissions within 6 months of receipt.		
– Standard Applications within 12 months:	FY 01: 90% FY 00: 90% FY 99: 90%	FY 01: FY 00: FY 99: 11/00 FY 98: 100% FY 97: 100% FY 96: 100%
– Standard Applications within 10 months:	FY 01: 70% FY 00: 50% FY 99: 30%	FY 01: FY 00: FY 99: 9/00 FY 98: N/A FY 97: N/A
– Priority Applications within 6 months: *FDA Plan*	FY 01: 90% FY 00: 90% FY 99: 90%	FY 01: FY 00: FY 99: 5/00 FY 98: 100% FY 97: 100%
Increase the percentage of Premarket Approval Application (PMA) first actions completed on time (within 180 days) and the percentage of Humanitarian Device Exemption (HDE) first actions completed on time (within 75 days). *FDA Plan*	FY 01: 90% FY 00: 85% FY 99: 65%	FY 01: FY 00: FY 99: 5/00 FY 98: 79% FY 97: 65% FY 96: 51%
Review and act on 70% of NADAs/Abbreviated New Animal Drug Applications (ANADAs) within 180 days of receipt. *FDA Plan*	FY 01: 70% FY 00: 65% FY 99: N/A	FY 01: FY 00: FY 99:N/A
Complete 100% of Investigational Device Exemption (IDE) "Agreement" meetings within 30 days. *FDA Plan*	FY 01: 100% FY 00: 80% FY 99: N/A	FY 01: FY 00: FY 99: 23% FY 98: 33%

Performance Goals	Targets	Actual Performance
Increase the level of animal drug pre-submission conferences with industry sponsors. *FDA Plan*	FY 01: 80% FY 00: 75% FY 99: N/A	FY 01: FY 00: FY 99: N/A
Enhance outreach to the private sector by: – Increasing Employee Invention Reports each year by 5% – Increasing Licensing Agreements over the previous year by 3% – Increasing executed Cooperative Research and Development Agreements (CRADAs) over the previous year by 3% *NIH Plan*	FY 01: 5% FY 00: 5% FY 99: 5% FY 01: 3% FY 00: 3% FY 99: 3% FY 01: 3% FY 00: 3% FY 99: 3%	FY 01: FY 00: FY 99: 2.5% FY 01: FY 00: FY 99: -5% FY 01: FY 00: FY 99: 10%
22 extramural awards will continue to be provided to conduct enhanced research investigations to assist in development and improvement of diagnostic tests for use in areas such as antimicrobial resistance, sexually transmitted diseases, malaria, Lyme disease, healthcare-associated infections, and blood safety. *CDC Plan*	FY 01: 45 FY 00: 22 FY 99: 22	FY 01: FY 00: FY 99: 22 awards FY 97: 17 awards

PROGRAMS SUPPORTING THIS OBJECTIVE

CDC
Infectious Diseases
FDA
Human Drugs
Biologics
Animal Drugs and Feeds
Medical Devices and Radiological Health
National Center for Toxicological Research
NIH
Research Program

HHS 6.6: Improve the Quality of Medical and Health Science Research by Strengthening the Base of Highly Qualified Scientific Investigators

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

NIH – Training and Career Development. The continued success and vitality of medical research depends in large part on our most important national scientific resource -- the scientist. The NIH sponsors and conducts a wide range of training and career development activities to increase our ability to attract and retain the best and brightest minds in medical research and to develop a corps of highly skilled, well-trained individuals ready to "hit the road running" as post-doctoral researchers and principal investigators, and to enhance diversity. Our research training programs teach pre- and post-doctoral trainees how to conduct innovative, high-quality science, including how to choose problems, choose model systems, develop logical hypotheses, design experiments, conduct research with the highest ethical standards, and see connections among different fields that allow a scientist to make quantum leaps in understanding a problem. Career development programs ensure that we can retain and sustain these trained investigators who have the specialized knowledge, methodological expertise, and creativity essential to generating the scientific knowledge that will improve the health of Americans.

NIH – Career Development Mechanisms. NIH uses a number of different award mechanisms to provide a flexible and varied series of high-quality training opportunities tailored to the career needs of recipients. Considerable attention is provided to ensure that experiences supported are focused on the acquisition of knowledge and skills necessary to become a productive researcher. Planning the approximate number of awards to be made in each category described above is a complex process that considers both program continuity and emerging needs. Career outcome evaluation studies help ensure that the NIH research training and career development programs are of uniformly high quality and are sufficient to meet the nation's needs for biomedical and behavioral researchers.

NIH – Support for Clinical Investigators. The NIH Director's Panel on Clinical Research and the Institute of Medicine's Committee on Addressing Career Paths for Clinical Research have recently addressed the need for strengthening national research capabilities in patient-oriented research. They identified a need to increase the pool of clinical researchers who can conduct patient-oriented studies, capitalizing on the discoveries of biomedical research and translating them to clinical settings. Among their recommendations were the initiation and improvement of training programs to enhance the attractiveness of careers in clinical research to medical students and mid-career clinical investigators. In response, NIH has established three new career development mechanisms: Mentored Patient-Oriented Research Career Development Awards (K23), Midcareer Investigator in Patient-Oriented Research Awards (K24), and Clinical Research Curriculum Development Awards (K30).

AHRQ – Nurture next generation of health services researchers. AHRQ will invest in programs that address the research and analytic needs of the changing health care systems. The priorities include building on prior efforts to make both curricula and practical research experiences more relevant to decision makers' concerns about effectiveness of health care and issues of cost, quality, and access. They also will incorporate evolving innovations in data systems and research tools so that researchers of the future can employ cutting edge methodologic, analytic, and data handling techniques. Additionally, AHRQ will focus on bringing needed diversity to the health services research workforce. This includes funding grants to develop and/or expand research infrastructure at minority and minority-serving institutions to train health services researchers and to conduct rigorous health services research. In order to build research capacity in States that have not traditionally been involved in health service research, the Institutional Training Innovative Incentive Award Program will be funded to pilot-test the feasibility of developing a program to broaden the geographic distribution of AHRQ funding and enhance the competitiveness for research funding of institutions located in states that have a low success rate for grant applications from AHRQ.

NIH – Biomedical Information Science and Technology Initiative. NIH must find ways to discover, encourage, train, and support the new kinds of scientists needed for tomorrow's science. The Biomedical Information Science and Technology Initiative (BISTI) will provide the first steps in meeting this need. This will be a trans-NIH initiative encompassing several mechanisms of research support: research project grants for interdisciplinary grants in bioinformatics, research centers, for National Programs of Excellence in Biomedical Computing Support, National Research Service Awards to begin training a new generation of researchers with cross-disciplinary skills, and the Library of Medicine, for development of informatics and molecular computational biology projects, as well as a small project in Intramural Research.

CDC – Epidemic Services. Epidemic services cover a vast spectrum of activities which include the training of public-health epidemiologists and preventive medicine residents. Through the Epidemic Intelligence Service (EIS) and the Preventive Medicine Residency (PMR), CDC provides training to public health professionals so that they attain proficiency in applied epidemiology and preventive medicine. Both participants and graduates of these programs help CDC carry out its mission to prevent and control disease and injuries, and provide epidemiologic service to the state and local health departments.

  In addition, in 1998, the Public Health Informatics Fellowship was implemented to develop a cadre of qualified professionals who can address the increasingly sophisticated information needs of public health programs in areas such as automated reporting of notifiable conditions, rapid dissemination of data from public health surveillance and outbreak investigations, and expeditious access to prevention and practice guidelines.

CDC – Infectious Diseases. CDC's efforts in infectious disease prevention focus on preventing illness, disability, and death caused by infectious diseases through various strategies. One of these strategies involves the delivery of training and information to the public health workforce using a variety of methods (self-study, computer-based training, satellite teleconferences, audio conferences, etc.) through the Public Health Training Network, as well

as through other efforts. Training and education ensure that current and future generations will be prepared to respond to infectious disease threats.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Strengthen the scope and nature of extramural public health research programs. Measure: CDC will increase the number of young investigator and public health research training opportunities. *CDC Plan*	FY 01: 5% increase in career development awards funded by PRI. FY 00: 5% increase in career development awards funded by PRI.	FY 01: FY 00: FY 99:
The annual number of health services providers participating in distance learning activities will be increased. *CDC Plan*	FY 01: 115,000 FY 00: 110,000 FY 99: 105,000	FY 01: FY 00: FY 99: 9/99 FY 97: 100,000
Public health microbiology fellows will be trained and available for employment in local, state, and federal public health laboratories. *CDC Plan*	FY 01: 100 fellows FY 00: 70 FY 99: 40	FY 01: FY 00: FY 99: 40 FY 97: 13
As a measure of an acceptable supply of well-trained medical researchers, maintain historical application success rates for:		
– fellowships (F32)	FY 01: 40% FY 00: 40% FY 99: 40%	FY 01: FY 00: FY 99: 44%
– research training grants (T32)	FY 01: 60% FY 00: 60% FY 99: 60%	FY 01: FY 00: FY 99: 64%
– entry-level career awards (K01, K08) *NIH Plan*	FY 01: 60% FY 00: 60% FY 99: 60%	FY 01: FY 00: FY 99: 37% (K01) 52% (K08)

Performance Goals	Targets	Actual Performance
To increase the pool of clinical researchers who can conduct patient-oriented research, increase awards in:		
– Mentored (K23) and Mid-Career Investigator (K24), Patient-Oriented Research Awards	FY 01: 80 FY 00: 80 FY 99: 80	FY 01: 1/02 FY 00: 1/01 FY 99: 85 (K23) 81 (K24)
– Curriculum Development Awards (K30)	FY 01: Not Applicable FY 00: Not Applicable FY 99: 20	FY 01: N/A FY 00: N/A FY 99: 35
NIH Plan		
Develop and facilitate the use of new tools, talent, products, and implementation methodologies stemming from research portfolio. *AHRQ Plan*	FY 01: ▸ Support a minimum of 165 pre-and post-doctoral trainees. ▸ Support a minimum of 15 minority investigators through individual and center grants.	FY 01:
	FY 00: Support a five percent increase, at a minimum, in number of pre- and post-doctoral trainees.	FY 00:
	FY 99: Support a minimum of 150 pre-and post-doctoral trainees.	FY 99: 167

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Research on Health Costs, Quality, and Outcomes
CDC
Epidemic Services
Infectious Diseases
NIH
Research Program
Research Training and Career Development
SAMHSA
Knowledge Development and Application

HHS 6.7: Ensure That Research Results Are Effectively Communicated to the Public, Practitioners, and the Scientific Community

KEY FY 2001 PROGRAMS, INITIATIVES, AND STRATEGIES

AHRQ – Translating Research Into Practice (TRIP). TRIP bridges the gap between the development of new knowledge and its implementation in the health care system. Building on the previous 10 years of research findings, AHRQ will identify ongoing gaps between what we know now and what we do in health care and will begin to close those gaps through research and demonstrations that develop and test implementation strategies in different settings in the health care system. A major focus within this is identifying existing implementation strategies in use in health care settings and demonstrating their applicability to wide spread dissemination in other areas of the system.

AHRQ places considerable focus on developing tools and products that facilitate the transfer of research findings into practice. The Agency has a well developed dissemination system that includes publications development, the Publications Clearinghouse, and an award winning Web site. This emphasis is critical to the Agency's success. Ongoing plans include incorporating regular customer feedback into our operations to continue to improve our efforts.

AHRQ recognizes that it is unable to undertake bridging this gap with its resources alone. A major aspect of the Agency's approach is to leverage its own resources through the development of partnerships. These partnerships, within HHS, with other Federal agencies, and with private sector professional and consumer advocate organizations, enable the Agency to create distribution mechanisms for its information, products, and tools. The Agency also will continue to focus on its own distribution mechanisms, such as the Agency's publications clearinghouse, to ensure that they are effective in disseminating Agency products.

NIH – Bioinformatics. Medical researchers are amassing enormous amounts of information today–from the Human Genome project, clinical trials, statistical studies, population genetics, and imaging research–thereby creating large repositories of information that far surpass all of the information collected previously. As the amount of data grows, the tools to compare and manipulate the data become more important and will be used to form bridges between databases to allow researchers to link disparate information sources. Critical to our efforts to analyze these data is the emerging field of bioinformatics that brings together cross-disciplinary expertise and technologies in biology, computer science, and mathematics. The focus of bioinformatics programs is on management of biological information that enables life science and novel therapeutic discovery to progress at a much faster pace. For example, the emerging field of pharmacogenetics will rely heavily upon the use of bioinformatics to integrate genomic information about populations and the response to therapeutic agents. Bioinformatic tools will be developed to integrate statistical genetic methods, gene sequence information, genetic variations in the populations, and epidemiologic data.

NIH – MEDLINE. Last year the National Library of Medicine (NLM) reported that usage of the MEDLINE bibliographic database had increased from 7 million searches a year in FY 1996 to 120 million in FY 1998. The rate at the end of FY 1999 is 220 million, a further increase of more than 50 percent in one year. The Library interprets this as a powerful continuing expression of the desire not only of scientists and health professionals, but of the general public to have access to the kind of information services the Library can provide. High on the Library's list of information improvements is a clinical trials database. This will be an easy-to-use Web-based file containing information about clinical trials, whether federally or privately funded, for experimental treatments for serious diseases and conditions. It will allow nonscientific users to understand the purpose of a clinical trial, the eligibility criteria for participating, where it is being conducted, and how to get in touch with those conducting it. The database, mandated by the Food and Drug Modernization Act of 1997, is being developed in stages, with NIH-sponsored trials as the first module becoming available in FY 2000. In FY 2001, NLM will expand the database to include data from other Federal agencies, the private sector, and international groups.

NIH – Public Library Initiative. NLM's pilot Public Library Initiative was begun late in FY 1998 with 37 local public library systems (more than 200 libraries in all). The project trained local librarians to use the Internet to find health information pertinent to their patrons' needs. Drawing on lessons learned in the public library pilot test, NLM is working through the National Network of Libraries of Medicine to support outreach projects that will involve health sciences, public and state libraries, local health professional associations, public health departments, schools, and community-based organizations, including churches, in improving the public's access to high quality health information.

NIH – National Network of Libraries of Medicine Outreach Projects. The National Network of Libraries of Medicine (NNLM) are involved in other NLM-sponsored outreach projects. One recent activity is the "Tribal Connections Project" in the Pacific Northwest that aims to provide remote villages with Internet access to health information. A continuing success story has been the NLM's work with historically black colleges and universities.

CDC – CDC focuses on assuring the public's health through the translation of research into effective community-based action. This goal is oriented towards developing the capacity of public health departments to carry out essential public health programs and services, and involve community institutions and community groups in health promotion and disease prevention. As CDC strengthens its ongoing relationships with State and local health agencies, it is also committed to building partnerships with non-governmental organizations at the community and national levels. These partnerships are essential for the design, implementation, and evaluation of sound prevention programs. What people understand about their health and potential risks to their health is of major concern in public health. CDC is committed to promoting effective health communication, conveying information to appropriate populations, and facilitating access to health information. The agency seeks to enhance the public's health knowledge through communication that is congruent with the values of diverse communities.

CDC – To ensure the scientific foundation of public health practices, CDC coordinates the development of the *Guide to Community Preventive Services*. This *Guide* provides public

health practitioners, their community partners, and policy makers with evidence-based recommendations for planning and implementing population-based services and policies at the community and state level.

FDA – FDA is committed to providing clear, up-to-date information to consumers and patients that they need to make health care decisions and to use health products appropriately. The Agency is aware of the growing diversity of consumer health needs and interests. FDA will continue to implement targeted public awareness campaigns such as the *Food Safety Program's BAC!*, *Mammography Awareness Seminars*, and *Over the Counter (OTC) Labeling Changes* and will continue to make information about newly approved products, product labels and a range of health issues available on the Internet in language consumers can understand. The Internet is being used not only to disseminate information to consumers but also to obtain their input on various issues of interest to the Agency. The *FDA Consumer* and other printed materials, many of which are available in several languages, are provided to persons who are without Internet capabilities. A general telephone number and several special interest hotlines are also available to consumers who have specific questions about FDA-regulated products. Public Affairs Specialists in FDA's field offices will continue to play a key role in furnishing up-to-date information about new and emerging products to interested consumers.

FDA – FDA is responsible for ensuring that drugs, biologics, medical devices and food are safe, effective and appropriately labeled. In addition to reviewing new drugs, biologics, medical devices and food additive products, FDA plays a key role in disseminating information about these new products to health professionals and in ensuring the correct use of these products.

FDA continues to collaborate with industry to inform physicians, patients and consumers about new drugs and food items. In FY 2001, FDA will continue to make information about newly approved products, product labels, correct use of medications, and risk information about FDA-regulated products available to health professionals, consumers and other interested persons on the Internet. FDA also has an outreach program for physicians to inform them of new drugs available to their patients. Information is also available on new therapies approved by foreign countries before the FDA approves them.

FDA – Although FDA-regulated products are rigorously tested during the premarket review period, certain rare adverse effects of products are not recognized until after a product is in widespread use. When new health risks related to FDA-regulated products are recognized, FDA ensures that manufacturers, health professionals, and consumers are alerted and corrective actions are taken.

MedWatch, the FDA Medical Products Reporting Program, is an initiative designed both to educate all health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events and problems to FDA and the manufacturer; and to ensure that new safety information is rapidly communicated to the medical community and that patient care improves as a result. FDA uses a variety of means to provide feedback to the health care community about safety issues involving medical products, including "Dear Health

Professional" letters, safety notifications, product recalls, and product label changes. These are available on the Internet and in print.

FDA – Communication of research results to the scientific community. FDA communicates its research findings in professional journal publications, at national and international scientific meetings, and other appropriate forums. FDA sponsors a Science Forum annually, which government and other scientists attend, and workshops to address crosscutting topics. In addition, FDA holds periodic meetings with its stakeholders to discuss research findings, gaps in scientific knowledge, and research and program priorities; to develop creative and innovative strategies; and to review progress made toward Agency goals.

FDA – Exchanging Scientific Expertise. Industry and FDA collaboration creates an atmosphere that encourages the exchange of scientific expertise. In addition, FDA sponsors workshops on cutting edge topics such as gene therapy and Simian Virus and DNA vaccines. Agency scientists are also encouraged to publish their research findings in professional journals so their non-government peers can learn from their work.

SAMHSA – The Knowledge Exchange Network program is a clearinghouse designed to ensure widespread dissemination of information about mental health resources and research results. The Addiction Technology Transfer Centers program disseminates multi-disciplinary, clinically relevant, research based information about substance abuse for practitioners. Working in conjunction with The Office of National Drug Control Policy, SAMHSA supports the National Clearinghouse for Alcohol and Drug Information (NCADI) which responds to thousands of requests for public information.

SAMHSA – The Prevention Enhancement Protocol System (PEPS) collects, synthesizes, and disseminates research and practice-based findings in useable form for application in communities. Under the National Center for Advancement of Prevention (NCAP), PEPS is a pioneering initiative that develops program and intervention guidelines for the field using established "rules of evidence" for assessing practice and research findings and combining this evidence into prevention approaches.

SAMHSA – The National Center for the Advancement of Prevention II (NCAP II) develops, synthesizes, adapts and disseminates state-of-the-art prevention knowledge about what works in prevention, for whom, and under what conditions. NCAP II makes knowledge-based tools, principles and models useful for developing prevention plans and programs available to States, communities, and local prevention practitioners and policy makers to improve the effectiveness of prevention efforts across the nation.

SAMHSA – The State Incentive Grant (SIG) Program extends CSAP's ability to help States improve their prevention service capacity. Funding enables States to examine their state prevention systems and redirect resources to critical targeted prevention service needs within their states. Eighty-five percent of SIG funds are directed toward implementing best practices within local programming to reduce the gap in prevention services. In this way SIG funds not only help improve access to needed services, they also improve the quality of the prevention

services provided. SIG States are also field testing their core measures to assess their feasibility for use in reporting on block grant activities, creating Statewide networks of public and private organizations to extend the reach of the primary prevention portion of the SAPT Block Grant and optimizing the application of State and Federal substance abuse funding streams.

IHS – Treatment and Prevention. The IHS maintains an infrastructure to support mission critical research and its dissemination to health care providers and the scientific community which includes an annual research conference, a peer reviewed journal for IHS health care providers, and the IHS institutional review board.

OPHS – Through Healthfinder™, the Federal government-wide Internet gateway to health information, the National Women's Health Information Center, and the Office of Minority Health Resource Center, OPHS provides nation-wide access to information and referral services for both health professionals and consumers.

OPHS – The Office of Minority Health Resource Center engages in a wide range of activities to inform and educate racial/ethnic minority communities and those who serve them regarding the nature and extent of racial/ethnic disparities in health, policies and programs underway to address such disparities, and actions they can take to improve their health care options. Some of these activities include: assistance in the development of Spanish-language radio broadcast messages to Hispanic communities on health promotion and how to use managed care plans appropriately; provision of Spanish-speaking staff to respond to public inquiries for information and recommendations following such radio broadcasts; and provision of information on and referrals to national organizations of minority health care providers and minority health advocacy organizations that, in turn, provide recommendations regarding local providers.

SELECTED FY 2001 PERFORMANCE GOALS AND MEASURES

Performance Goals	Targets	Actual Performance
Based on established criteria, continue to publish the *Morbidity and Mortality Weekly Reports (MMWR)* series of publications including Reports and Recommendations, Surveillance Summaries, and the Annual Summary to communicate major public health events to the media, public policy makers and health professionals through multiple media channels - print, television, radio, interactive World Wide Web. *CDC Plan*	FY 01: 86 issues FY 00: 81 issues FY 99: 77 issues	FY 01: FY 00: FY 99: 77 issues published. Also, available on CDC web site

Performance Goals	Targets	Actual Performance
Make data more readily accessible to decision makers and researchers by releasing statistics in new formats to speed the release of data on high-priority topics. *CDC Plan*	FY 01: Release two reports in such format. FY 00: Release one report.	FY 01: FY 00: FY 99: *1999 Health and Aging Chart book* - projected publication - September 1999. FY 98: *Teenage Births in the United States: National and State Trends 1990-96* was published.
Research findings will be disseminated by investigators receiving PRI funds. *CDC Plan*	FY 01: Implement dissemination tracking system. FY 00: Establish dissemination goals for PRI-funded projects and methods for collection of data, including the number of published peer-reviewed studies and the number of products developed and distributed to consumers.	FY 01: FY 00:
Distribute information on availability of research findings. *CDC Plan*	FY 01**:** Increase by 5% the number of hits to website highlighting PRI-funded research projects. FY 00:Establish website with highlights of selected PRI-funded studies and linkages to CIOs websites on projects, where available.	FY 01: FY 00:

Performance Goals	Targets	Actual Performance
Maximize dissemination of information, tools, and products developed from research results for use in practice settings. *AHRQ Plan*	FY 01: ▸ Formation of a minimum of 8 partnerships to support dissemination of AHRQ products through intermediary organizations, such as health plans and professional organizations. ▸ Evidence-based practice centers (EPCs) will produce a minimum of 12 evidence reports and technology assessments that can serve as the basis for interventions to enhance health outcomes and quality. FY 00: At least 10 purchasers/businesses use AHRQ findings to make decisions. FY 99: At least 5 purchasers/businesses use AHRQ findings to make decisions.	

PROGRAMS SUPPORTING THIS OBJECTIVE

AHRQ
Research on Health Costs, Quality, and Outcomes
CDC
HIV/AIDS Prevention
Sexually Transmitted Diseases
Tuberculosis
Diabetes and Other Chronic Diseases
Heart Disease and Health Promotion
Breast and Cervical Cancer Prevention
Prevention Centers
Infectious Diseases
Lead Poisoning
Health Statistics
Prevention Research
Epidemic Services
Environmental Disease Prevention
Occupational Safety and Health
Eliminating Racial and Ethnic Disparities
FDA
Foods
Human Drugs
Medical Devices and Radiological Health
Biologics
Animal Drugs and Feeds
National Center for Toxicological Research

Tobacco
IHS
Direct Operations
NIH
Research Program
OPHS
Office of Disease Prevention and Health Promotion
Office of Minority Health
Office of Women's Health
Office of the Surgeon General
SAMHSA
Knowledge Exchange Network
State Incentive Grants