Department of Health and Human Services

2010 - 2015

Strategic Plan Measure Detail Report

FY 2011 Version

The Department of Health and Human Services (HHS) has compiled these illustrative examples of performance measures that support the FY 2010 – 2015 Strategic Plan. In 2010 there were more than 1,050 performance measures that are used by 16 Operating and Staff Divisions of HHS to demonstrate the effect of federal funding for the American people. This sub-set of 80 measures most closely exemplifies how HHS will monitor, manage, and measure performance and the achievement of the Strategic Plan.

Click on the performance measure number in the left column of the table to link to the detailed report by measure.

Appendix B: HHS Performance Measures

		Most Recent Result	FY 2015 Target	Source
Goal 1: Transform Health Care				
Objective A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured				
1.A.1	Increase the proportion of legal residents under age 65 covered by health insurance by establishing healthcare insurance Exchanges and implementing Medicaid expansions	84% (FY 2008)	93% of legal residents with insurance coverage [1]	Current Population Survey
1.A.1.a *Interim Goal*	Increase the number of young adults ages 19 to 25 who are covered as a dependent on their parent's employer-sponsored insurance policy	6.8 million (FY 2008)	7.9 million (FY 2013) [2]	Current Population Survey
1.A.2	Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-Low Income Subsidy (LIS) Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap	100% of cost paid out-of-pocket while in coverage gap (FY 2010)	48% of cost paid out-of-pocket while in coverage gap	Reconciled Prescription Drug Event (PDE) data
Objective B: Improve healthcare quality and patient safety				
1.B.1	Increase the number of Patient Safety Organizations (PSOs) listed by HHS Secretary.	75 listed PSOs (FY 2009)	85	AHRQ PSO Web site,http://www.pso.ahrq.gov/

		Most Recent Result	FY 2015 Target	Source
1.B.2	Protect the health of Medicare beneficiaries by increasing the percentage of dialysis patients with fistulas as their vascular access for hemodialysis	54% (FY 2009)	62% of Medicare dialysis patients will receive arteriovenous fistula as their vascular access for hemodialysis	Data submitted by the dialysis facilities Large dialysis facilities submit directly to CMS through a file transfer The 18 End Stage Renal Disease (ESRD) Networks collect data from independent dialysis facilities
1.B.3	Increase the number of hospitals and other selected healthcare settings that report into the National Healthcare Safety Network (NHSN)	2,619 (all types) (FY 2010)	31,000 healthcare facilities	National Healthcare Safety Network (NHSN)
Objective C: Emphasize primary and preventive care linked with community prevention services				
	Increase the proportion of individuals who receive Affordable Care Act-targeted clinical preventative services Proportion of privately insured children under age 18 who receive appropriate preventative services	See Measures Below.		
1.C.1.a	Proportion of privately insured children ages 10-17 who received a well-child check-up in the past 12 months	71.4% (FY 2008)	75%	National Health Interview Survey (NHIS)
	Proportion of privately insured adults under age 65 who receive appropriate preventative services	See Measures Below.		

		Most Recent Result	FY 2015 Target	Source
1.C.1.b	Colorectal cancer screenings for privately insured adults ages 50-64	64.7% (FY 2010)	70%	NHIS
1.C.1.c	Flu shot in last year for privately insured adults ages 50-64	41.9%	50%	NHIS
	Proportion of Medicare beneficiaries who receive appropriate preventative services	See Measures Below.		
1.C.1	Colorectal cancer screening for Medicare enrollees ages 50-75	63.8% (FY 2007)	70%	Medicare Current Beneficiary Survey (MCBS
1.C.2	Identify three key factors influencing the scaling up of research-tested interventions across large networks of services systems such as primary care, specialty care, and community practice	Variables for measuring implementation include organizational culture and climate, capacity for organizational change, dimensions of supervisory adherence to treatment principles, and adherence to clinical guidelines (FY 2009)	Identify three key factors that influence the scaling up of research-tested interventions across large networks of services systems, such as primary care, specialty care, and community practice	Progress reports and publications
1.C.3	Increase percentage of pregnant women who receive prenatal care in the first trimester	69% (FY 2006)	72%	National Vital Statistics Reports
Objective D: Reduce the growth of healthcare costs while promoting high-value, effective care				

		Most Recent Result	FY 2015 Target	Source
1.D.1	Reduce unnecessary hospital readmission rates among Medicare beneficiaries	TBD (Hospital readmission rate of Medi-care recipients in FY 2012)	Reduce all-cause hospital readmission rates by 5% per year from 2012 to 2015	Medicare claims data
1.D.2	Review and appropriately value potentially misvalued codes (i.e., high expenditure or high cost) under the Medicare Physician Fee Schedule system for analysis under misvalued code process	TBD	80%	Annual Physician Fee Schedule Regulation
Developing 1.D.3	HHS currently is working to develop meaningful performance measure(s) in support of reducing the incidence of hospital-acquired conditions in Medicare and Medicaid. New performance measure(s) for this objective will be incorporated into the HHS Strategic Plan once this work has been completed.			
Developing 1.D.4	HHS currently is working to develop meaningful performance measure(s) in support of delivery system reform in Medicare. New performance measure(s) for this objective will be incorporated into the HHS Strategic Plan once this work has been completed.			
Objective E: Ensure access to quality, culturally competent care for vulnerable populations				
1.E.1.a	Broaden availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid.	CHIP: 7,717,317 (FY 2009) Medicaid: 31,440,320 (FY 2008)	TBD	Statistical Enrollment Data System (SEDS) and CMS-2082 data; targets will be developed in the near future
1.E.2	Increase the proportion of adults ages 18 and older who are screened in IHS–funded clinical facilities for depression	44% (FY 2009)	60%	Clinical Reporting System (CRS)

		Most Recent Result	FY 2015 Target	Source
1.E.3	Increase the number of pilot sites administering Aging and Disability Resource Centers (ADRCs)	197 (FY 2008)	320	ADRC discretionary grant semi-annual reports
1.E.4	Increase the number of patients served by Health Centers [4]	18.8 million (FY 2009)	38.7 million	HRSA Bureau of Primary Health Care's Uniform Data System
1.E.5	Implement recommendations from Tribes annually to improve the consultation process.	0 (FY 2009)	At least 3 recommendations	Routine IHS Tribal consultation documentation for HHS consultation report and IHS Director's Activities database
Objective F: Promote the adoption and meaningful use of health information technology				
1.F.1	Increase the percentage of eligible primary care professionals participating in Medicare and Medicaid who receive meaningful use payments[5]	TBD (FY 2011)	TBD	CMS Meaningful Use Registration and Attestation System
1.F.2	Increase the percentage of office-based primary care physicians who have adopted EHRs (basic).	TBD	TBD	National Ambulatory Medical Care Survey (NAMCS)
Goal 2: Advance Scientific Knowledge and Innovation				
Objective A: Accelerate the process of scientific discovery to improve patient care				
2.A.1	Make freely available to researchers the results of 300 high-throughput biological assays screened against a library of 300,000 unique compounds, and the detailed information on the molecular probes that are developed through	The NIH Molecular Libraries Small Molecule Repository (MLSMR) contains 341,830 unique compounds (FY 2009)	Make freely available to researchers the results of 300 high-throughput biological assays screened against a library of 300,000 unique compounds, and the detailed information on the molecular probes that are developed through that screening process	NIH Molecular Libraries Small Molecule Repository (an NIH Roadmap project) http://mli.nih.gov/mli/compound-repository/

	that screening process			
		Most Recent Result	**FY 2015 Target**	**Source**
2.A.2.a	Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers	--6 Systematic Reviews --13 Summary Guides --16 Effective Health Care Research Reports (FY 2009)	--53 Systematic Reviews --83 Summary Guides --110 Effective Health Care Research Reports	AHRQ Effective Health Care Program Web Site: http://effectivehealthcare.ahrq.gov/
2.A.3	Identify and characterize two molecular pathways of potential clinical significance that may serve as the basis for discovering new medications for preventing and treating asthma exacerbations	A SNP (-251) in the Interleukin-8 gene was identified and found to be associated with exacerbations of asthma in children (FY 2009)	Characterize two molecular pathways of potential clinical significance that may serve as the basis for discovering new medications for preventing and treating asthma exacerbations	Progress reports or publications
Objective B: Foster innovation to create shared solutions				
2.B.1	Increase the number of identified opportunities for public engagement and collaboration across agencies	TBD	TBD	Data collection associated with development of Open Government Plan
2.B.2	Increase the number of high-value data sets and tools that are published by HHS	TBD	TBD	HHS Data Council
2.B.3	Increase the number of participation and collaboration tools and the activities conducted by the participation and collaboration community of practice	TBD	TBD	HHS Innovation Council

Objective C: Invest in the regulatory sciences to improve food and medical product safety				
		Most Recent Result	**FY 2015 Target**	**Source**
2.C.1	Promote innovation and predictability in the development of safe and effective nanotechnology-based products by establishing scientific standards and evaluation frameworks to guide nanotechnology-related regulatory decisions	TBD	Publish at least two guidances related to the safe use of nanoparticles in cosmetic products and nanotechnologies in foods	Office of the Chief Scientist systems
Objective D: Increase our understanding of what works in public health and human service practice.				
2.D.1	Increase the number of annual Community Guide reviews	13 (FY 2009)	20	Program Data
Goal 3: Advance the Health, Safety, and Well-Being of the American People				
Objective A: Ensure the safety, well-being, and healthy development of children and youth				
3.A.1	Take actions to strengthen the quality of early childhood programs by advancing recompetition, implementing improved performance standards and improving training and technical assistance system in Head Start; promoting community efforts to integrate early childhood services; and expanding the number of States with QRIS that meet high quality benchmarks for Child Care and	Head Start: Published Funding Opportunity Announcement for four National Training and Technical Assistance Centers (June 2010) Child Care/QRIS: Notice of Proposed Rulemaking submitted to the Office of Management and Budget	Child Care/QRIS: Targets for QRIS performance are not yet available Targets will be established once quality benchmarks are finalized and baseline data is collected	Head Start: Office of Head Start Monitoring Reviews Child Care/QRIS: QRIS data from state submissions to the ACF Child Care Bureau

	other early childhood programs developed by HHS in coordination with the Department of Education [6]	(June 2010)		
		Most Recent Result	**FY 2015 Target**	**Source**
3.A.2	Increase the number of low-income children receiving Federal support for access to high-quality early care and education settings, including Head Start, Early Head Start (EHS), and Child Care [7]	10,766 additional Head Start children served 34,270 additional EHS children served (June 2010) 195,000 (estimated) children receiving child care subsidies supported by Recovery Act funds (June 2010)	Increase the number or percentage of low-income children receiving Child Care and Development Fund (CCDF) subsidies who are enrolled in high-quality care settings	The Head Start Enterprise System and Child Care Bureau Information System (CCBIS) from state monthly case-level administrative data report (ACF-801) The ACF Child Care Bureau plans to revise the case level administrative data report (ACF-801) to support new reporting on the quality of care for children receiving Child Care and Development Fund subsidies
3.A.3	Improve outcomes for children with trauma-related mental health issues	76% (FY 2009)	79%	Grantee data from SAMHSA's National Child Traumatic Stress Network
Objective B: Promote economic and social well-being for individuals, families, and communities				
3.B.1	Increase the percentage of adult TANF recipients who become newly employed	34.6% (FY 2008)	1.9 percentage points over FY 2009 result	National Directory of New Hires (NDNH)
3.B.2	Maintain the collection rate for current child support orders	62% (FY 2009)	62%	Child Support Enforcement Annual Data Report (Form OCSE 157), Office of Child Support Enforcement (OCSE)
3.B.3	Increase the percentage of refugees entering employment through ACF-funded refugee employment services	40% (FY 2009)	60%	Performance Report (ORR-6)

Objective C: Improve the accessibility and quality of supportive services for people with disabilities and older adults				
		Most Recent Result	**FY 2015 Target**	**Source**
3.C.1	Increase the number of individuals enrolled in CLASS	0 (FY 2009)	7.7 million	Program data from the agency administering CLASS
3.C.2	Maintain at least 90% of Older Americans Act clients from selected home and community-based services who rate services “good” to “excellent”	> 91.03% (FY 2008)	90%	National Survey
Objective D: Promote prevention and wellness				
3.D.1	Reduce the proportion of adolescents (grades 9–12) who are current cigarette smokers	19.5% (FY 2009)	17.5%	Youth Risk Behavior Surveillance (YRBS) and the National Youth Tobacco Survey
3.D.2	Reduce underage drinking in America (as measured by the percentage of youth ages 12–20 who report drinking in the past month)	26.4% (FY 2008)	23.8% (represents a 10% reduction)	National Household Survey on Drug Use and Health (NSDUH)
3.D.3	Increase the number of States with policies to improve nutritional quality of competitive foods (foods and beverages available or sold outside of the federally-reimbursed school meals programs) in schools	27 (FY 2009)	42	National Association of State Boards of Education (NASBE) policy database
3.D.4	Increase behavioral health outcomes (as measured by the SAMHSA National Outcome Measures) for military members	TBD	60%	SAMHSA Performance Measure Measurement system(s) (TRAC, SAIS, CSAMS)

	and their families served through SAMHSA-supported programs			
		Most Recent Result	**FY 2015 Target**	**Source**
3.D.5	Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology (and Laboratory) Training Program (FELTP)	2,166 total graduates 134 active trainees (FY 2009)	3,166 total graduates 219 active trainees	Program and Administrative Data
Objective E: Reduce the occurrence of infectious diseases				
3.E.1	Reduce the rate of illness caused by Salmonella enteritidis [8]	2.5 cases per 100,000 (3-year average, FY 2007–2009)	1.8 cases per 100,000	FoodNet system
3.E.2	Reduce the estimated number of cases of invasive MRSA infection	89,785 (FY 2008)	56,152	Active Bacterial Core Surveillance
3.E.3	Reduce the Central Line Associated Blood Stream Infection (CLABSI) standardized infection ratio	0.8 (FY 2010)	0.4	National Healthcare Safety Network
3.E.4	Increase proportion of racial and ethnic minorities served in Ryan White HIV/AIDS-funded programs	73% (FY 2008)	Proportion of racial and ethnic minorities in Ryan White HIV/AIDS-funded programs served exceeds representation in national AIDS prevalence data by 5 percentage points	HRSA HIV/AIDS Bureau's Ryan White HIV/AIDS Program Services Report

Objective F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies.				
		Most Recent Result	**FY 2015 Target**	**Source**
3.F.1	Increase the percentage of State public health agencies that can convene—within 60 minutes of notification—a team of trained staff that can decide on appropriate response and interaction with partners [9]	70% (FY 2009)	100%	Division of State and Local Readiness (DSLR)
3.F.2	Increase the number of new medical countermeasures for CBRN and emerging infectious diseases under EUA or licensed	CBRN Licensed: 4 EUA: 4 EID: Licensed: 6 EUA: 1 (FY 2009)	CBRN: Licensed: Plus 4 EUA: Plus 2 EID: Licensed: Plus 5 EUA: TBD [10]	ASPR contract files
Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs				
Objective A: Ensure program integrity and responsible stewardship of resources				
4.A.1	Ensure that ARRA Recipients submit at least 96% of expected quarterly reports required under Section 1512 of the Recovery Act	99% response rate (Quarter ending 03/31/2010) (19,874 reports submitted out of 20,079 expected)	98%	Recovery.gov
4.A.2	Maintain the average survey results from appellants reporting good customer service (on a 1—5 scale) at the ALJ Medicare Appeals level	4.30 (FY 2009)	4.30	Appellate Climate Survey
Objective B: Fight fraud and work to eliminate improper payments				
4.B.1	Prevent Medicare fraud and abuse by strengthening CMS provider enrollment actions Increase the	TBD	25%	Developmental[11]

	percentage of administrative actions taken on Medicare enrollment site visits to targeted high-risk providers and suppliers			
		Most Recent Result	**FY 2015 Target**	**Source**
4.B.2	Increase the Medicaid Integrity Program Return on Investment (ROI)	175% (FY 2009)	180%	Medicaid Integrity Contractors will compile the data on audits where overpayments are identified and recouped; Results from state system audits identifying overpayments using algorithms
4.B.3	Decrease improper payments in Title IV-E Foster Care Program by lowering the national error rate	4.7% (FY 2009)	3.7%	Regulatory IV-E Foster Care Eligibility Reviews
Objective C: Use HHS data to improve the health and well-being of the American people				
4.C.1	Increase the electronic media reach of CDC Vital Signs through the use of mechanisms such as CDC.gov and social media outlets	250,000 (FY 2010)	509,355 (5% over FY 2014)	The data source for this measure is Omniture ® web analytics, which is a software product that provides consolidated and accurate statistics about interactions with CDC.gov and social media outlets as individuals seek and access information about CDC Vital Signs.
4.C.2	Reduce the average number of field staff hours required to collect data per respondent household for the MEPS	13.0 field staff hours (FY 2009)	12.75 field staff hours	Interviewer pay reporting system
Objective D: Improve HHS environmental, energy, and economic performance to promote sustainability				
4.D.1	Increase % employees who use telework or an alternative work schedule (AWS) to reduce commuting by four days per pay period	TBD	20%	Departmentwide Data Calls
4.D.2	Reduce total HHS fleet emissions by 2%	13,778 MT CO2e (FY 2008)	13,502 MT CO2e	PSC

		Most Recent Result	FY 2015 Target	Source
4.D.3	Ensure power management is enabled in 100% of HHS computers, laptops, and monitors	32% (FY 2010)	100%	Departmentwide Data Calls
Goal 5: Strengthen the National Health and Human Service Infrastructure and Workforce				
Objective A: Invest in the HHS workforce to help meet America's health and human service needs today and tomorrow				
Developing 5.A.1	Reduce HHS-wide hiring lead times from their current levels to 65 days or less (Time from receipt of the complete recruitment request in the HR Office to the date the employee enters on duty.)	130 days (FY 2009)	65 days	Capital HR
Objective B: Ensure that the Nation's healthcare workforce can meet increased demands				
5.B.1	Expand the field strength of the National Health Service Corps (NHSC)[12]	4,808 (FY 2009)	9,025	HRSA Bureau of Clinician Recruitment and Service's Management Information Support System
5.B.2	The number of primary care providers who complete their education through HRSA's Bureau of Health Professions-supported programs with FY 2010 Prevention and Public Health funding	0 (New program in FY 2010)	500 primary care physicians 600 physician assistants 600 nurse practitioners	HRSA grantee reporting
Objective C: Enhance the ability of the public health workforce to improve public health at home and abroad				
5.C.1	Increase the number of CDC trainees in State, tribal, local, and territorial public health agencies	119 (FY 2009)	198	Program and administrative data
Objective D: Strengthen the Nation's human service workforce				

		Most Recent Result	FY 2015 Target	Source
5.D.1	Increase the percentage of Head Start teachers with AAs, BAs, advanced degrees, or a degree in a field related to early childhood education	83.2% (FY 2009)	100%	Head Start Program Information Report (PIR)
5.D.2	Increase the number of individuals trained by SAMHSA's Science and Services Program (e.g., ATTCs, CAPT, Medical Residency)	48,297 (FY 2009)	49,746	Data from SAMHSA's three science and Services programs
Objective E: Improve national, State, local, and tribal surveillance and epidemiology capacity				
5.E.1	Increase the number of counties and communities that implement evidence-based policies and interventions as a result of their county health ranking	Baseline to be established in 2010	TBD	Association of State and Territorial Health Officials

[1]Target provided from Douglas W. Elmendorf, Director, Congressional Budget Office, to the Honorable Nancy Pelosi, Speaker, U.S. House of Representatives, in letter dated March 20, 2010.
[2]Cannot project beyond 2013 because young adults may prefer to get their own policies in the Exchanges once they are available.
[3]Data from first quarter 2010. Baseline will be updated with full year 2010 data when available.
[4]This measure also represents a HHS High Priority Performance Goal. More information is available athttp://www.goals.performance.gov/. (This site may still be under development and should be available to the public soon.)
[5]Includes Medicaid incentive payments for adopting, implementing, and upgrading certified EHR technology in the first year.
[6]This measure also represents a HHS High Priority Performance Goal. More information is available athttp://www.goals.performance.gov/. (This site may still be under development and should be available to the public soon.)
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[9]This measure also represents a HHS High Priority Performance Goal. More information is available athttp://www.goals.performance.gov/. (This site may still be under development and should be available to the public soon.)

[10]EID (pandemic influenza) products would be eligible for use in a public health emergency under EUA in advance.
[11]During FY 2011, in coordination with CMS, the Medicare Administrative Contractors (MACs) and Zone Program Integrity Contractors (ZPICs) will develop a methodology for computing Risk Indicators for Part A and B providers and suppliers similar to the National Supplier Clearinghouse's (NSC's) Fraud Level Indicators for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers and utilize them to identify "high risk" providers. For this measure, Risk Indicators will be defined per the proposed regulations at 42 CFR Parts 424, 431, 438, 455, and 457 Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers; CMS-6028-P. Medicare contractors will utilize CMS-developed reporting requirements to compile the data on the numbers of targeted "high risk" enrollment site visits conducted and the percentage which resulted in an administrative action and to track and report the results of the administrative actions (e.g., dollars denied as a result of prepayment review). While the goal is national, based on the aggregate number of "high risk" site enrollment site visits conducted, individual contractors will be strongly encouraged to meet and exceed the national goal to the extent appropriate for the provider population in their jurisdiction.
[12]This measure represents a HHS High Priority Performance Goal. More information is available athttp://www.goals.performance.gov.

Performance Indicators

Goal 1: Transform Health Care

Objective A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured

1.A.1 Increase the proportion of legal residents under age 65 covered by health insurance by establishing healthcare insurance Exchanges and implementing Medicaid expansion.

Note: As Health Insurance Exchanges (Exchanges) and Medicaid expansion will not be fully in place until 2014, CMS is reporting on the process measure below in the interim. This interim measure tracks CMS's progress towards setting up the Exchanges that are instrumental in expanding health insurance coverage. Tracking the proportion of residents with health insurance allows CMS to track its progress towards achieving the goal of providing quality, affordable health insurance to all Americans.

Number of States in which the following key milestones for the establishment of Exchanges, either State or Federally-operated, have occurred:
1. Stakeholder consultation is performed to gain public input into Exchange planning process. [FY 2011 Target]
2. The necessary legal authority exists to establish and operate an Exchange that complies with Federal requirements. [FY 2012 Target]
3. Agreement drafted regarding coordination with State Medicaid, Department of Insurance and applicable State health subsidy programs, as appropriate. [FY 2012 Target]
4. Information infrastructure plan developed that assesses existing information systems, identifies gaps and needs, and proposes strategies to achieve seamless eligibility and enrollment. [FY 2012 Target]

In addition, we will establish financial integrity and auditing protocols for Exchange in 2013.

Exchanges are a keystone of the health insurance reform provided by the Affordable Care Act of 2010. The Affordable Care Act provides each State with the option to set up an Exchange, or to have the Federal government set up an Exchange in that State. An Exchange is an organized marketplace to help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive health insurance markets for individuals and small employers.
Although States are at various stages of readiness to operate Exchanges, CMS and all States that elect to establish their own Exchanges will undertake significant work to prepare for open enrollment prior to January 1, 2014. Section 1311 of the Affordable Care Act (P.L. 111-148) provided amounts necessary to enable the Secretary to award Planning and Establishment Grants to States no later than March 23, 2011 and allowed for renewal of grants through January 1, 2015, at which time Exchanges will be self-sustaining. This funding will allow for the completion of the work necessary to develop policies, establish a governance structure, build information technology (IT) systems, develop marketing and consumer outreach campaigns, and the other work necessary to establish an Exchange. Continuation of funding under the grants is contingent upon States meeting specific milestones, such as the ones outlined in this goal. In the

event that a State does not implement its own Exchange, CMS will perform the necessary work to establish a Federally-operated Exchange

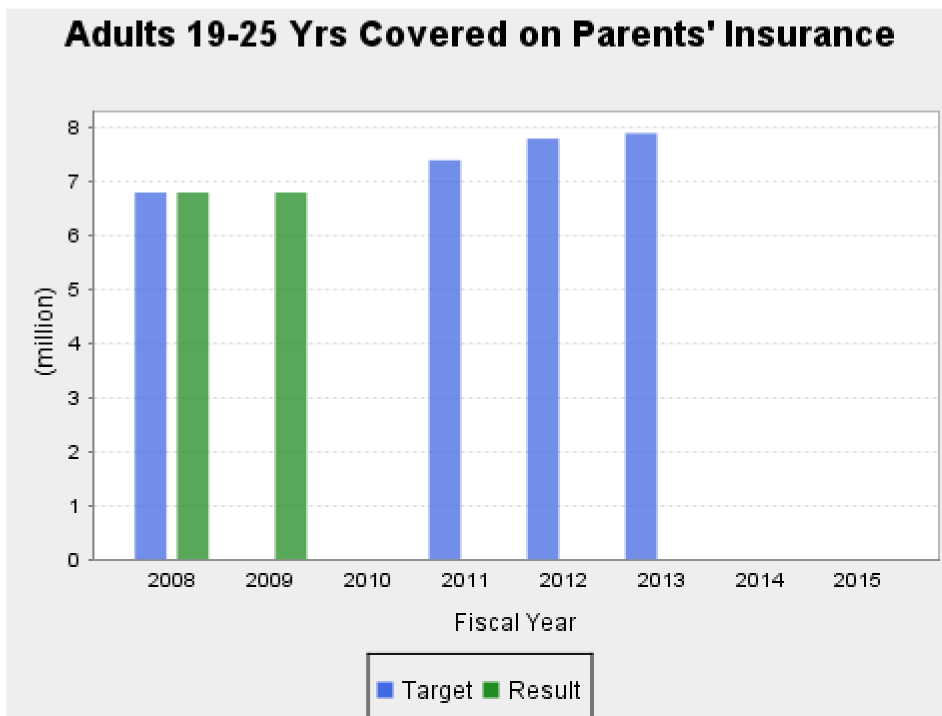
This is a new performance measure and does not yet have any trends associated with it.

Also Supports: Healthy People 2020 AHS-1; AHS-1.1

1.A.1.a Number of young adults ages 19 to 25 who are covered as a dependent on their parent's insurance policy.

The Affordable Care Act requires group health plans and private health insurance issuers offering group or individual health insurance coverage that provides dependent coverage of children, to continue to cover an adult child until the age of 26. This provision went into effect on September 23, 2010, and it is important because it increases the availability of health insurance to a population that currently has a high uninsured rate. OCIIO's goal is to increase the number of adult children covered as dependents on a parent's insurance policy to 7.3 million by 2012.

This is a new performance measure. Some historical actuals were used to develop targets for future years.



Data Source: Current Population Survey

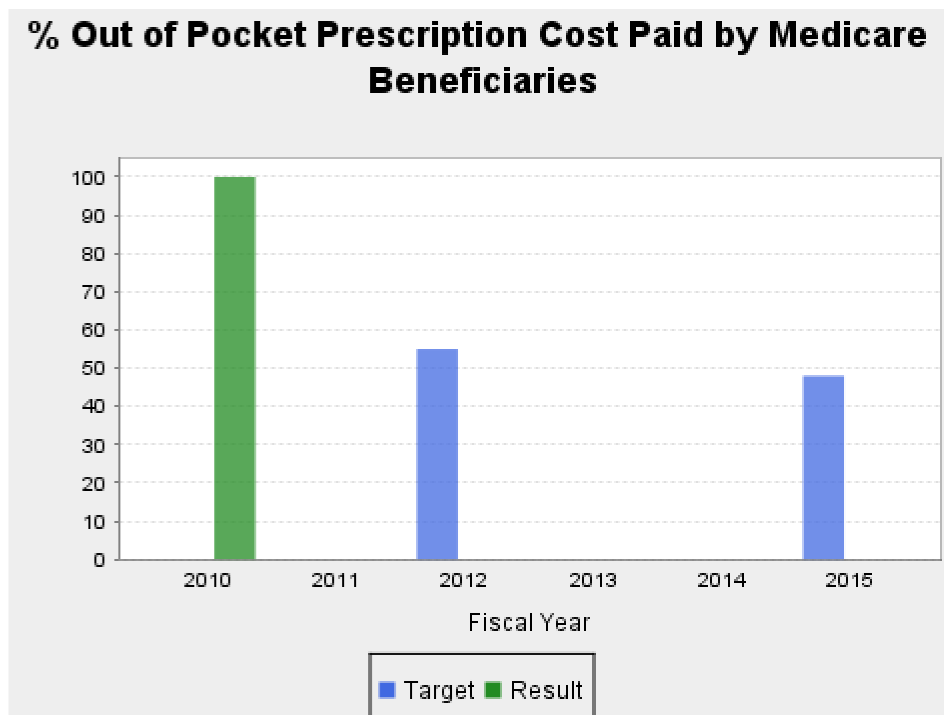
Also Supports: Healthy People 2020 - AHS 1.3; AHS-6.4

1.A.2 Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-Low Income Subsidy (LIS) Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap.

The Affordable Care Act includes provisions to reduce the out-of-pocket costs of prescription drugs for Medicare beneficiaries, including closing the coverage gap ("Donut hole") *completely* by 2020.

The Affordable Care Act will reduce the cost Medicare Part D enrollees are required to pay for their prescriptions once they reach the coverage gap[1]. This will be accomplished through a combination of rebate checks, significant manufacture discounts, and increased Medicare coverage according to a predetermined scale[2]. These discounts are available to eligible beneficiaries who are in the coverage gap and will be applied at the point of sale. 100 percent of the negotiated price would count toward the annual out-of-pocket threshold (True Out-of-Pocket Costs; TrOOP).

With an FY 2010 baseline of 100 percent[3], the FY 2012 target was set at 55 percent.



[1]The coverage gap for a defined stand plan in 2011 is $2,840 to $4,550.
[2]111th United States Congress. (2010). 111th United States Congress: The Health Care and Education Reconciliation Act of 2010. Washington, D.C.: 111th United States Congress. Pages 8-12. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872enr.txt.pdf.
[3]The beneficiaries are responsible for 100 percent of drug coverage while in the coverage gap.

Data Source: The Prescription Drug Event (PDE) data

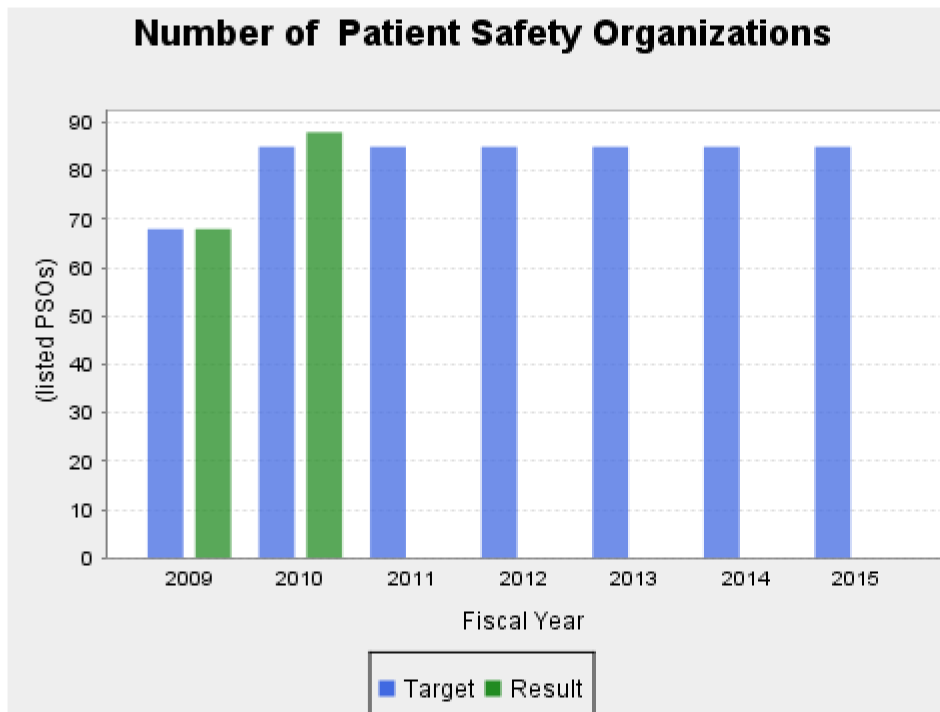
Also Supports: Healthy People 2020 AHS 1.3 and AHS 6.4

Goal 1: Transform Health Care
Objective B: Improve health care quality and patient safety

1.B.1 Patient Safety Organizations (PSOs) listed by DHHS Secretary.

AHRQ's count of listed Patient Safety Organizations (PSOs) functions as a practical measure of start up operations for the AHRQ PSO program in FY 2009 and 2010. This measure indicated success in implementing AHRQ's administrative responsibilities under the Patient Safety Act and Rule, and the measure demonstrated a high level of interest in the private sector in becoming a Federally-listed PSO. AHRQ believes that the number of PSOs has reached maturity.

As of December 31st, 2010, AHRQ had 80 listed PSOs. We noted a dramatic drop off in applications for PSO listings in FY 2010 compared to FY 2009. The total number of PSOs listed since inception of PSO Operations (November 2008) is 94. Fourteen PSOs have been de-listed during this time. By the end of their second year of operations, PSOs that do not successfully complete the minimum number of contracts with healthcare providers undergo a de-listing process. PSOs are voluntary and their operations are not funded by the government. A number of PSOs have not been able to succeed in developing a successful business model. AHRQ does continue to receive requests for new listings, albeit at a much slower rate. AHRQ also expects a small number of PSOs to be delisted over the next year, as well, which leads to our projection of the number of listed PSOs at approximately 85.

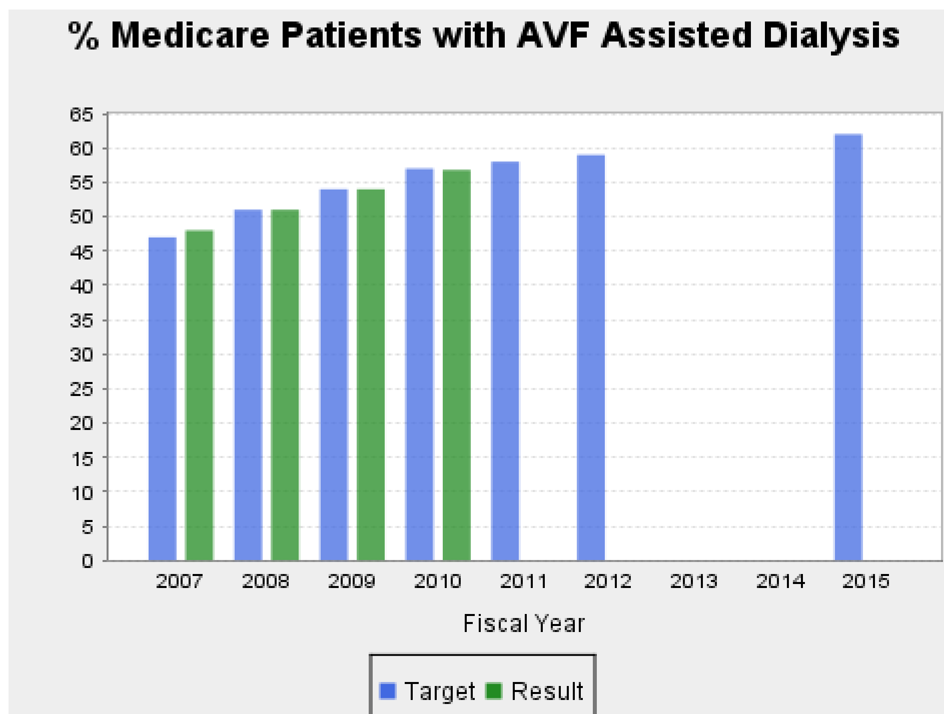


Data Source: AHRQ PSO web site

1.B.2 Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis.

Hemodialysis is the most common treatment for End Stage Renal Disease (ESRD). Approximately 356,000 Medicare beneficiaries currently receive this treatment. Of the vascular access options for hemodialysis arteriovenous fistula (AVF) is generally the best access. An increased rate of AVF for access would improve quality of life for patients by improving adequacy of dialysis and decreasing emergent treatment of and hospitalizations related to complications and failures of grafts and catheters, thus decreasing program costs. Additionally, it is anticipated that the ESRD survival rate would improve because the complications of grafts and catheters can be fatal.

Quality improvement work continues as the ESRD Networks and a sub-group of Quality Improvement Organizations (QIOs) reach out to providers and hemodialysis patients regarding the most appropriate vascular access methods available to them. CMS is holding ESRD Network Organizations accountable for driving regionally based fistula rates upward as one of their tasks under their CMS ESRD Quality Initiative Statement of Work. In addition, the work of the Fistula First Breakthrough Initiative National Coalition serves as a national coordinating point for pooling the resources of public and private stakeholders together to focus the renal community on this vital topic for all hemodialysis patients. CMS has also engaged QIOs to work with the ESRD Networks in a sub-national effort within the 9th Statement of Work (SOW) from August 2008 through July 2011 to improve AVF rates for new patients beginning hemodialysis. For FY 2010, we improved to a rate of 56.8 percent, a 2.8 percent increase over FY 2009, just short of our 57 percent target. By October 31, 2010, the rate was 57.1 percent.

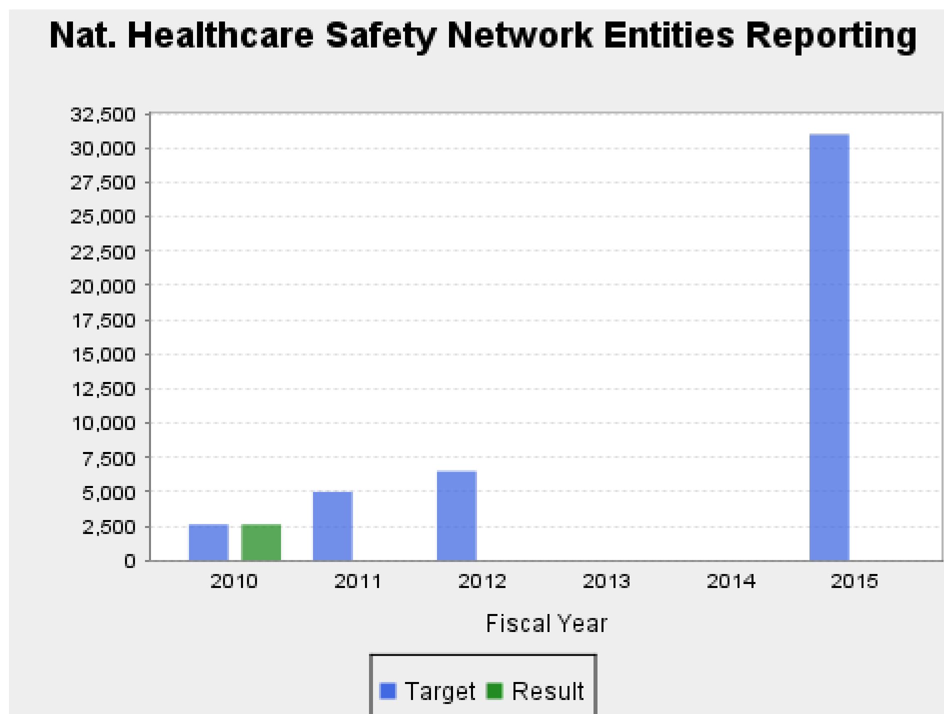


Data Source: Data is self reported by the dialysis facilities. Dialysis facilities submit directly to the 18 ESRD Networks who then submit directly to CMS through a file transfer.
Also Supports: HHS *Healthy People 2020*, Objective 1.D.1

1.B.3 Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (NHSN).

Healthcare-associated infections (HAI) occur in all settings of care. It has been estimated that in 2002, 1.7 million infections and 99,000 associated deaths occurred in hospitals alone. The financial burden attributable to these infections is staggering with an estimated $33 billion in added healthcare costs (2009[1],[2]). Recent research efforts supported by the CDC and the Agency for Healthcare Research Quality (AHRQ) have shown that implementation of CDC HAI prevention recommendations can reduce some healthcare-associated infections by as much as 70 percent. Broad implementation of HAI prevention guidelines can result in dramatic reductions in HAIs, which will not only save lives and reduce suffering, but will result in healthcare cost savings.

This measure tracks progress using standardized data reporting of HAIs in hospital and other select settings.



CDC's National Healthcare Safety Network (NHSN) monitors infections, antimicrobial resistance, and other healthcare related issuesin hospitals and other healthcare facilities in all 50 states. CDC's National Healthcare Safety Network (NHSN) is the tool used for fulfilling HAI public reporting mandates in 22 states and is used in hospitals in all 50 states and the District of Columbia. As of December 2010, NHSN participation includes over 4,100 healthcare facilities.

[1]Scott, R. Douglas. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. March 2009. http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf

[2]Klevens RM, Edwards JR, Richards CL, Horan T, Gaynes R, Pollock D, Cardo D. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. Public Health Rep 2007;122:160-166.

Data Source: National Healthcare Safety Network (NHSN)

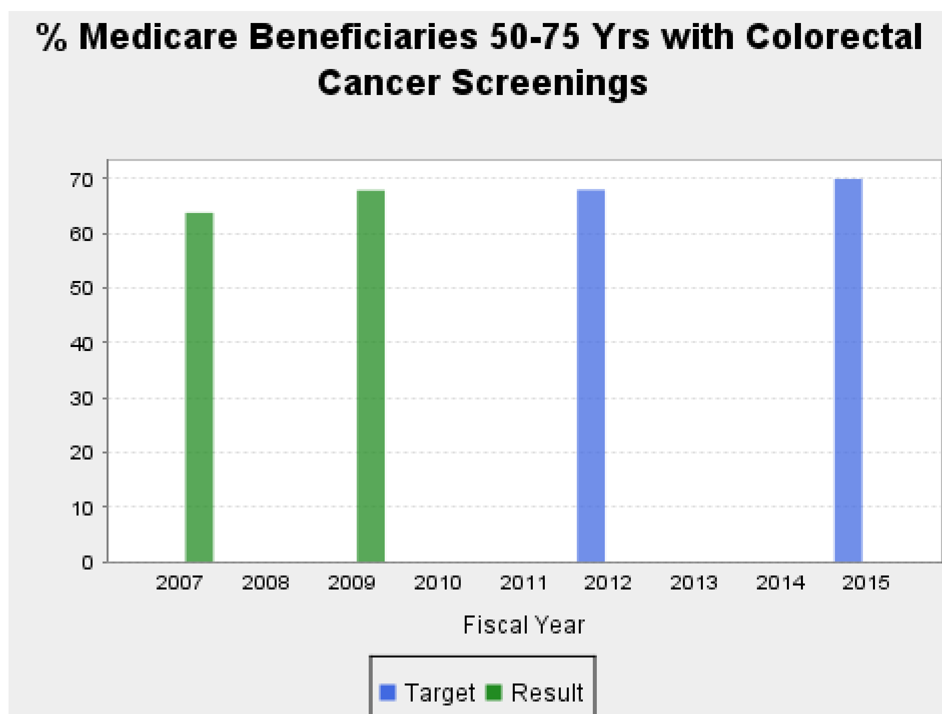
Also Supports: HHS Strategic Plan 1.3 and 3.E; Healthy People 2020 Objectives: HAI-1, HAI-2, BDBS-18, BDBS-18.1 and BDBS 18.2; HHS Action Plan to Prevent Health Care Associated Infections

Goal 1: Transform Health Care
Objective C: Emphasize primary and preventive care linked with community prevention services

1.C.1 Increase the proportion of Medicare beneficiaries, ages 50-75, who receive colorectal cancer screening.

The purpose of this measure is to increase the awareness and utilization of the colorectal cancer screening benefit through the Medicare program. The Affordable Care Act removes the beneficiary co-pay for certain covered, recommended preventative services including colorectal cancer screening (CRC). The removal of the co-pay is intended to increase utilization of preventative services.

The United States Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen men and women 50 years of age until age 75 for colorectal cancer (CRC), using fecal occult blood testing, sigmoidoscopy, or colonoscopy. The USPSTF concluded that there is high certainty that the net benefit is substantial for CRC screening using fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy in adults age 50 to 75 years, and found convincing evidence that several screening methods are effective in reducing mortality from CRC. With an FY 2007 baseline rate of 63.8 percent, the FY 2012 target was set at 68 percent for Medicare beneficiaries ages 50-75.



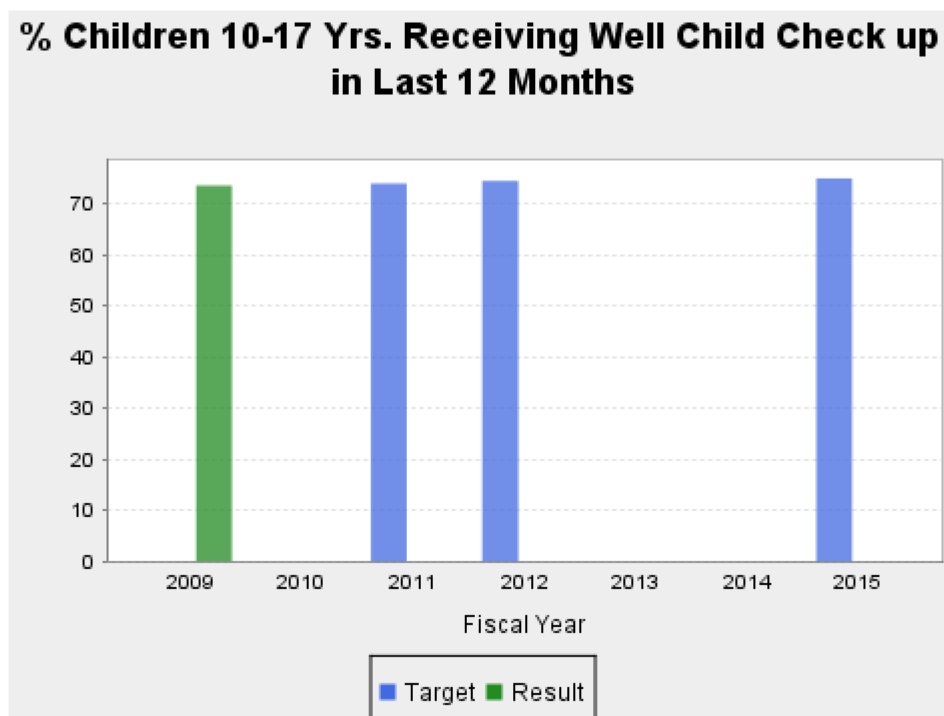
Data Source: The Medicare Current Beneficiary Survey (MCBS), an ongoing survey of a representative national sample of the Medicare population, including beneficiaries who reside in long-term care facilities. (This question was not included in the MCBS for 2008 and 2010.)

Also Supports: *HHS Healthy People 2020, Objective C-16 and OA-2*

1.C.1.a Proportion of privately insured children ages 10-17 who received a well-child check-up in the last 12 months.

In order to ensure that Americans are able to take full advantage of preventive care measures that will detect health problems at an early stage and allow for more effective and cost-efficient interventions, CMS is monitoring the implementation of new rules that eliminate patient cost sharing for preventive care procedures. The new requirement applies to new health coverage in the small group, large group, individual, and self-funded marketplace. CMS, along with the Departments of Labor and Treasury, is responsible for monitoring compliance with the new guideline and implementing the regulation. Section 2713 of the Affordable Care Act requires that a new group health plan and a health insurance issuer offering group or individual health insurance coverage must provide coverage for, and not impose any cost sharing requirements on, recommended preventive health services when delivered by in-network providers. Examples of recommended preventive health services include: mammograms, colonoscopies, and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. CMS will track the rate of three selected preventive services within given populations: Well-Child Visits: Well-child visits are a means of monitoring the healthy development of children. This measure indicates children are receiving quality care. CMS plans to provide guidance to issuers and States regarding the requirements of Section 2713, and to monitor through audits issuer compliance with the requirement that coverage for this Health Resources Services Administration (HRSA) endorsed preventive health service be offered.

This is a new performance measure. Historical data was used to develop targets for future years.



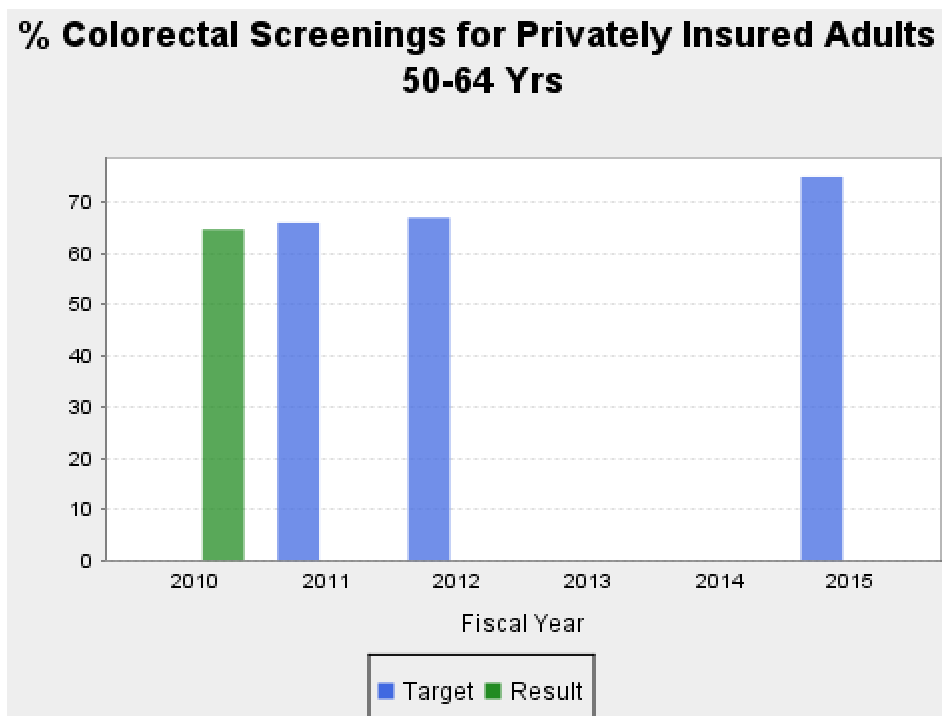
Data Source: National Health Interview Survey (NHIS)

1.C.1.b Colorectal cancer screening for privately insured adults age 50 - 64.

In order to ensure that Americans are able to take full advantage of preventive care measures that will detect health problems at an early stage and allow for more effective and cost-efficient interventions, CMS is monitoring the implementation of new rules that eliminate patient cost sharing for preventive care procedures. The new requirement applies to new health coverage in the small group, large group, individual, and self-funded marketplace. CMS, along with the Departments of Labor and Treasury, is responsible for monitoring compliance with the new guideline and implementing the regulation. Section 2713 of the Affordable Care Act requires that a new group health plan and a health insurance issuer offering group or individual health insurance coverage must provide coverage for, and not impose any cost sharing requirements on, recommended preventive health services when delivered by in-network providers. Examples of recommended preventive health services include: mammograms, colonoscopies, and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Colorectal Cancer Screening: The United States Preventative Services Task Force recommends screening for colorectal cancer (CRC) in adults, beginning at age 50 years and continuing until age 75 years. Screening for colorectal cancer can detect cancer at an earlier stage, where it is more treatable. CMS plans to provide guidance to issuers and States regarding the requirements of Section 2713 and to monitor through audits issuer compliance with the requirement that coverage for this preventive health service be offered.

This is a new performance measure. Historical actual data was used to develop targets for future years.



Data Source: National Health Interview Survey (NHIS)

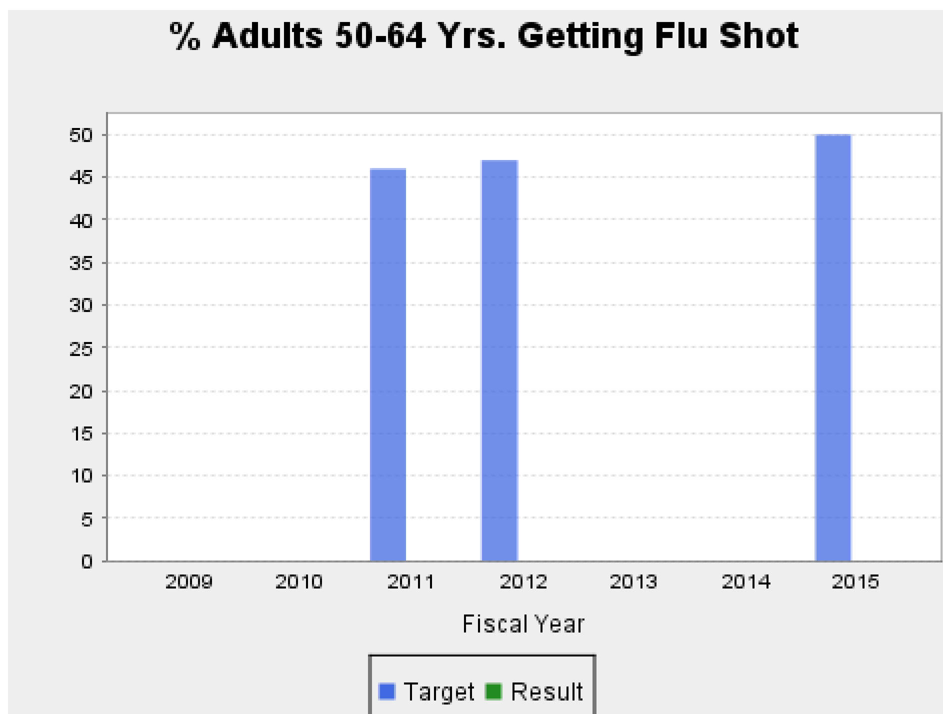
Also Supports: Healthy People 2020 OA-2

1.C.1.c Flu shot in last year for privately insured adults age 50-64.

In order to ensure that Americans are able to take full advantage of preventive care measures that will detect health problems at an early stage and allow for more effective and cost-efficient interventions, CMS is monitoring the implementation of new rules that eliminate patient cost sharing for preventive care procedures. The new requirement applies to new health coverage in the small group, large group, individual, and self-funded marketplace. CMS, along with the Departments of Labor and Treasury, is responsible for monitoring compliance with the new guideline and implementing the regulation. Section 2713 of the Affordable Care Act requires that a new group health plan and a health insurance issuer offering group or individual health insurance coverage must provide coverage for, and not impose any cost sharing requirements on, recommended preventive health services when delivered by in-network providers. Examples of recommended preventive health services include: mammograms, colonoscopies, and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Flu Shots for Adults: The CDC recommends that adults receive an annual flu shot every fall or winter. CMS plans to provide guidance to issuers and States regarding the requirements of Section 2713 and to monitor through audits issuer compliance with the requirement that coverage for this preventive health service be offered.

This is a new performance measure and does not yet have any trends associated with it.



Data Source: National Health Interview Survey (NHIS)

Also Supports: Health People 2020 OA-2

1.C.2 By 2015, identify three (3) key factors influencing the scaling up of research-tested interventions across large networks of services systems such as primary care, specialty care and community practice.

NIH has broadened its portfolio in implementation research by encouraging trans-disciplinary teams of scientists and practice stakeholders to work together to develop innovative approaches for identifying, understanding, and overcoming barriers to implementation of research-tested intervention in service settings. The NIH studies have taken various approaches to examine factors that influence the development, implementation, and dissemination of evidence-based interventions, including scaling-up a mental health intervention in foster care; treating drug abuse and testing a continuum of care for HIV treatment in the criminal justice system; and implementing alcohol screening, intervention, and treatment in primary care.

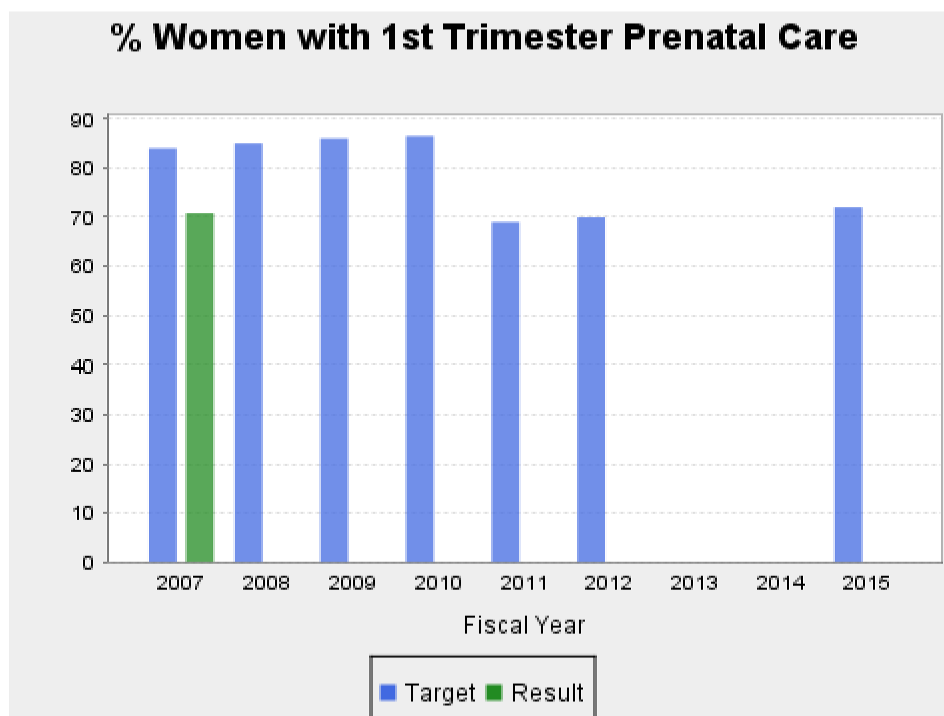
In FY 2010, the NIH met its target to identify at least three systemic (or services) intervention studies which utilize implementation mechanisms, strategies or techniques to improve the uptake of effective interventions in healthcare settings. One study tests how well the Community Development Team (CDT) model is able to promote the adoption, implementation, and sustainability of an evidence-based intervention called Multidimensional Treatment Foster Care (MTFC) to decrease the prevalence of foster care placements in publicly-funded child services systems throughout the State of California and in selected counties of Ohio. A second, multisite, initiative, the Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS), is developing and testing evidence-based approaches for treating drug abuse and related conditions in the criminal offender population. A third study is examining the effectiveness of an implementation model called the Practice Partner Research Network's Accelerating Alcohol Screening – Translating Research into Practice (AA-TRIP) in increasing the use of a Clinician's Guide to improve screening, brief intervention, and treatment (medical management and pharmacotherapy) in primary care.

Data Source: Wang W, Saldana L, Brown CH, and Chamberlain P. Factors that influenced county system leaders to implement an evidence-based program: A baseline survey within a randomized controlled trial. *Implement Sci*. 2010 Oct 6;5:72.
http://www.implementationscience.com/content/5/1/72

1.C.3 Increase percent of pregnant women who received prenatal care in the first trimester.

Prenatal care is one of the most important interventions for ensuring the health of pregnant women and their newborn babies. Early identification of maternal disease and risks for complications of pregnancy or birth can help to ensure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes. Monitoring timely entry into prenatal care provides an indicator of both access to care and quality of care.

The Federal government has recently moved to the use of a Revised Standard Birth Certificate for reporting birth-related information, including receipt of prenatal care. Not all States have begun to use the revised certificate. In the States (18) using the revised certificate to report 2006 information, 69% of pregnant women received prenatal care in the first trimester. In the States (22) using the revised certificate to report 2007 information, the percentage was 70.8%. In the 18 States that used the revised certificate for both 2006 and 2007 reporting, 67.5% of pregnant women received prenatal care in the first trimester.[1]



Data Source: Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC).

Also Supports: This measure aligns with the following Healthy People 2020 objective: Increase the proportion of pregnant women who receive early and adequate prenatal care (MCH-10).

[1] The new baseline and the FY 2007 result for this measure are based on the use of the Revised Birth Certificate. The FY 2007–FY 2010 targets were established based on use of the Unrevised Birth Certificate. Therefore, the target and results should not be compared until FY 2011 when targets are results are both based on the Revised Birth Certificate.

Goal 1: Transform Health Care
Objective D: Reduce the growth of health care costs while promoting high-value, effective care

1.D.1 Reduce all-cause hospital readmission rate per year from 2012 to 2015.

The Affordable Care Act includes provisions to reduce unnecessary all-cause hospital readmissions in order to reduce Medicare payments, while ensuring patient quality.

The Affordable Care Act created the hospital readmission reduction program for certain potentially preventable Medicare inpatient hospital readmissions covering the following three conditions: heart attack, pneumonia and congestive heart failure. This performance measure will apply to *all conditions*. The rate of readmissions is calculated as the number of readmissions to the same or another acute-care hospital that occur within 30 days of discharge from an acute care hospital compared to total hospital admissions for that time period. The numerator will be the number of hospital readmissions to any acute care hospital within 30 days of an acute care hospital discharge. The denominator is the total number of admissions for that time period. The baseline for this performance measure will be set in FY 2012 based on FY 2009 to FY 2011 data. The FY 2015 target is an annual reduction of the readmission rate of 5 percent relative to the previous year.

Data Source: Medicare claims data. The data used to calculate the performance measures are administrative claims data submitted by hospitals and Medicare Advantage plans. Administrative claims data is a validated data source and is the data source for public reporting of hospital readmission rates on the Hospital Compare website. As stated on the Hospital Compare website, research conducted when the measures were being developed demonstrated that the administrative claims-based models perform well in predicting readmission compared with models based on chart reviews.

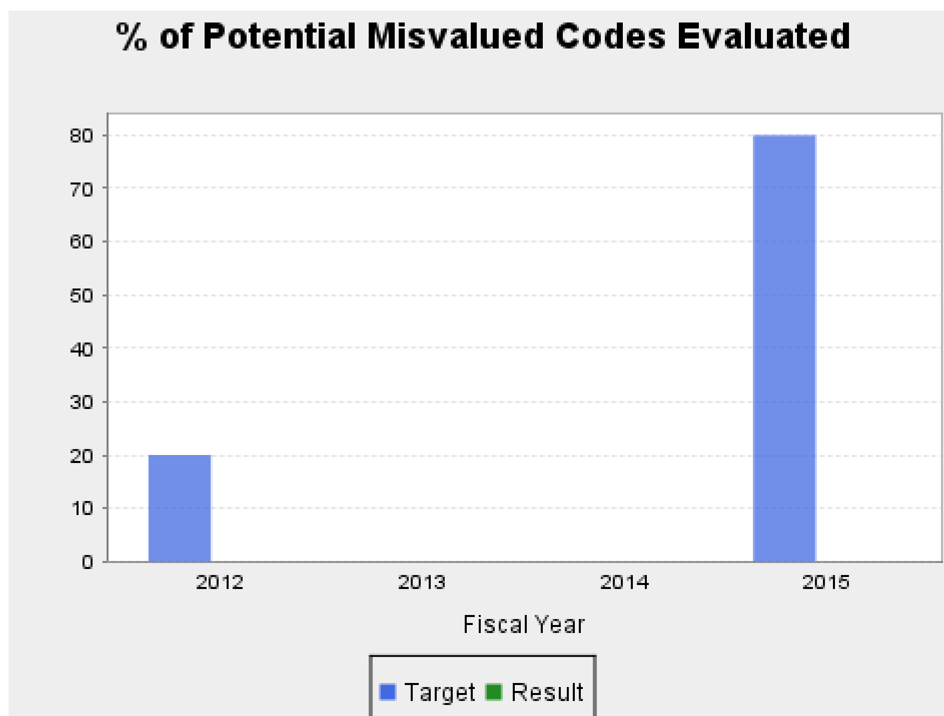
Similar to what is described on the Hospital Compare website, the administrative claims data has a risk-adjustment model applied to adjust for differences in patients' risks unrelated to their hospital care.

Also Supports: CMS will educate and provide the public information and each hospital's performance on reducing unnecessary all-cause hospital readmissions through the Hospital Compare website (www.hospitalcompare.hhs.gov).

1.D.2 Reduce the Growth of Health Care Costs by Identifying, Reviewing, and Appropriately Valuing Potentially Misvalued Codes (i.e. high expenditure or high cost) under the Medicare Physician Fee Schedule (PFS) System through the Potentially Misvalued Code Analysis Process.

The Affordable Care Act directs the Secretary of the Department of Health and Human Services (DHHS) to examine potentially misvalued services in the Medicare Physician Fee Schedule (PFS) to prevent overpayment. In order to achieve the Centers for Medicare & Medicaid Services' (CMS) goal of moving to a value driven health care system, it is imperative to have a payment system that provides accurate reimbursement for the services rendered.

CMS will procure analytic contractors to identify and analyze potentially misvalued codes. After conducting surveys or collecting data, the contractors will make recommendations on the review and appropriate adjustment of potentially misvalued services, enhancing the current process of reviewing codes with the American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee (RUC).We anticipate that the contractor will be in place in 2011 in order to develop a baseline and provide initial estimates of potentially misvalued codes. In 2012, we plan to have reviewed and appropriately valued at least 20 percent of the total estimated potentially misvalued codes identified through the potentially misvalued code analysis process which will include codes that CMS identifies through the AMA RUC as well as the contractor. We note that currently, there are approximately 7,500 codes payable under the Medicare PFS of which a subset will ultimately be identified as potentially misvalued.



Data Source: The PFS rules and regulations; the Relative Value Scale Update Committee (RUC) database; relevant PFS utilization data available at the time of analysis.

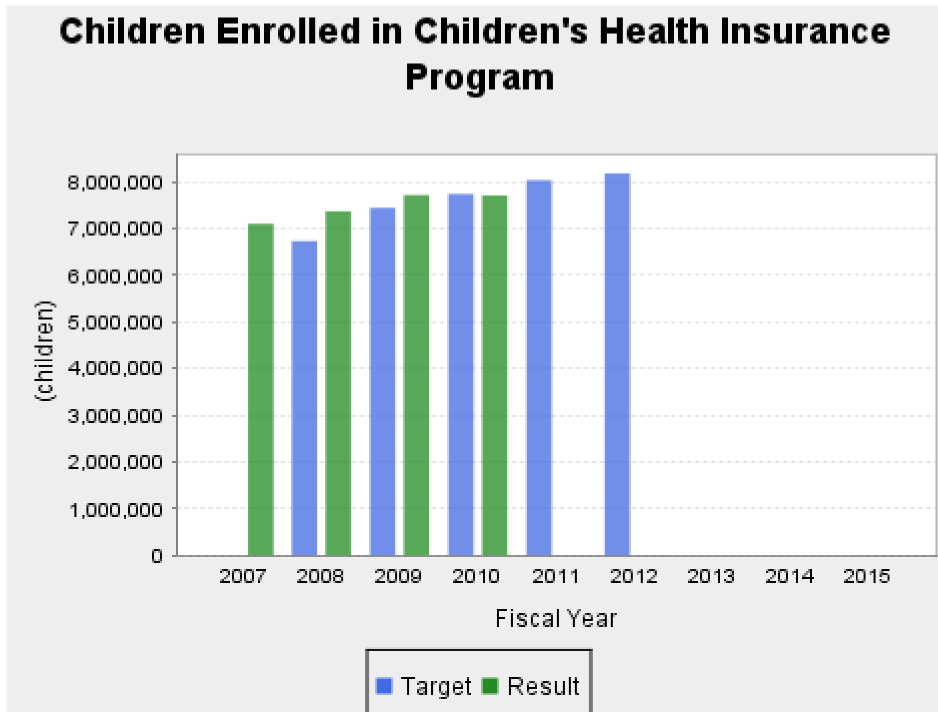
Also Supports: This performance measure supports Provision 3134 of the Affordable Care Act. This initiative will help create a payment system that provides accurate reimbursement for the services rendered, which is essential in the DHHS goal of moving toward a value driven health care system.

Goal 1: Transform Health Care
Objective E: Ensure access to quality, culturally competent care for vulnerable populations

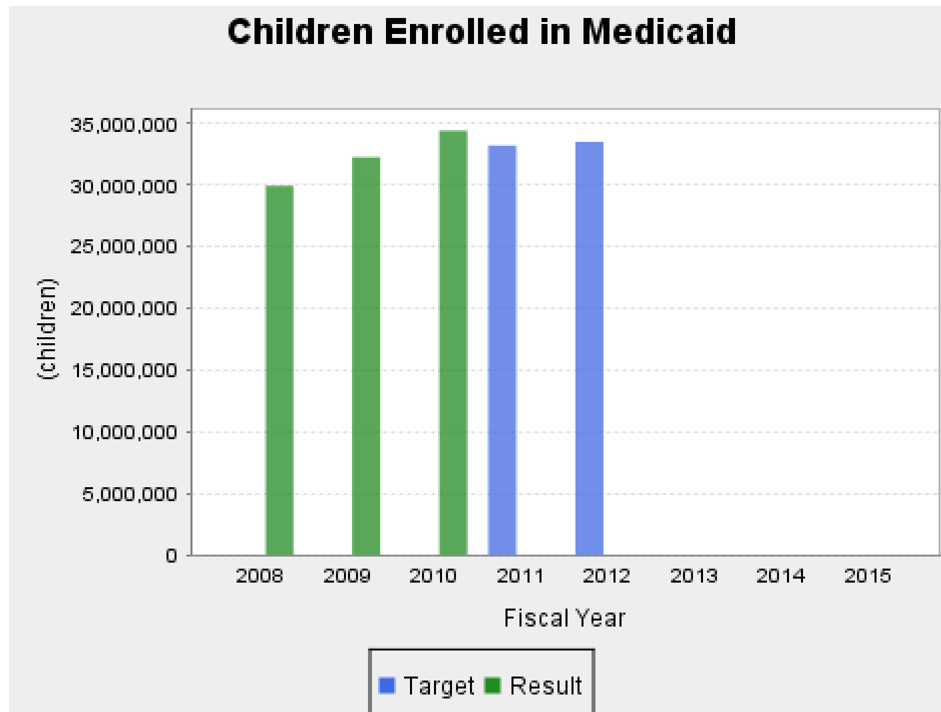
1.E.1.a Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid.

This measure supports the Department's High Priority Performance goal to, "Broaden availability and accessibility of health insurance coverage by increasing enrollment of eligible children in the Children's Health Insurance Program (CHIP) by 9 percent over the 2008 baseline and in Medicaid by 11 percent over the 2008 baseline by the end of 2011." The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3), which reauthorized CHIP through September 30, 2013, provides options for States to expand their Title XXI programs. The Affordable Care Act will also make significant changes to enrollment in the CHIP program as States expand their Medicaid programs. Many additional factors will affect enrollment, including States' economic situations and programmatic changes as well as State reporting accuracy and timeliness.

CHIP: CMS exceeded its FY 2009 target to increase enrollment +1 percent over the FY 2008 baseline of 7,368,479 children. In FY 2009, 7,717,317 children were enrolled in CHIP, a 5 percent increase over FY 2008. CMS fell short of the FY 2010 target to increase enrollment by 5 percent (7,736,903 children) over FY 2008. Actual FY 2010 CHIP enrollment increased by 4.6 percent (7,705, 723 children). The FY 2011 target is to increase enrollment 9 percent (8,031,642 children) over FY 2008; and the FY 2012 target is to increase enrollment 11 percent (8,179,012 children) over the FY 2008 baseline.



Medicaid: The FY 2008 baseline enrollment is 29,943,162 children. In FY 2009, 32,292,253 children were enrolled in Medicaid and in FY 2010, 34,441,217 children were enrolled in Medicaid. The FY 2011 target is to increase the number of children enrolled in Medicaid by 11 percent (33,236,910 children) over the FY 2008 baseline and the FY 2012 target is to increase enrollment by 12 percent (33,536,341 children) over the FY 2008 baseline.



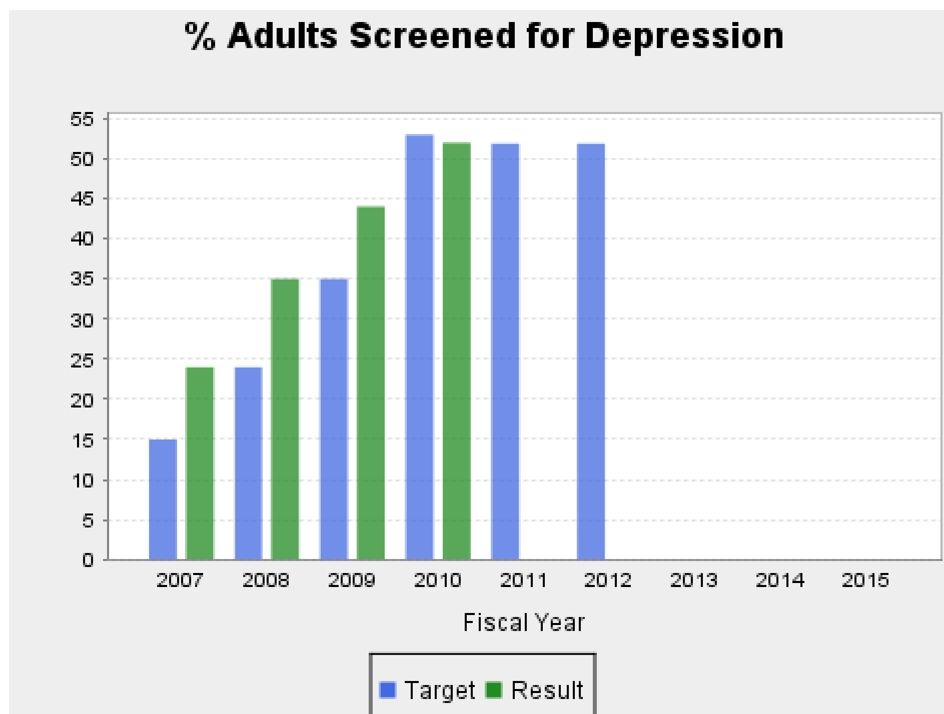
Data Source: States are required to submit quarterly and annual CHIP statistical forms to CMS through the automated Statistical Enrollment Data System (SEDS). Using these forms, States report quarterly and annually on unduplicated counts of the number of children under age 19 who are enrolled in separate CHIP programs and Medicaid expansion CHIP programs. The enrollment counts presented reflect an unduplicated number of children ever enrolled during the year in separate CHIP and Medicaid expansion CHIP programs.

Also Supports: This measure is a High Priority Performance Goal and is included the CMS GPRA plan and Healthy People 2020 AHS-1 and AHS-5.2

1.E.2 Behavioral Health: Proportion of adults ages 18 and over who are screened for depression.

The Indian Health Service (IHS) lists Depression Screening to help fulfill its mission of raising the physical, mental, social and spiritual health of American Indian and Alaska Native people to the highest level. Depression screening improves detection, referral, and treatment of mental health needs. Depression is often an underlying component contributing to suicide, accidents, domestic/intimate partner violence, and alcohol and substance abuse. Early identification of depression will contribute to reducing incidence among American Indians and Alaska Natives, as well as allow providers to plan interventions and treatment to improve the mental health and well-being of American Indian and Alaska Native people who experience depression.

The FY 2011 GPRA target for depression screening is 51.9 percent. The IHS depression screening results in FY 2009 was 44 percent and screening goals traditionally exceeded targets until FY 2010, when the IHS set a goal of 53 percent but achieved 52 percent. Increased accountability for achieving targets at the regional and local levels will be promoted for IHS operated programs and a more focused educational campaign will be undertaken for Tribally operated programs to convey the benefits of depression screening. Increasing use of electronic records across the Indian health delivery system will continue to be supported as screening tools are integral to the electronic records utilized by the IHS.



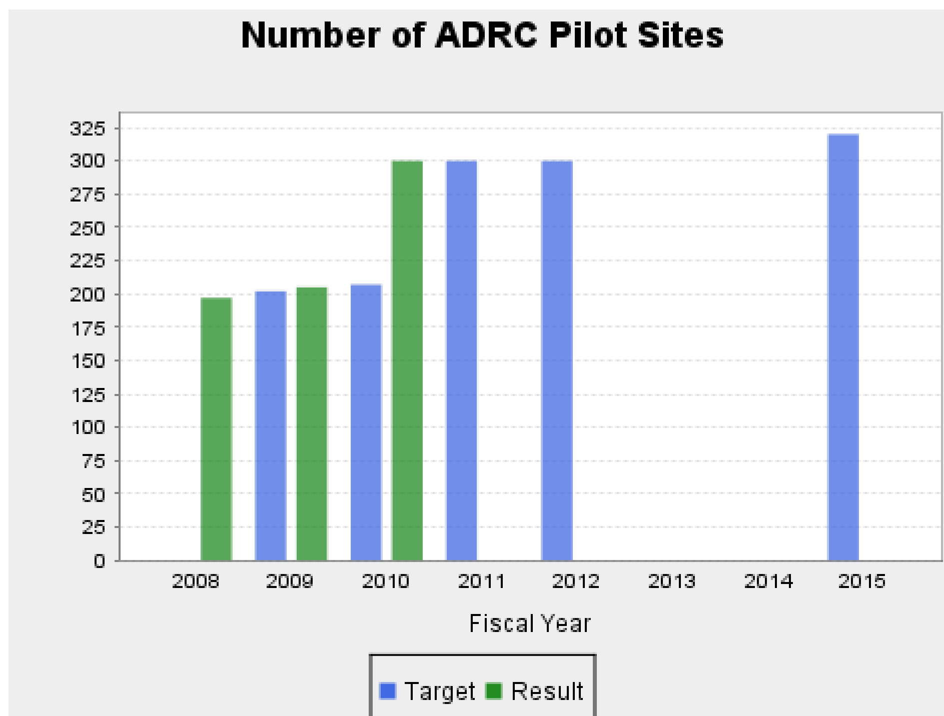
Data Source: Clinical Reporting System (CRS)

Also Supports: HHS Strategic Plan, Goal 3.D and Healthy People 2020, Mental Health and Mental Disorders Objective 11.

1.E.3 Increase the number of ADRC pilot programs.

Aging and Disability Resource Centers (ADRCs) support State efforts to develop more efficient, cost-effective, and consumer-responsive systems of consumer information and integrated service access. Currently, about 45% of the US population has access to ADRCs. The goal to expand the number and coverage of ADRCs will enable individuals throughout the nation to have improved access to qualty care.

ADRCs started in 2003 with both Administration on Aging and CMS investing in their start-up, development and expansion. Since 2008 the number of ADRCs has expanded from 197 to 205, with plans for further expansion as funding becomes available.



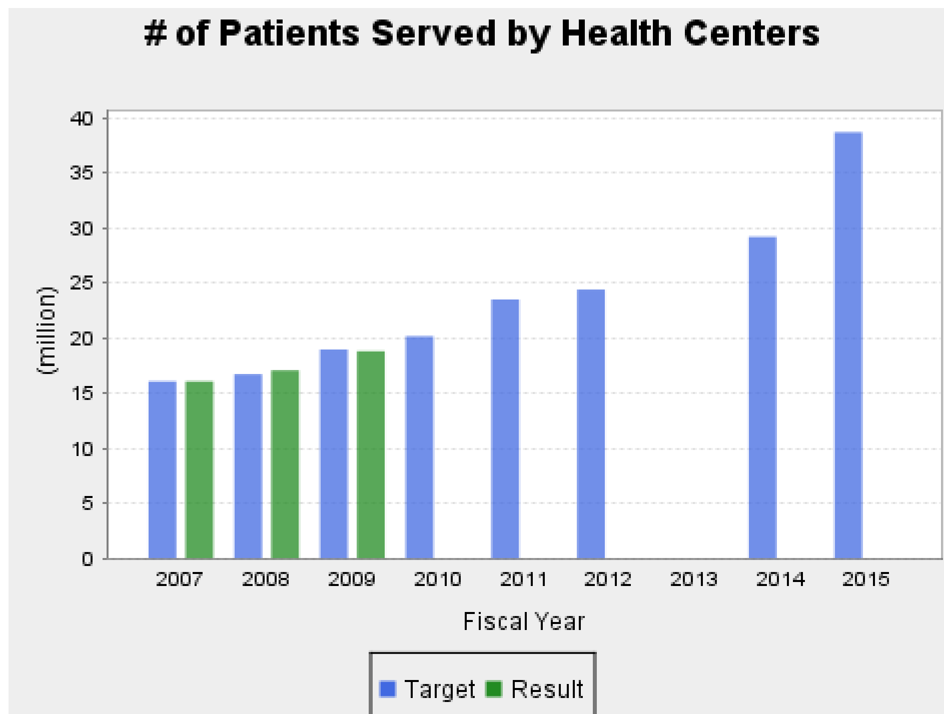
Data Source: Administration on Aging grant distribution accounting system.

Also Supports: HHS measure 3.B

1.E.4 Number of patients served by Health Centers.

Health Centers are community-based and patient-directed organizations that serve populations lacking access to high quality, comprehensive, and cost-effective primary health care. Monitoring the number of patients served annually by Health Centers is key to assessing performance in increasing access to care for underserved and vulnerable populations.

Health Centers served 18.8 million patients in FY 2009. This is 1.7 million more than the 17.1 million patients served in FY 2008 and 2.7 more than the 16.1 million served in FY 2007. Since 2001, the number of patients has increased by over 82 percent. Success in increasing the number of patients served has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics.



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

Also Supports: Aligns with Healthy People 2020 access goals to increase the proportion of persons with a usual primary care provider (AHS-3) and proportion of persons who have a specific source of ongoing care (AHS-5).

1.E.5 Implement recommendations from Tribes annually to improve the Tribal consultation process.

To renew and strengthen the federal/tribal partnership, it is essential that American Indian and Alaska Native Tribes and the Indian Health Service (IHS) engage in open, continuous, and meaningful Tribal consultation. The IHS lists the target of implementing at least three additional recommendations from Tribes to improve the Tribal consultation process each fiscal year. Tribal consultation is an ongoing process that leads to information exchange, respectful dialogue, mutual understanding, and informed decision making.

The Tribal Consultation measure is a new performance measure in 2010 and does not have any trends associated with it. At the end of the first quarter of FY 2011, the IHS has implemented six recommendations from Tribes to improve the Tribal consultation process, which include: forming the Director's Tribal Advisory Workgroup on Consultation; developing an electronic mail (e-mail) address to encourage feedback via e-mail in addition to submitting a letter (consultation@ihs.gov); developing a Tribal Consultation website (under the Director's Blog); posting all letters to Tribal Leaders on the Director's Blog and electronically mailing them via list serves; conducting listening sessions in IHS Areas and meeting individually with Tribes; and, hosting listening sessions and meetings at National conferences (such as the National Congress of American Indians annual convention and the National Indian Health Board consumer conference).

Data Source: Routine IHS Tribal consultation documentation for HHS consultation report and IHS Director's Activities database

Also Supports: In addition to directly supporting HHS Strategic Plan, Goal 1, Objective 5, the Tribal consultation measure also supports Presidential Executive Order 13175; HHS Tribal Consultation Policy (2010); and the IHS Tribal Consultation Policy (2006).

Goal 1: Transform Health Care
Objective F: Promote the adoption and meaningful use of health information technology

1.F.1 Percent of eligible primary care professionals receiving meaningful use incentive payments.

The American Recovery and Reinvesment Act of 2009 (P.L. 111-5) created an incentive program to assist medical providers who serve Medicare and Medicaid patients in adopting electronic health records and becoming “meaningful users” of health IT. The incentive program provides payments between 2011 and 2021 to eligible providers that meet established criteria during each of the three stages of the meaningful use incentive payment program. To earn meaningful use incentive payments during stage 1, providers are required to use the electronic health record technology to:

- improve care coordination,
- reduce healthcare disparities,
- engage patients and their families,
- improve population and public health, and
- ensure adequate privacy and security.

The meaningful use incentive payment program is being implemented by the Centers for Medicare & Medicaid Services (CMS) through the Medicare and Medicaid programs and information about the payment of incentives is collected by CMS. This is a new measure and trend data is not currently available.

This is a new performance measure and does not yet have any trends associated with it.

Data Source: The CMS Meaningful Use Registration and Attestation System is the source of Meaningful Use incentive payment data. The number of eligible professionals is determined using the CMS OACT estimates.CMS Meaningful Use Registration and Attestation System

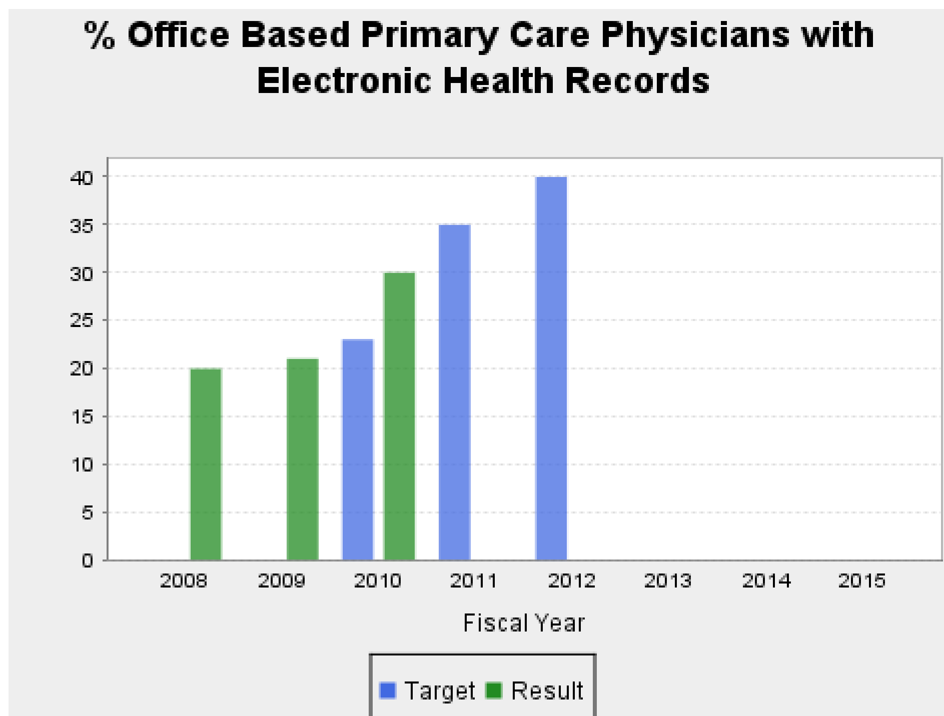
Also Supports: HHS Strategic Plan 1.D

1.F.2 Percent of office-based primary care physicians who have adopted electronic health records (basic).

"Adoption" of an electronic health record for this measure is defined as "basic" adoption as in DesRoches et al. 2008 in the New England Journal of Medicine article *Electronic Health Records in Ambulatory Care – A National Survey of Physicians*

Physicians are assessed to have adopted a "basic" electronic health record system when the main site of their practice includes a computerized system capable in the following areas: patient demographics, patient problem lists, electronic lists of medications taken by patients, clincal notes, orders for prescriptions, viewing laboratory results, and viewing imaging results.

The information for this measure is gathered in partnership between the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) and ONC. Each year since 2008, NCHS has included in its National Ambulatory Medical Care Survey (NAMCS) questions pertaining to electronich health record adoption.



Data Source: The information for this measure is gathered in partnership between the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) and ONC. Each year since 2008, NCHS has included in its National Ambulatory Medical Care Survey (NAMCS) questions pertaining to electronich health record adoption.

Also Supports: HHS Strategic Plan 1.D

Goal 2: Advance Scientific Knowledge and Innovation
Objective A: Accelerate the process of scientific discovery to improve patient care

2.A.1 By 2015, make freely available to researchers the results of 300 high-throughput biological assays screened against a library of 300,000 unique compounds, and the detailed information on the molecular probes that are developed through that screening process.

The Molecular Libraries Program (MLP) initiative established the Molecular Libraries Probe Production Centers Network (MLPCN) as a nationwide scientific resource to accelerate the discovery of small molecule probes for use in biological research. The MLP is expected to identify small molecules that can be optimized as chemical probes to study the functions of genes, cells, and biochemical pathways, leading to new ways to explore the functions of genes and signaling pathways in health and disease. The program also facilitates the development of new therapeutics by providing early stage chemical compounds that enable researchers in the public and private sectors to validate new drug targets or by serving as starting points that feed into a drug-discovery pipeline.

In FY 2010, the NIH exceeded its target by adding 98 new high-throughput screening (HTS) assays to the MLP portfolio, well above the target of adding 35 assays. As of October 1, 2010, the MLP has selected 490 HTS assays for entry into the MLPCN production pipeline in the program to date (2005-2010). The assay portfolio represents a wide range of biology related to various disease areas: cancer (28%), allergy and infectious diseases (24%), neuroscience (18%), general medical sciences (12%), diabetes/metabolic/endocrine (8%), heart/lung/blood (6%), other (4%). The HTS assay campaigns undertaken to date have led to more than 181 chemistry projects and generated 169 small molecule probes. The seven probes submitted during the fourth quarter of FY2010 are applicable to understanding disease mechanisms in the areas of neurological disorders, diabetes/metabolic/endocrine disorders, and cancer. The MLP has made the results of 117 HTS assays screened against 300,000 compounds in the central MLSMR freely available to researchers through PubChem, along with detailed information on the probes developed though the screening process.

Data Source: NIH Roadmap Molecular Libraries Program: http://mli.nih.gov/mli/mlp-overview/

Notice of Opportunity for Fast Track Entry of Assay Projects for High Throughput Screening into the NIH Roadmap Molecular Libraries Probe Production Centers Network
http://grants.nih.gov/grants/guide/notice-files/NOT-RM-09-011.html

Identification of Metabotropic Glutamate Receptor Subtype 5 Potentiators Using Virtual High-Throughput Screening. Mueller R, Rodriguez AL, Dawson ES, Butkiewicz M, Nguyen TT, Oleszkiewicz S, Bleckmann A, Weaver CD, Lindsley CW, Conn PJ, Meiler J. *ACS Chem Neurosci.* 2010 Apr 21;1(4):288-305. Epub 2010 Jan 28.
http://www.ncbi.nlm.nih.gov/pubmed/20414370

Synthesis and SAR of novel, 4-(phenylsulfamoyl)phenylacetamide mGlu4 positive allosteric modulators (PAMs) identified by functional high-throughput screening (HTS).
Engers DW, Gentry PR, Williams R, Bolinger JD, Weaver CD, Menon UN, Conn PJ, Lindsley

CW, Niswender CM, Hopkins CR. *Bioorg Med Chem Lett.* 2010 Sep 1;20(17):5175-8. Epub 2010 Jul 8. http://www.ncbi.nlm.nih.gov/pubmed/20667732

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A Novel and Specific NADPH Oxidase-1 (Nox1) Small-Molecule Inhibitor Blocks the Formation of Functional Invadopodia in Human Colon Cancer Cells. Gianni D, Taulet N, Zhang H, Dermardirossian C, Kister J, Martinez L, Roush WR, Brown SJ, Bokoch GM, Rosen H. *ACS Chem Biol.* 2010 Oct 15;5(10):981-93. http://www.ncbi.nlm.nih.gov/pubmed/20715845

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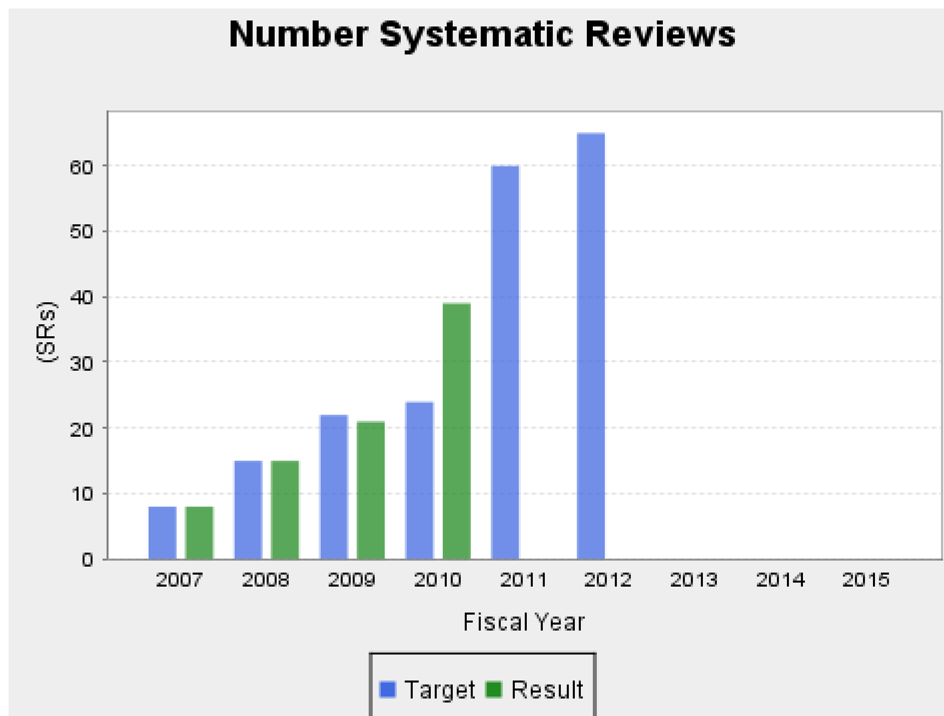
Identification of known drugs that act as inhibitors of NF-κB signaling and their mechanism of action. Miller, S.C., Huang, R., Sakamuru, S., Shukla, S.J., Attene-Ramos, M.S. Shinn, P., Van Leer, D., Leister, W., Austin, C.P., Xia, M. *Biochem Pharmacol,* 2010, 79:1272-1280. http://www.ncbi.nlm.nih.gov/pubmed/20067776

2.A.2.a Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers - Systematic Reviews (SR).

Systematic Reviews (SRs) - This measure captures one of the three products produced by the Effective Health Care (EHC) Program of the Agency for Healthcare Research and Quality. A systematic review is a critical assessment and evaluation of all research studies that address a particular clinical issue. The researchers use an organized method of locating, assembling, and evaluating a body of literature on a particular topic using a set of specific criteria. A systematic review typically includes a description of the findings of the collection of research studies.

In FY 2010, the EHC Program released 18 SRs bringing the cumulative number available to 39. This represents an increase from a cumulative total of 21SRs in FY 2009. In FY 2011, the EHC program has set a target of releasing an additional 21SRs, making the cumulative total 60 SRs.

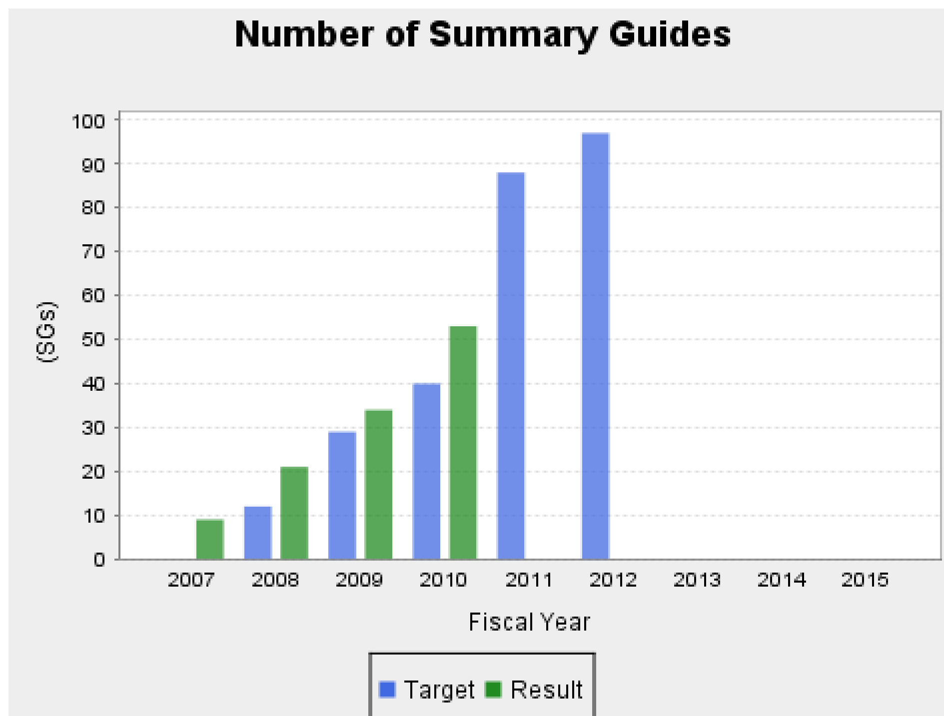


Data Source: All AHRQ systematic reviews are entered into a database, which is used to populate the AHRQ Effective Health Care Program Web site, http://effectivehealthcare.ahrq.gov/.

2.A.2.b Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers - Summary Guides (SG).

Summary Guides (SGs) - This measure captures one of the three products produced by the Effective Health Care (EHC) Program of the Agency for Healthcare Research and Quality. Summary Guides are short, plain-language guides that are tailored to consumers, patients, clinicians, or policymakers. These guides summarize research reviews' findings on the benefits and harms of different treatment options. Consumer guides provide useful background on health conditions. The guides on medications also contain basic wholesale price information.

In FY 2010, the EHC Program released 19 SGs bringing the cumulative number available to 53. This represents an increase from a cumulative total of 34 SGs in FY 2009. In FY 2011, the EHC program has set a target of releasing an additional 35 SGs, making the cumulative total 88 SGs.

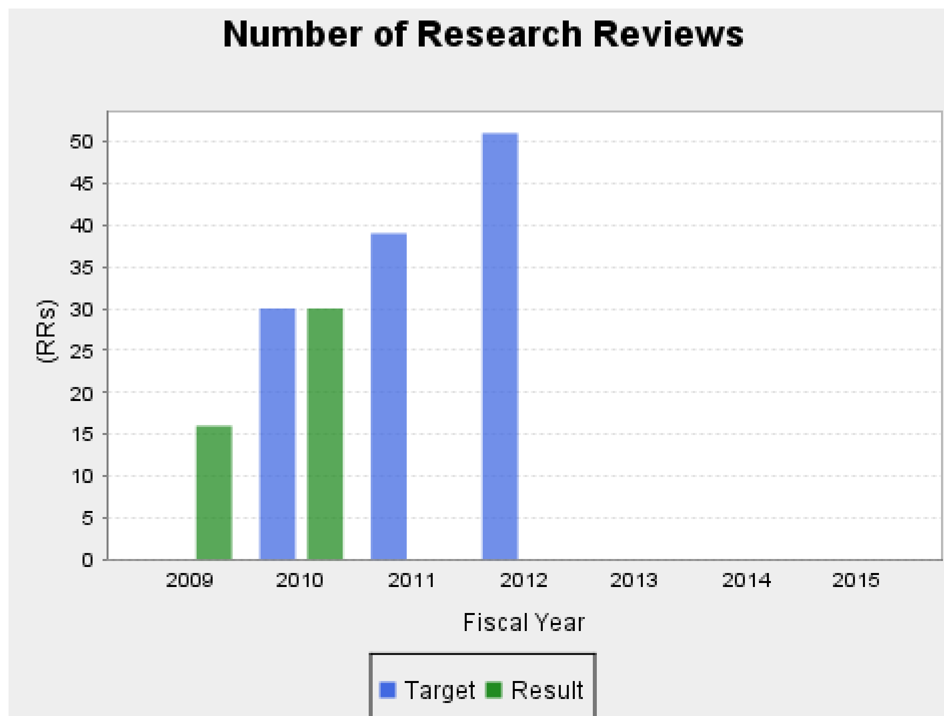


Data Source: All AHRQ summary guides are entered into a database, which is used to populate the AHRQ Effective Health Care Program Web site, http://effectivehealthcare.ahrq.gov/.

2.A.2.c Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers - Effective Health Care Research Reports (RRs).

Research Reviews (RRs) - This measure captures one of the three products produced by the Effective Health Care (EHC) Program of the Agency for Healthcare Research and Quality. Research reviews are the reports that result from research studies conducted by the AHRQ DEcIDE Network research centers and include research studies, white papers, technical documents, and DataPoints. These original research reports summarize studies on the outcomes, effectiveness, safety, and usefulness of medical treatments and services.

In FY 2009, the EHC added 16 Research Reviews to the list of products. An additional 14 RRs were released in FY 2010. In FY 2011, the program has set a target of releasing an additional 9 RRs, making the cumulative total 39 RRs.



Data Source: All AHRQ research reports are entered into a database, which is used to populate the AHRQ Effective Health Care Program Web site, http://effectivehealthcare.ahrq.gov/.

2.A.3 By 2015, identify and characterize two molecular pathways of potential clinical significance that may serve as the basis for discovering new medications for preventing and treating asthma exacerbations.

Asthma exacerbations (often called asthma attacks) are a significant cause of morbidity in patients with asthma and represent a significant public health burden. However, not all asthma patients are equally susceptible to them. In order to ensure more effective treatment of those patients who are prone to exacerbations, markers are needed that are associated with their phenotypes and/or sub-phenotypes. Having such markers will aid investigators in their efforts to develop mechanism-based treatments that can be successfully targeted to responsive patient sub-groups.

In FY 2010 NIH met its target of describing the phenotypic characteristics of a group of asthma patients prone to exacerbations. Researchers were able to conduct non-invasive investigations of the association of the ABO glycan phenotype of mucins that are associated with ABO antigens in saliva and ABO blood type in peripheral blood with risk for asthma exacerbations. Using this approach, investigators determined that the O-secretor mucin glycan phenotype is associated with a significant increase in the risk for severe asthma exacerbations.

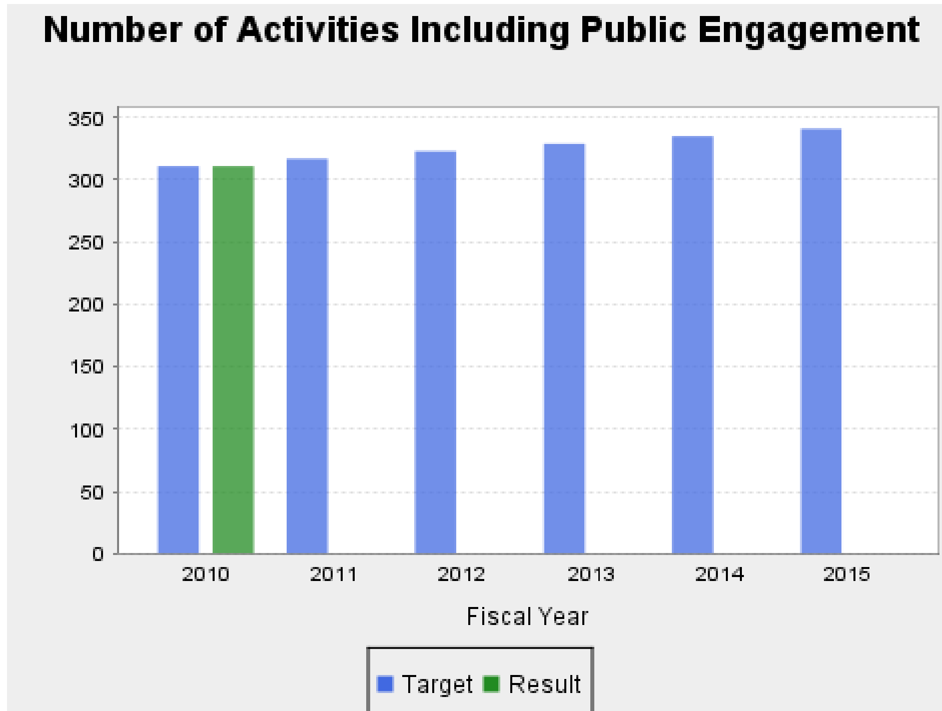
Data Source: Anh L Innes, Kelly Wong McGrath, Ryan H Dougherty, Charles E McCulloch, Prescott G Woodruff, Max A Seibold, Kimberly S Okamoto, Kelsey J Ingmundson, Margaret C Solon, Stephen D Carrington, and John V Fahy **The H Antigen at Epithelial Surfaces is Associated with Susceptibility to Asthma Exacerbation**
Am. J. Respir. Crit. Care Med., Aug 2010; doi:10.1164/rccm.201003-0488OC http://www.ncbi.nlm.nih.gov/pubmed/20732988

Goal 2: Advance Scientific Knowledge and Innovation
Objective B: Foster innovation at HHS to create shared solutions

2.B.1 Increase number of the identify opportunities for public engagement and collaboration among agencies.

Enhancing opportunities for public participation and collaboration in HHS activities is a key priority for the HHS Open Government efforts. It is widely understood that to effectively deliver on our mission, we must leverage the collective creativity and wisdom of our stakeholders. Federal Advisory Committees are one key way of ensuring public and expert involvement and advice in Federal decision-making. Other opportunities include mechanisms such as feedback websites and listening sessions. This quantitative measure is a combined summary of all identified opportunities made available to the public on our "Get Involved" page at http://www.hhs.gov/open/getinvolved/index.html

This is a new performance measure which consolidates HHS's participation and collaboration opportunities into a centralized, updated web-accessible location. Thus, it is difficult assess trends beyond the past year (which is the baseline). However, based on comments received through the HHS blog on the HHS Open Government website, and basic web analytics such as on-line inputs it appears that HHS's efforts are increasing visibility of participation and collaboration opportunities. As the HHS Innovation Council assists HHS in understanding the tools it can use to enhance public participation and collaboration, we should expect to see additional public engagement and collaboration opportunities identified in the future.



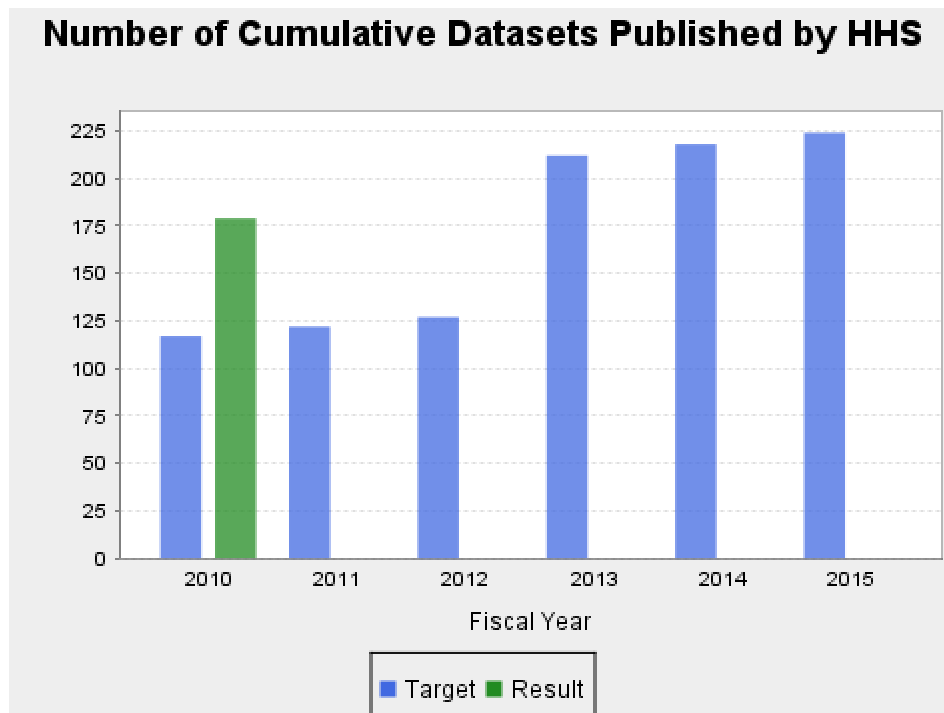
Data Source: "Get Involved" website http://www.hhs.gov/open/getinvolved/index.html

Also Supports: HHS Strategic Plan 4.C and Open Government Plan

2.B.2 Increase number of high-value data sets and tools that are published by HHS.

A high priority for the HHS Open Government Plan is to make HHS data more available to the public. The HHS Data Council is working with the CIO Council to enhance opportunities for publishing data and tools. This information can be used to increase agency accountability and responsiveness, improve public knowledge of the agency and its operations, further the core mission of the agency, create economic opportunity, or respond to need and demand as identified through public consultation. In addition, these data sets can be used by researchers and analysts to add knowledge and understanding to existing health and human service issues. This quantitative measure is based on real time submissions posted at http://www.healthdata.gov.

This is a new performance measure. In CY2010, HHS published 103 datasets bringing the total number of datasets to 179. These results, which exceeded initial projections, were the result of the high quality datasets developed and maintained by HHS agencies; and of HHS Data Council and HHS chief Technology Officer's outreach efforts to the HHS community and review of potential submissions.



Data Source: www.healthdata.gov

Also Supports: HHS Strategic Plan 4.C and Open Government Plan

2.B.3 Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice.

Developing new types of effective collaboration and participation initiatives at HHS may involve additional expertise above and beyond the capacities of current personnel. Thus, HHS's approach to broadening use of participation and collaboration tools across HHS is to engage specific high-impact projects with a consulting team. The consulting team, which is comprised of key staff associated with the HHS Innovation Council, is available to provide guidance and technical expertise to agencies to a select number of agencies each year. This quantitative measure consists of the major consulting projects undertaken by the consulting team associated with the innovations community of practice.

This is a new performance measure. The six projects in which the consulting team undertook in CY2010 included: 1) OS: Paperwork Reduction Act information collection request workflow analysis; 2) NIH Office of Technology Transfer: develop a Web 2.0 tool-enabled website improve marketing; 3) FDA Center for Tobacco Products: mobile phone quiz contest on the new tobacco regulations; 4) Office of the Executive Secretary correspondence management reengineering; 5) HHS: HHS*innovates* web tool development and implementation; and 6) HHS: healthdata.gov design and deployment. Moving forward, it is expected that the proliferation of new web-based tools will increase collaboration activities across the Department; moreover, new authorities granted to federal agencies to engage in prize and challenge contests under the America COMPETES Act of 2010 should increase uptake of these consulting services.

Data Source: HHS Innovation Council Administrative records

Also Supports: HHS Strategic goal 4.C and Open Government Plan

Goal 2: Advance Scientific Knowledge and Innovation
Objective C: Invest in the regulatory sciences to improve food and medical product safety

2.C.1 Promote innovation and predictability in the development of safe and effective nanotechnology-based products by establishing scientific standards and evaluation frameworks to guide nanotechnology-related regulatory decisions.

For the FDA, a science-based regulatory agency whose mission is to protect and promote public health, nanotechnology poses regulatory challenges that are inherent in emerging technologies. Like many emerging technologies, there is the potential benefit that nanotechnology can bring to food, medicine, and other FDA-regulated product areas, but the risks to human and animal health are not yet completely identified or understood. Establishing scientific standards and evaluation frameworks to guide nanotechnology-related regulatory decisions will promote innovation and predictability in the development of safe and effective nanotechnology-based products.

In February 2010, the FDA Nanotechnology Task Force developed and published the agency's FY 2011 regulatory science research plan for nanotechnology that enables regulatory science studies relevant for the development of safe and effective nanotechnology-based products (http://www.nano.gov/NNI_2011_budget_supplement.pdf). The Task Force presented the agency's FY 2011 research plan to the Science Board in a public forum in August 2010, and solicited comments from the Science Board and the public. The Science Board concurred with FDA's FY 2011 research plan, including supporting studies such as those described above for the responsible development of nanotechnology. In FY 2011, FDA plans to implement its proposed regulatory science research plan for nanotechnology, including developing the CORES (Collaborative Opportunities for Research Excellence in Science) Program to support studies that can serve as a platform for the targets above, building laboratory capacity to assess nanotechnology products, and investing in training and staff development in the area of nanotechnology.

Goal 2: Advance Scientific Knowledge and Innovation
Objective D: Increase our understanding of what works in public health and human service practice

2.D.1 Increase the number of annual Community Guide reviews.

Community Guide systematic review findings form the basis for evidence-based recommendations about effective programs and policies designed to improve health and promote safety at the community level. This measure tracks the number of annual *Community Guide* reviews for which the CDC Task Force on Community Preventive Services issues one or more findings or recommendations.

In FY 2007, four *Community Guide* reviews were completed; in FY 2008, 20; and in FY 2009, 10. In FY 2010, the *Community Guide* completed 18 reviews. The FY 10 actual reported number for Community Guide reviews was much higher than the FY 10 target because there were an unusually large number of updated reviews.

The actual number of reviews initiated and completed by the *Community Guide* varies from year to year and is affected by several factors: the number of available trained and qualified scientific staff; the complexity of the specific review; the amount of scientific evidence available; whether the review is a new review or an update of an existing review; and availability of funding

Data Source: The Guide to Community Preventive Services (Community Guide) Project Management System

Also Supports: HHS Strategic Plan 4.C

Goal 3: Advance the Health, Safety and Well-Being of the American People
Objective A: Ensure the safety, well-being, and healthy development of children and youth

3.A.1 Quality of Early Childhood Education.

This indicator supports the following Administration for Children and Families (ACF) High Priority Performance Goal: Take actions in 2010 and 2011 to strengthen the quality of early childhood programs by advancing recompetition, implementing improved performance standards and improving training and technical assistance systems in Head Start; promoting community efforts to integrate early childhood services; and by expanding the number of States with Quality Rating and Improvement Systems that meet high quality benchmarks for child care and other early childhood programs developed by HHS in coordination with the Department of Education.

ACF is also on track to achieve this goal and the related milestones.

Head Start: On September 21, 2010, ACF published a Notice of Proposed Rulemaking on a system of designation renewal that would determine if Head Start and Early Head Start agencies are delivering high-quality and comprehensive programs. The proposed rule requires that grantees determined not to be providing high quality services compete with other eligible local applicants, ensuring that the provider best qualified to provide high quality services is the Head Start and/or Early Head Start grantee in that community.

Also on September 21, 2010, ACF announced the awarding of funds for four National Training and Technical Assistance Centers (per cooperative agreement). For additional detail, see: http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/Initiatives/roadmap/HHS_Announces_National_Centers.pdf. These four centers are as follows:

- The National Center on Cultural and Linguistic Responsiveness: http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-OHS-HC-0090
- The National Center on Parent, Family, and Community Engagement: http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-OHS-HC-0087
- The National Center on Program Management and Fiscal Operations: http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-OHS-HC-0088
- The National Center on Quality Teaching and Learning: http://www.acf.hhs.gov/grants/open/foa/view/HHS-2010-ACF-OHS-HC-0089

Child Care: With respect to the Child Care quality initiatives, on-line access is now available to a Quality Rating and Improvement Systems (QRIS) Resource Guide at http://nccic.acf.hhs.gov/qrisresourceguide and to an interactive Cost Estimation Model at http://qriscostmodel.nccic.acf.hhs.gov. In addition, a link to a compendium of research through the Office of Planning, Research and Evaluation, as well as other QRIS research and resources is available at http://nccic.acf.hhs.gov/poptopics/qris_resources.html.

From July through September (2010), progress on quality initiatives included three webinars with State Administrators and national organizations to gather and share information on developing benchmarks in the framework of QRIS. These webinars, in conjunction with information from the national meeting held in June, formed the basis for work that is now underway in the Office of Child Care to develop the high quality benchmarks. This work is being coordinated with a proposed revision to the Child Care Development Fund (CCDF) State Plan and new Quality Performance Report that includes data collection on quality measures, and was released for public comment in September.

Data Source: Head Start: Office of Head Start Monitoring Reviews

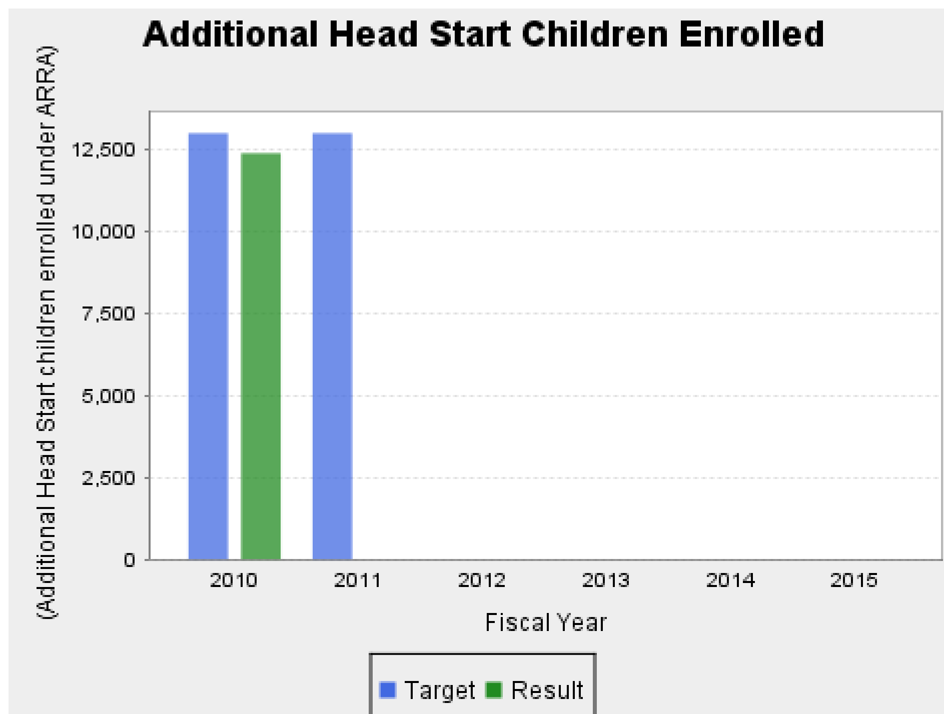
Child Care: Quality Rating and Improvement Systems (QRIS) data from state submissions to the Office of Child Care.

Also Supports: This measure supports HHS Strategic Plan Objective 3A: Ensure the safety, well-being, resilience, and healthy development of children and youth. This measure also supports the Secretary's Priority "Promote Early Childhood Health and Development." This measure is part of the ACF High Priority Performance Goal "Quality of Early Childhood Education," and is related to a second ACF High Priority Performance Goal, "Access to Early Childhood Education."

3.A.2.a Head Start Enrollment.

This indicator supports the following Administration for Children and Families (ACF) High Priority Performance Goal: By the end of 2010, increase the number of low-income children receiving federal support for access to high quality early care and education settings including an additional 61,000 children in Head Start and Early Head Start and an average of 10,000 additional children per month through the Child Care and Development Fund (CCDF) over the number of children who were enrolled in 2008.

As of December 30, 2010, a total of 58,302 total additional Head Start and Early Head Start children were enrolled as a result of American Recovery and Reinvestment Act (Recovery Act) funds. The Early Head Start total was 45,435, and the Head Start total was 12,867. ACF is confident we will achieve the overall goal of 61,000 total additional slots because the Office of Head Start (OHS) has already funded this number of slots. Part of the shortfall to date may be attributed to the difficulties faced by Recovery Act expansion grantees to enroll and serve children on the originally projected timeline. These difficulties include delays in licensing or in renovating facilities, or problems securing alternate space when facilities fall through. Some grantees encountered difficulties in switching to a home-based option on an interim basis until the proposed center-based program is fully operational. OHS is working extensively with these grantees to provide technical assistance to get on track.



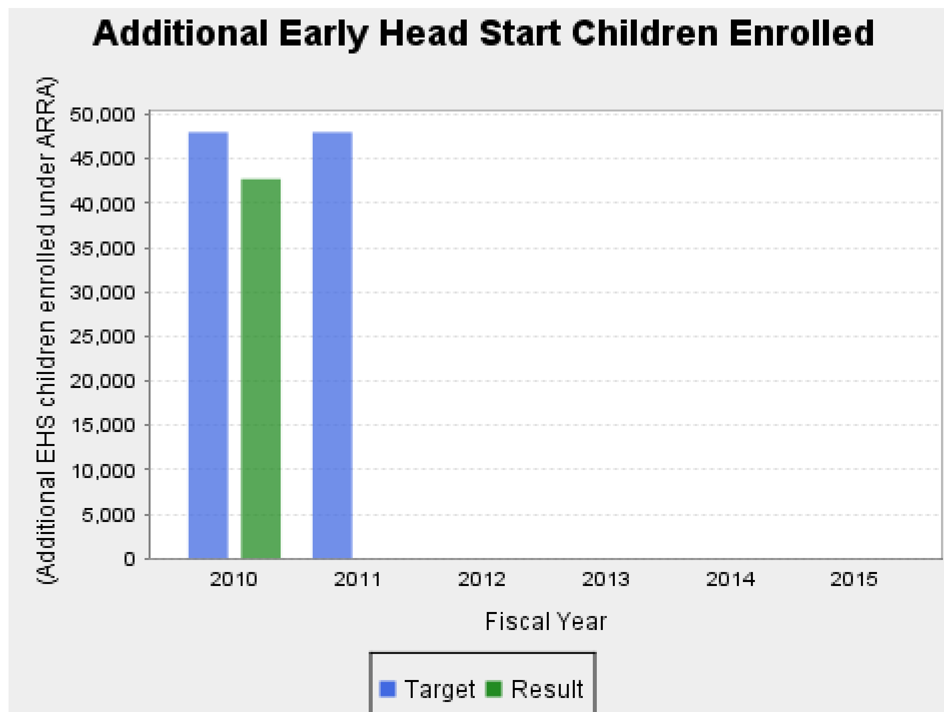
Data Source: The Head Start Enterprise System and Office of Child Care Information System state monthly case-level administrative data report (ACF-801).

Also Supports: HHS Strategic Plan Objective 3A. This measure also supports the Secretary's Priority "Promote Early Childhood Health and Development." This measure is part of the ACF High Priority Performance Goal "Access to Early Childhood Education", and is related to a second ACF High Priority Performance Goal, "Quality of Early Childhood Education."

3.A.2.b Early Head Start Enrollment.

This indicator supports the following ACF High Priority Performance Goal: By the end of 2010, increase the number of low-income children receiving federal support for access to high quality early care and education settings including an additional 61,000 children in Head Start and Early Head Start and an average of 10,000 additional children per month through the Child Care and Development Fund (CCDF) over the number of children who were enrolled in 2008.

As of December 30, 2010, a total of 58,302 total additional Head Start and Early Head Start children were enrolled as a result of American Recovery and Reinvestment Act (Recovery Act) funds. The Early Head Start total was 45,435, and the Head Start total was 12,867. ACF is confident we will achieve the overall goal of 61,000 total additional slots because the Office of Head Start (OHS) has already funded this number of slots. Part of the shortfall to date may be attributed to the difficulties faced by Recovery Act expansion grantees to enroll and serve children on the originally projected timeline. These difficulties include delays in licensing or in renovating facilities, or problems securing alternate space when facilities fall through. Some grantees encountered difficulties in switching to a home-based option on an interim basis until the proposed center-based program is fully operational. OHS is working extensively with these grantees to provide technical assistance to get on track.



Data Source: The Head Start Enterprise System and Office of Child Care Information System state monthly case-level administrative data report (ACF-801).

Also Supports: This measure supports HHS Strategic Plan Objective 3A. This measure also supports the Secretary's Priority "Promote Early Childhood Health and Development" AND is part of the ACF High Priority Performance Goal "Access to Early Childhood Education."

3.A.2.d Increase Child Care Enrollment.

This indicator supports the following ACF High Priority Performance Goal: By the end of 2010, increase the number of low-income children receiving federal support for access to high quality early care and education settings including an additional 61,000 children in Head Start and Early Head Start and an average of 10,000 additional children per month through the Child Care and Development Fund (CCDF) over the number of children who were enrolled in 2008.

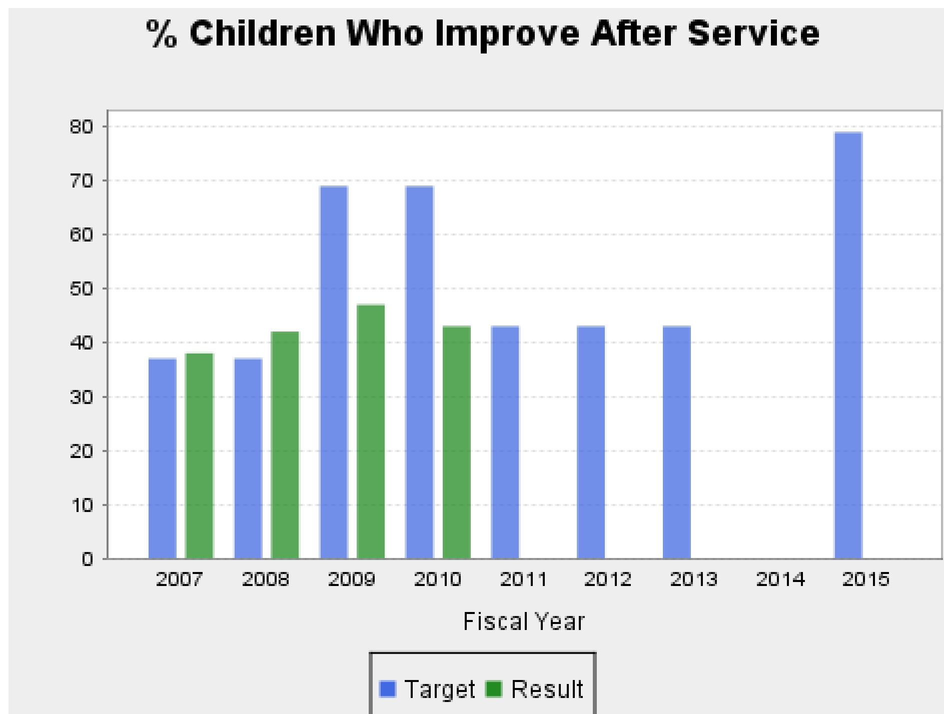
Data on the number of children served by the CCDF program is available on an annual basis only. The $2 billion in child care funding made available by the Recovery Act is allowing states to maintain services to thousands of families who would not otherwise have been served. We expect these services to be reflected in the data once it is available. Furthermore, quarterly data reported by states on the CCDF expenditure reports (ACF-696) and the government-wide 1512 reports confirm state progress. Based on information from the expenditure reports, through September 30, 2010, states had spent enough Recovery Act child care funds on direct services to support child care services for an estimated 252,000 children.

Also Supports: This measure supports HHS Strategic Plan Objective 3A: Ensure the safety, well-being, resilience, and healthy development of children and youth. This measure also supports the Secretary's Priority "Promote Early Childhood Health and Development." This measure is part of the ACF High Priority Performance Goal "Access to Early Childhood Education", and is related to a second ACF High Priority Performance Goal, "Quality of Early Childhood Education."

3.A.3 Percentage of children receiving services showing clinically significant improvement.

SAMHSA is refining and beginning the implementation of its Strategic Initiative on Trauma and Justice. This includes a number of steps to improve its approach to violence and trauma, but one of the key programs of focus is the National Child Traumatic Stress Initiative. This program is ongoing and is being used as a proxy measure for the success of this initiative. It represents a critical outlet to develop, test, and implement evidence-based practices in trauma-related care for children.

Based on the latest available data from FY 2010, SAMHSA has made strong progress towards the goal of addressing trauma and violence based on this chosen proxy measure. There has been substantial improvement in the percentage of children showing clinically significant improvement as a result of the services provided by the National Child Traumatic Stress Initiative (NCTSI) in recent years. Since FY 2007, the program has had (approximately 10%) notable increases in the data recorded. This shows that this program is working in the communities that it serves and therefore is improving the outcomes for children with trauma-related mental health issues.



Data Source:
TRAC on-line data reporting and collection system.

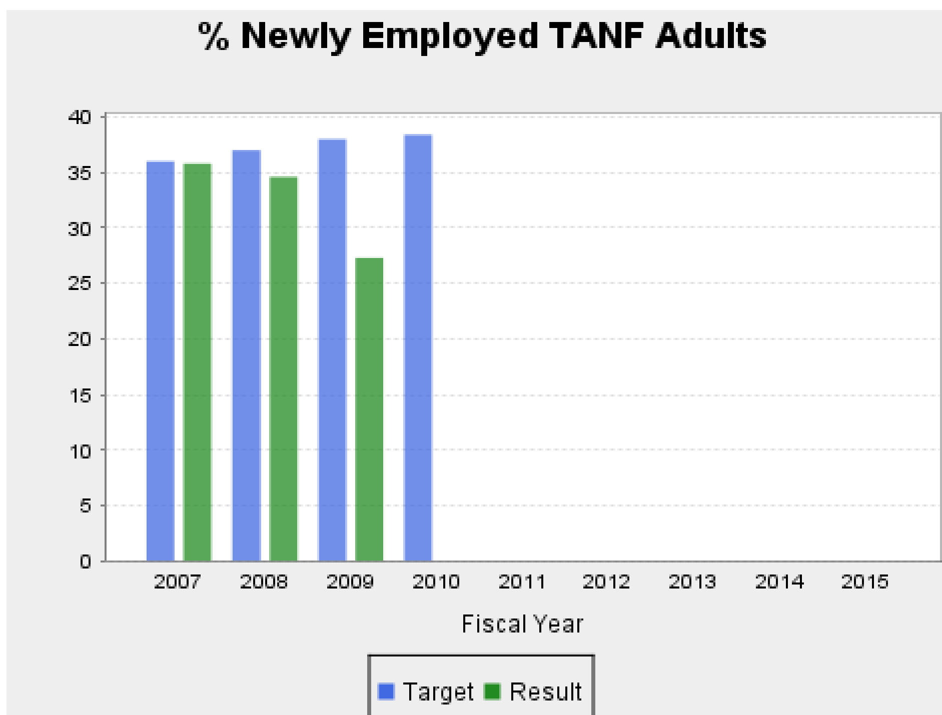
Also Supports: HHS Strategic Plan 2.D; 3.A

Goal 3: Advance the Health, Safety and Well-Being of the American People
Objective B: Promote economic and social well-being for individuals, families and communities

3.B.1 Increase the percentage of adult TANF recipients who become newly employed.

In FY 2009, 27.3 percent of TANF recipients became newly employed. States continue to help TANF adult recipients enter employment, and these efforts have been augmented by other factors including the employment focus of Personal Responsibility and Work Opportunity Act, ACF's commitment to finding innovative and effective employment tools through research, and the identification and dissemination of information on the effects of alternative employment strategies and a range of targeted technical assistance efforts. While these approaches have been helpful in the past, it is now clear how much the weak economy has affected performance on this measure.

Strategic plan measure 3.B.1 has the goal of increasing the rate in FY 2015 by 1.9 percentage points above the FY 2009 actual result. New targets for fiscal years 2006 and 2007 were established during the program assessment in CY 2005. The TANF regulations resulting from DRA defined each of the countable work activities for the first time. However, the employment entry rate for TANF recipients fell in 2008 and 2009, and in light of the challenging labor market in many states, ACF anticipates that it will be difficult to meet our goal of increasing the number of adult TANF recipients that enter the workforce.



Data Source: National Directory of New Hires (NDNH)

Also Supports: HHS Strategic Plan 3.B, Promote economic and social well-being for individuals, families, and communities.

3.B.2 Maintain the IV-D (child support) collection rate for current support.

The collection rate for current child support (Strategic Plan measure 3.B.2), an important proxy for the regular and timely payment of support, compares total dollars collected for current support in IV-D cases with total dollars owed for current support in IV-D cases. Over the past ten years, the child support program has nearly doubled the amount of total distributed collections, going from $14.3B in FY 1998 to $26.6B in FY 2008—an increase of more than 85 percent. Fiscal year 2009 data suggest that outcomes in this area weakened, most likely as a result of the slow economic recovery. The total amount of child support distributed as current support in FY 2009 was $20 billion, an increase of 2.4 percent over FY 2008 as compared to a 3.3 percent increase the previous year. The total amount of current support due in FY 2009 was over $32 billion. This provided a collection rate for current support of 62 percent, which met the target of 62 percent for FY 2009.

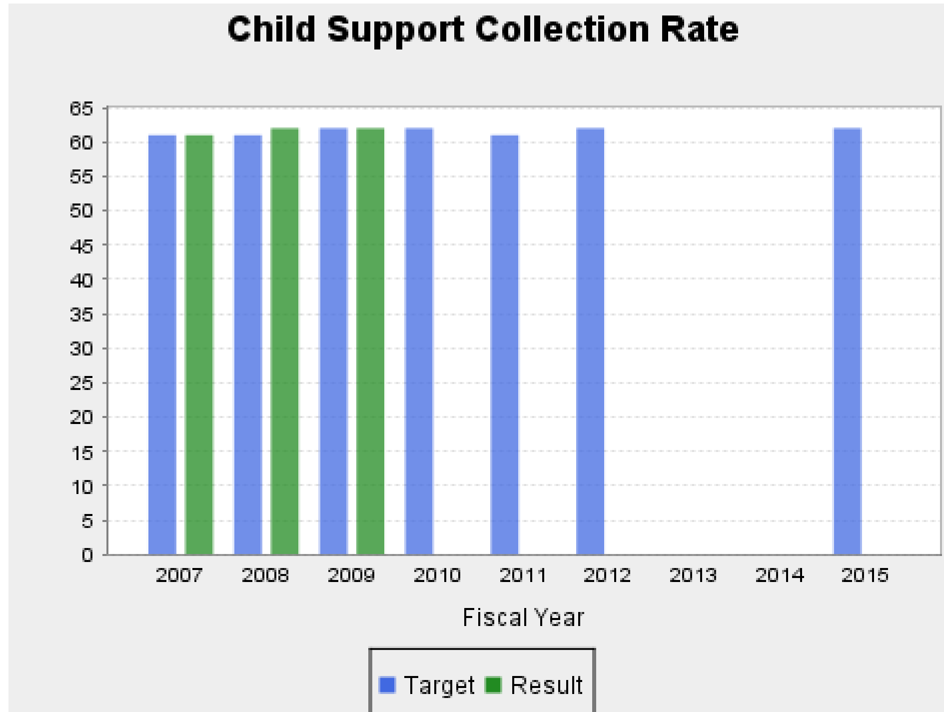
The percent collection rate target for FY 2010 will remain at 62 percent. The ACF Office of Child Support Enforcement (OCSE) recently reduced the target for FY 2011 to 61 percent due to the dampening outlook for future performance increases; the target for FY 2012 is set to increase back to 62 percent in anticipation of a slight improvement in economic conditions. However, the pace of the recovery is still unknown. As a result, we will annually re-evaluate our targets and the progress we are making to meet them.

In light of the current economic climate, the program anticipates potential decreases in the collection rate due to rising levels of non-custodial parent unemployment as well as current state budget constraints. OCSE also expects that the Deficit Reduction Act (DRA) funding cuts will result in reduced current support collections compared to previous years. The Congressional Budget Office also estimates that the DRA cuts will lead to lower collections. OCSE continues to work to eliminate the gap between the current support collection target and the actual performance by working with parents to ensure that they have the tools and resources they need to provide for their children, focusing on new and improved enforcement techniques, and preventing and addressing accumulated child support debt.

The Project to Avoid Increasing Delinquencies (PAID) initiative was launched in 2007 to focus on activities that result in increasing collections of current support and reducing arrears. In support of measure 20C and its improvement in 2009, PAID continued to produce projects that influence child support payments. PAID activities include:

- Focusing federal technical assistance on efforts that address root causes of nonpayment of support (e.g., establishing appropriate orders and early intervention upon nonpayment).
- Capitalizing on states' best practices through training, technical assistance, and cross-regional meetings.
- Increasing awareness and encouraging use of data findings in program and policy decisions.

- Targeting automation opportunities such as electronic Income Withholding Orders (e-IWO), Level of Automation Guidance through technical assistance site visits, and other outreach efforts.



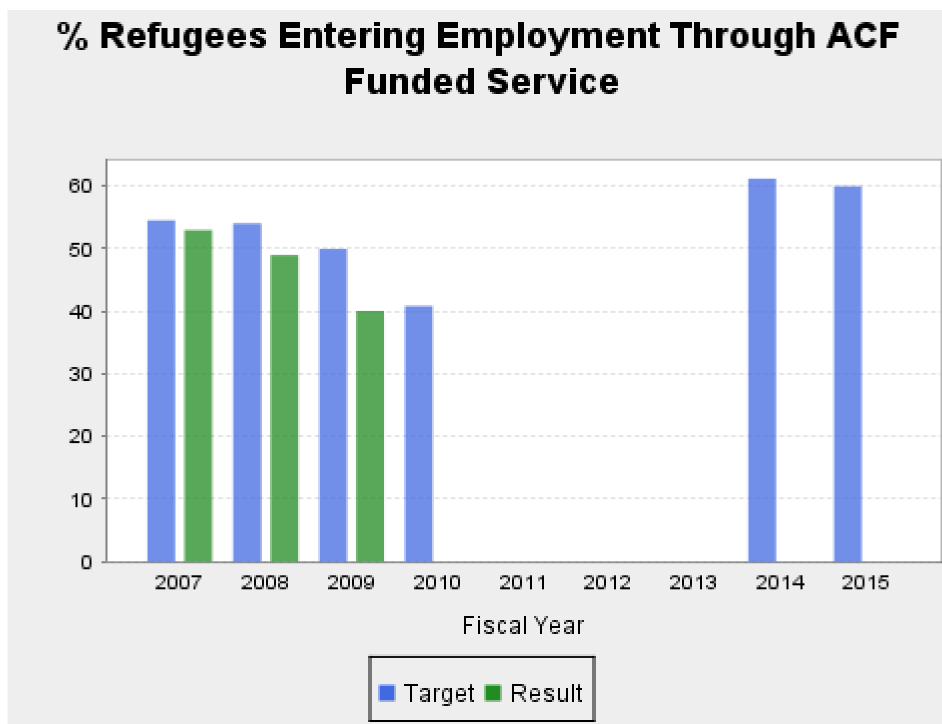
Data Source: Office of Child Support Enforcement (OCSE) Form 157

Also Supports: HHS Strategic Plan 3.B, promote economic and social well-being for individuals, families, and communities.

3.B.3 Increase the percentage of refugees entering employment through ACF-funded refugee employment services.

Strategic plan measure 3.B.3 reflects the emphasis of the ACF Office of Refugee Resettlement (ORR) on improving grantees' ability to assist refugees in entering employment. States (including states providing services under the Wilson-Fish program) with an entered employment rate (EER) of less than 50 percent are expected to achieve an annual increase of at least five percent over the prior year's actual percentage outcome. States with an EER greater than 50 percent are expected to achieve an annual increase of at least three percent over the prior year's performance. States that reach a high employment and self-sufficiency rate of 85 percent among employable refugees may choose to maintain their target levels rather than increase them. Although there are no monetary punishments or rewards, ORR has implemented a number of strategies and incentives aimed at challenging states to improve performance for targets that were not achieved. ORR publishes state performance results in the Annual Report to Congress and ORR teams negotiate the targets and provide technical assistance and monitoring to the states to achieve mutually acceptable goals.

In FY 2009, the result fell short of the target of 49.98 percent, with an actual result of 40.07 percent. ORR faces many challenges in terms of performance for this measure given the changing demographics of the U.S. Resettlement Program, as many populations require extended employment services in order to enter the U.S. labor market and integrate into U.S. society. Many recent arrivals have spent protracted periods of time in refugee camps in countries of first asylum, have experienced intense trauma, and have limited work skills. By FY 2015, the program aims to continue to increase performance to 60 percent by improving ORR's collaboration with states and Wilson-Fish agencies to better communicate ORR priorities and to share knowledge of best practices that can be transferred across programs. This endeavor includes increasing ORR monitoring activities in which program challenges are followed up with technical assistance and further monitoring. ORR is also intending to work more closely with technical assistance providers to ensure effective guidance to states and Wilson-Fish agencies. ORR plans to work with states and Wilson-Fish agencies to improve data collection procedures and reporting processes.



Data Source: Performance Report (Form ORR-6)

Also Supports: HHS Strategic Plan Objective 3.B.

Goal 3: Advance the Health, Safety and Well-Being of the American People
Objective C: Improve the accessibility and quality of supportive services for people with disabilities and older adults

3.C.1 Increase the number of individuals enrolled in CLASS.

The Community Living Assistance Services and Supports Act (CLASS) is a self-funded, voluntary insurance program. Participants pay in premiums and those who meet benefit eligibility requirements can receive a cash benefit to purchase long-term services and supports. Based on estimates from the Congressional Budget Office, an expected 7.7 million individuals will sign up in 2015.

NOTE: This output target is derived from the Congressional Budget Office's estimates prior to the passage of the Affordable Care Act. This measure is subject to change based on the actuarial projections that accompanies the benefit plan designed by the Secretary.

CLASS is in development, there are no results currently available.

Data Source: CLASS enrollment software.

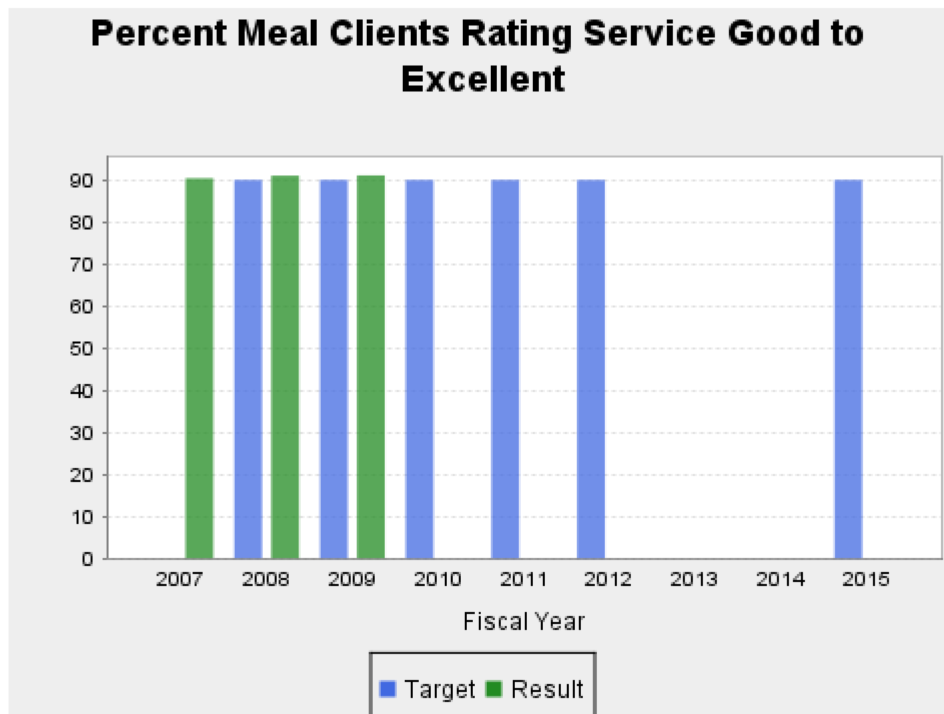
Also Supports: HHS strategic plan goals 1.A and 3.B.

3.C.2.a Maintain at least 90% of Older Americans Act clients from selected home and community based services who rate services "good" to "excellent

90% of home delivered meal clients rate services good to excellent.

The Administration on Aging (AoA) funds home delivered meals for elderly individuals who are too ill or too frail to be able to prepare their own meals. Obtaining adequate nutrition is key to recovery from recent illness or hospitalization, and is important in managing chronic conditions including diabetes and heart disease. Nearly 40% of home delivered meal clients have 3 or more Activity of Daily Living (ADL) limitations, the same level of disability that is required for nursing home placement. Eighty three percent of service participants report that the meals help them remain at home and live independently in the community. This measure documents client reported quality and is part of a set of measures which also include assuring targeting services to those most in need and measuring program efficiency.

For the past four years 90% or more of the clients have reported the quality of the service was good to excellent. The Aging Services network is committed to continuing this positive trend in the future.



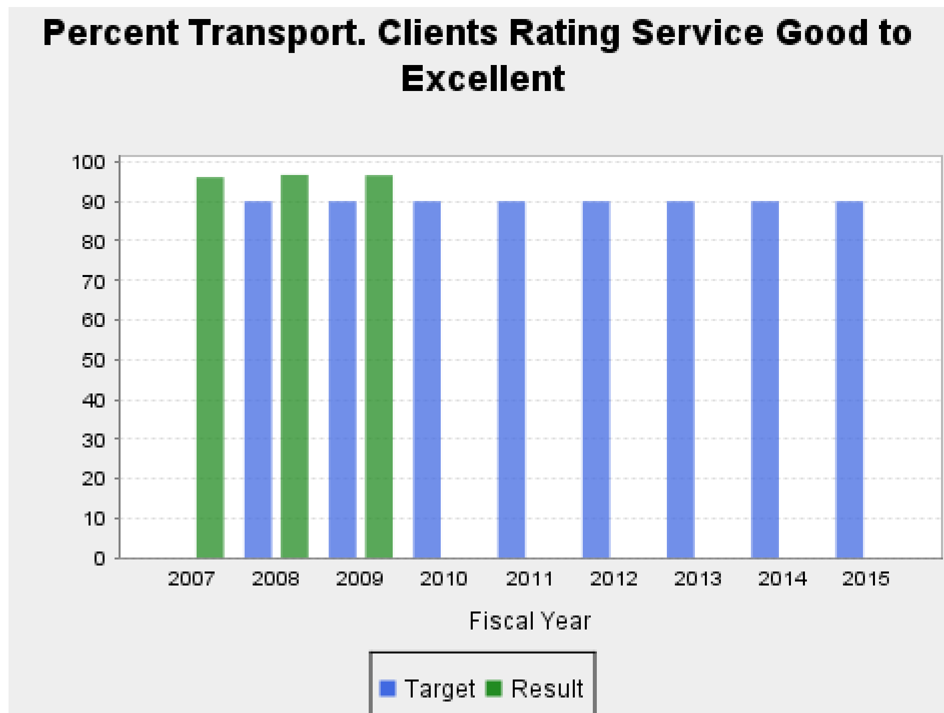
Data Source: National Survey

Also Supports: HHS measures 1.C; 1.E; and 3.B

3.C.2.b 90% of transportation clients rate services good to excellent.

The Administration on Aging (AoA) funds transportation services for elderly individuals who have mobility challenges including those who are no longer able to drive their own car or who don't have access to public transportation. Being able to get to doctors appointments, grocery stores, senior centers, and other locations enables seniors to continue to be active and engaged in their community. More than 65% of senior transportation users indicated that they use this transportation services to get to their doctor or medical appointments; more than 50% of senior transportation users say that they use the transportation service for the majority of their trips in a month. Client reported quality of the transportation service is key to enabling seniors to remain not only in their own home, but to be able to get out, go to appointments so they can remain healthy and connected to their community.

Client reported quality of service has been consistently high, above 90%, for several years. The Administration on Aging is committed to continuing high quality service in the future. In addition to the general high rating, several specific indicators related to performance quality are consistently above 90%. In the most recent survey of participants 92.5% said they were always or usually picked up on time; 97.5% said that their driver was always or usually polite; 94.6% said that they always or usually arrived on time; 92% said that the transportation service always or usually gets them where they need to go.



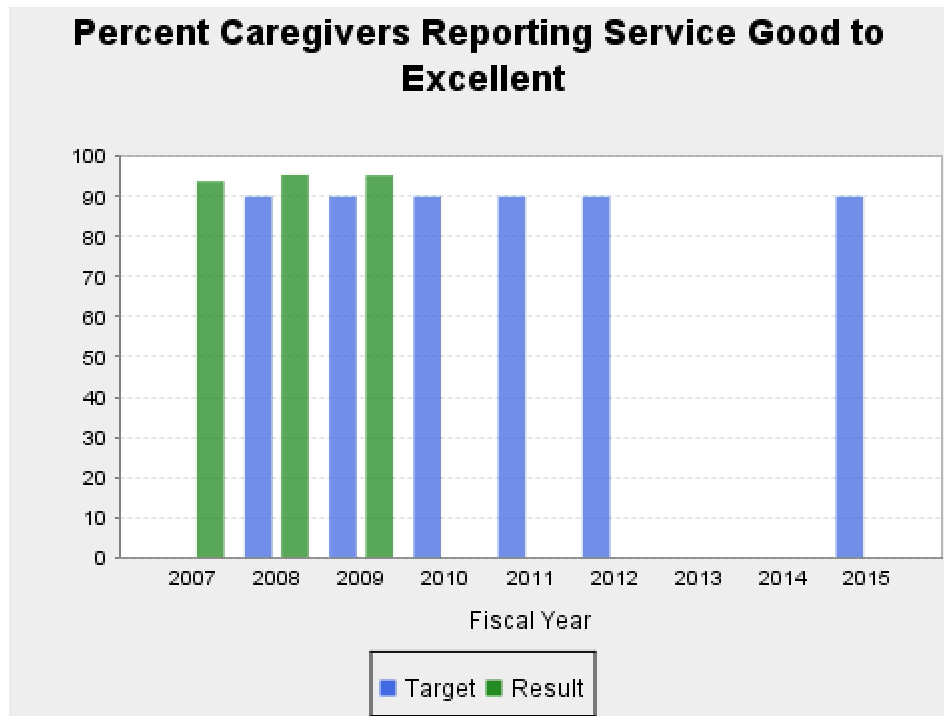
Data Source: National Survey of Older Americans Act Service Receipients

Also Supports: HHS 1.C; I.E; 3B

3.C.2.c 90% of NFCSP clients rate services good to excellent.

The Adminsitration on Aging (AoA) National Family Caregiver Support Program (NFCSP) enables family members who have a loved one with disabilities or conditions which require assistance to use an array of supportive services including: respite care, information and assistance, support groups, and training. Caregivers are frequently are under substantial strain with the responsiblities of caregiving their ill relative while also caring for children or other family members while employed. A random sample of caregivers are surveyed to report on the quality and impact of service. This measure is part of a set of measures which also include assuring targeting services to those most in need and tracking program efficiency.

For the past four years 90% or more of caregivers have reported the quality of the service was good to excellent. The Aging Services netowk is committed ton continuing this positive trend in the future.



Data Source: National Survey

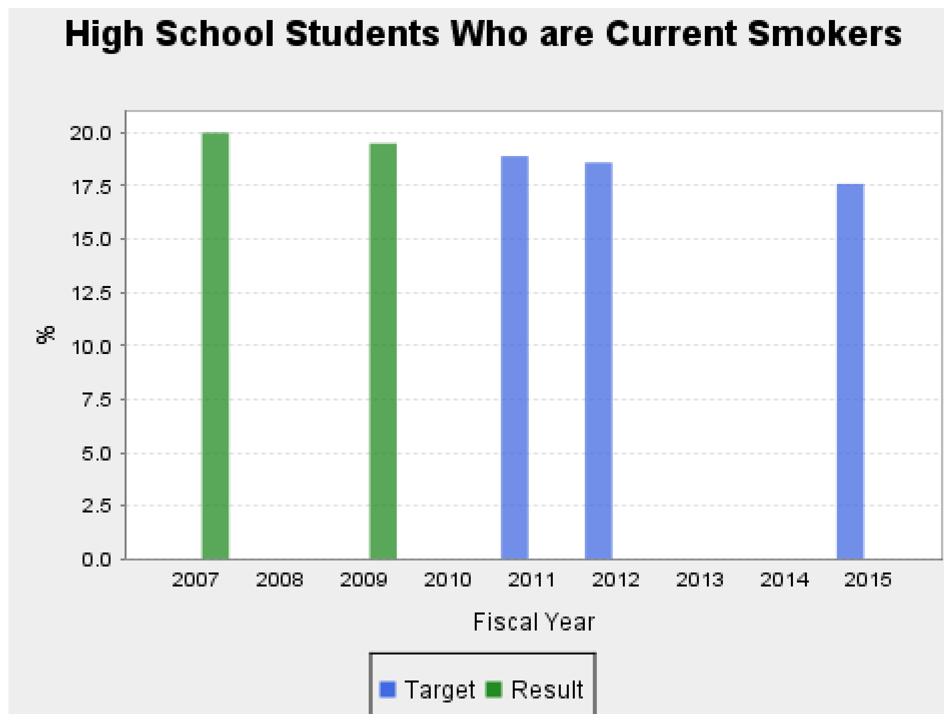
Also Supports: HHS measures 1.E and 3.B

Goal 3: Advance the Health, Safety and Well-Being of the American People
Objective D: Promote prevention and wellness

3.D.1 Reduce the proportion of adolescents (grade 9 through 12) who are current cigarette smokers.

Tobacco use continues to be the single leading preventable cause of death and disease in the United States. Cigarette smoking is almost always initiated and established during adolescence. More than 80% of adult smokers begin smoking before 18 years of age. Each day, about 4,000 youth in the United States try their first cigarette and over 1,000 (or approximately 1,100) youth under 18 years of age become new regular, daily smokers. That's 400,000 new underage daily smokers in this country each year.

Since the mid-1990's high school smoking prevalence has declined significantly. Prevalence has declined from 28 percent in 2001 to 19.5 percent in 2009. However, the decline has slowed over the past 3 years.



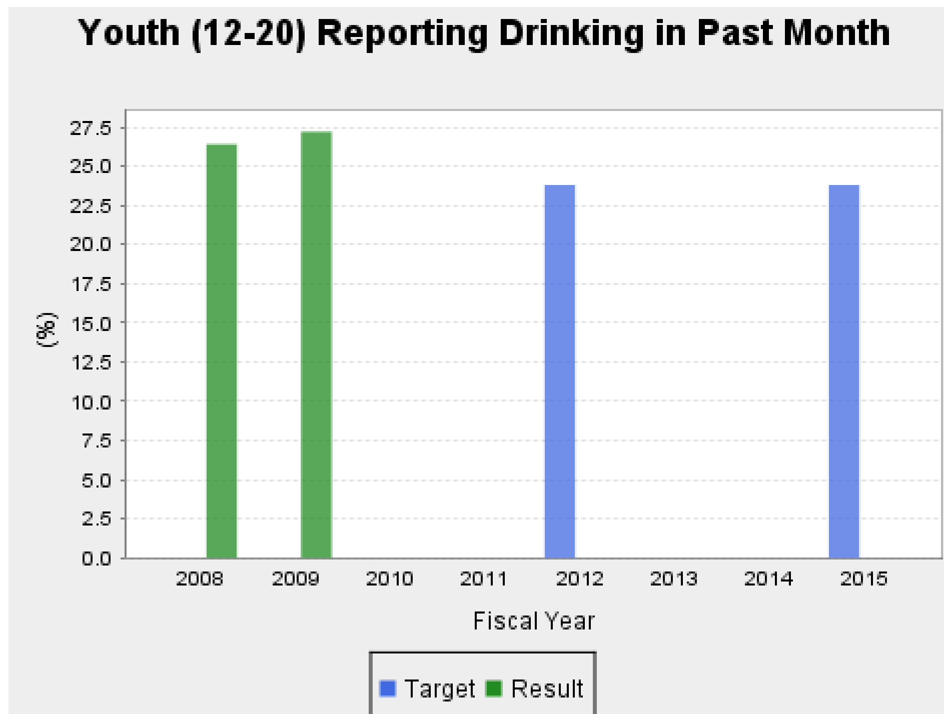
Data Source: There are two data sources for this measure: 1) Youth Risk Behavior Surveillance System (YRBSS) and 2) National Youth Tobacco Survey (NYTS). The primary data source for setting and reporting targets is YRBSS, which monitors priority health-risk behaviors and is conducted every other year (odd years). To obtain data on an annual basis, CDC will conduct the NYTS in the intervening years, which tracks closely with YRBSS.

Also Supports: Healthy People 2020 objective TU-2.2; HHS Tobacco Control Strategic Action Plan: Ending the Tobacco Epidemic (2010)

3.D.2 Percentage of youth age 12-20 who report drinking in the past month.

SAMHSA is currently refining and beginning the implementation of its Strategic Initiative on the Prevention of Substance Abuse and Mental Illness. The primary focus of this Initiative is to promote prevention and wellness across the nation. The success of this initiative will be monitored through population-based measures. It is expected that SAMHSA prevention programs, as well as other programs addressing underage drinking and its precursors, will contribute, over time, to changes observed through these measure.

Between 2002 and 2008, data suggested that alcohol use was on the decline among youth aged 12-20. However, data suggests that the percentage of persons in this age group that reported drinking alcohol in the past month increased from 26.4% in 2008 to 27.2% in 2009. Results also showed an increase in the percentage of youth ages 12-20 that were binge drinkers (+0.6 percentage points); while the percentage of youth who were heavy drinkers remained unchanged between 2008 (5.5%) and 2009 (5.4%). Collectively, these data may suggest that the declining trends in alcohol use among this age group may have ended.



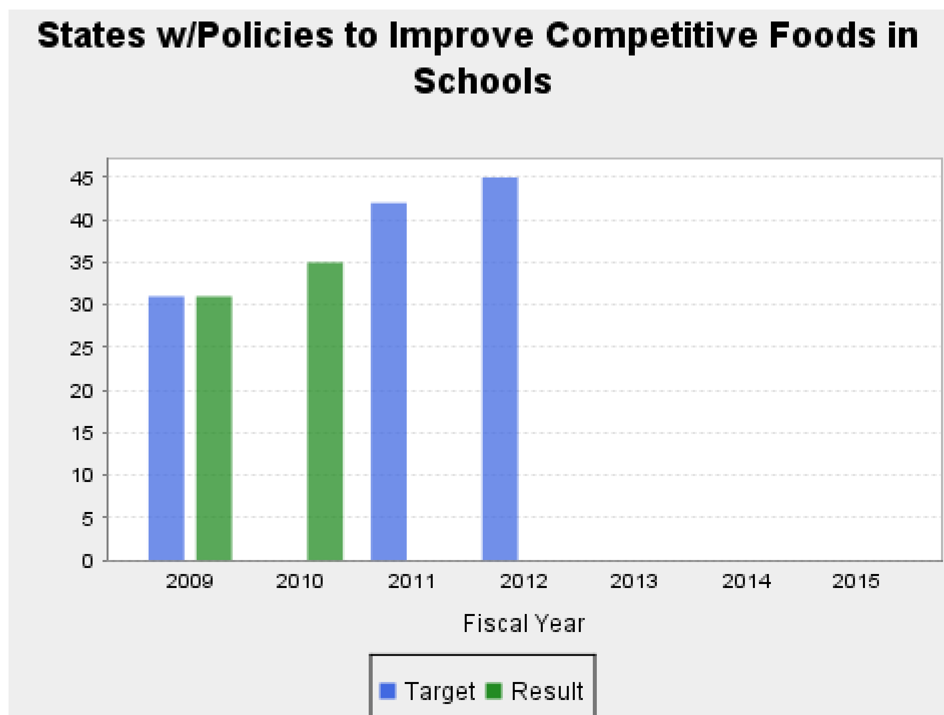
Data Source: National Survey on Drug Use and Health

Also Supports: HHS Strategic Plan 3.A

3.D.3 Increase the number of states with policies to improve nutritional quality of competitive foods in schools.

Foods and beverages provided through school breakfast, lunch, and afterschool snack programs must meet certain nutritional requirements to receive federal reimbursement. However, many schools also sell foods separate from these school meals—as à la carte offerings in school cafeterias or in school stores, snack bars, or vending machines—that are not subject to federal nutritional requirements. These foods are called "competitive foods" because they compete with school meals. Research shows that students who attend schools that sell competitive foods have lower intake of fruits, and vegetables, and milk at lunch, lower daily intake of fruits and vegetables, and higher daily percent of calories from total fat and saturated fat.

CDC identified this measure in 2009 so there is no trend data or past performance activities to report. In FY 2010, 35 states had policies to improve nutritional quality of competitive foods in schools. This is an improvement over the 2009 baseline of 31 states. The data source is the National Association of State Boards of Education's School Healthy Policies Database available at http://www.nasbe.org/healthy_schools/hs/index.php.



Data Source: National Association of State Boards of Education's School Health Policies Database

Also Supports: Healthy People 2020 Objectives: NWS 2.1; NWS 17.1 - 17.3; NWS 18; NWS 19

3.D.4 The number of behavioral health outcomes for military personnel and their families served through SAMHSA supported programs.

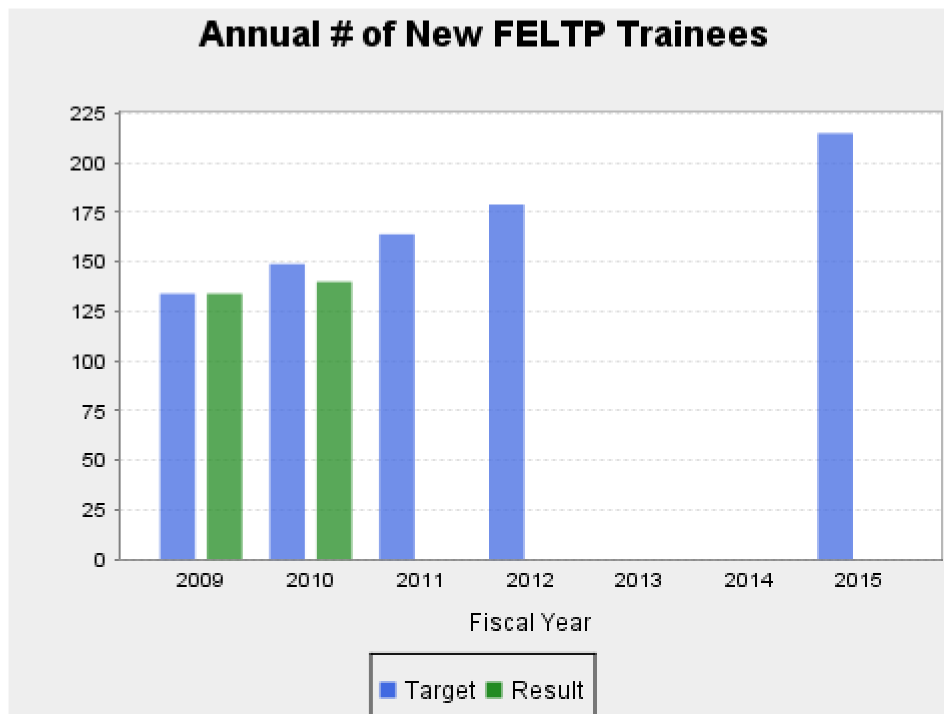
This initiative supports the HHS Strategic Plan Objectives responding to the mental health and substance abuse needs of military families and builds on the recent work at SAMHSA including a national conference on the behavioral health needs of returning veterans, returning veteran State policy academies and collaboration with the National Guard Bureau addressing behavioral health needs of guardsman and their families. The two-phased funding approach and would support infrastructure development, including coordination and capacity building as well as direct service supports for prevention, treatment and recovery support services for those communities most impacted by the needs of service members, veterans, and their families.

This measure is still under development. Baseline and targets will be set at the end of the first year of program operations, the end of FY 2012. Although there is no current data for identifying this population as a sub-set of those served through SAMHSA grants, 58% of the total population receiving mental health-related services in FY 2009 showed reduced morbidity and it is expected that the percentage for reduction in morbidity would be similar for this special population.

3.D.5.a Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology (and Laboratory) Training Program (FELTP). New Trainees.

This measure tracks the number of new trainees that begin CDC's Field Epidemiology (and Laboratory) Training Program (FELTP). This measure allows CDC to track the progress of new programs in graduating well-trained applied epidemiologists.

Since 1980, CDC has developed 40 international Field Epidemiology and Laboratory Training programs (FELTP) serving 56 countries, graduating 2,254epidemiologists. Twenty mature programs are sustained without a need for full-time Resident Advisors. For FY 2009, there were 134 active trainees. The numbers of programs and thus trainees that CDC is supporting varies from year to year as new programs are started and mature programs become sustained. The number of trainees per year can also vary because some programs only enroll new trainees every two years.



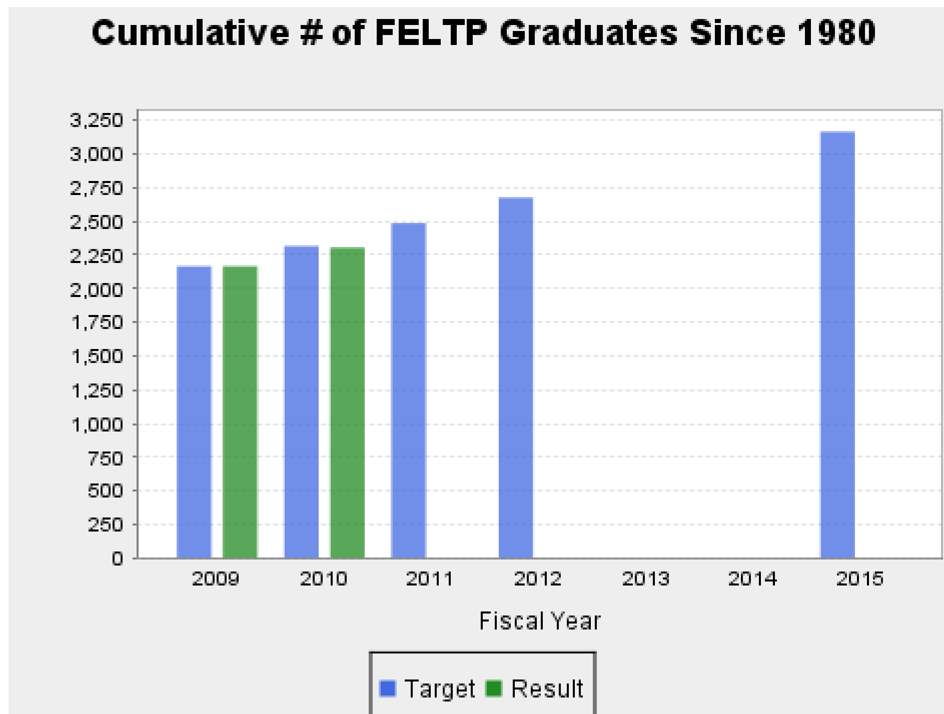
Data Source: FELTP Annual Program Reports

Also Supports: President's Global Health Initiative; HHS Strategic Plan Measure 5.C

3.D.5.b Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology (and Laboratory) Training Program (FELTP). Total Graduates.

This measure tracks the total (comprehensive) number of graduates who complete CDC's Field Epidemiology (and Laboratory) Training Program (FELTP) program. This measure allows CDC to track the progress of new and expanded programs in graduating well-trained applied epidemiologists.

Since 1980, CDC has developed 40 international Field Epidemiology and Laboratory Training programs (FELTP) serving 56 countries, graduating 2,254 epidemiologists. Twenty mature programs are sustained without a need for full-time Resident Advisors. For FY 2009, there were 134 active trainees. The numbers of programs and thus trainees that CDC is supporting varies from year to year as new programs are started and mature programs become sustained. The number of trainees per year can also vary because some programs only enroll new trainees every two years.



Data Source: FELTP Annual Program Reports

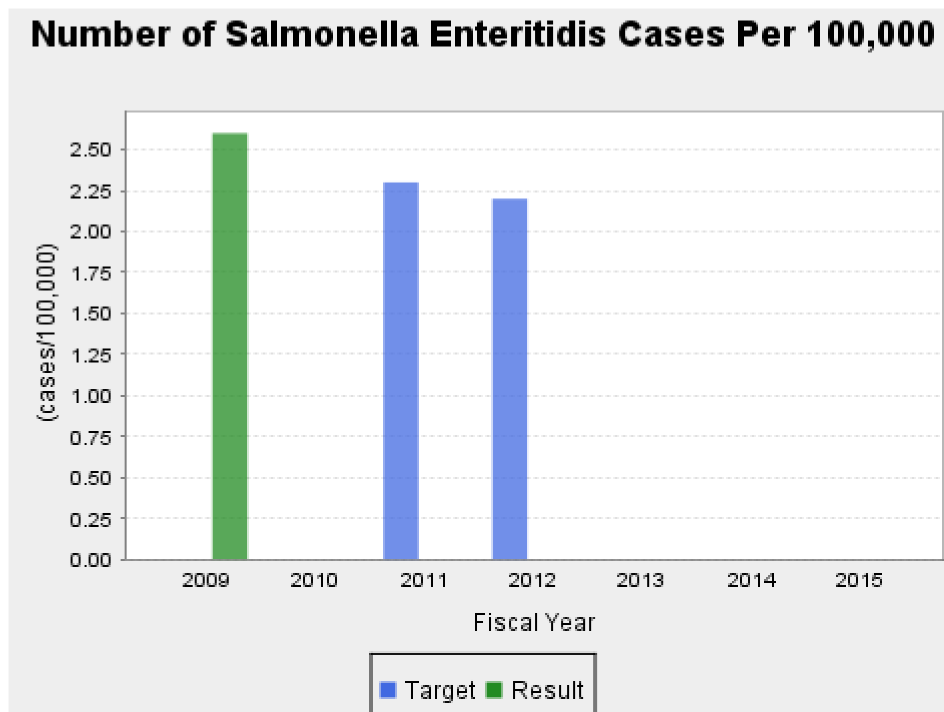
Also Supports: President's Global Health Initiative; HHS Strategi Plan Measure 5.C

Goal 3: Advance the Health, Safety and Well-Being of the American People
Objective E: Reduce the occurrence of infectious diseases

3.E.1 Decrease the rate of Salmonella Enteritidis (SE) illness in the population (cases per 100,000).

Salmonella is the leading known cause of bacterial foodborne illness and death in the United States. Each year, food contaminated with Salmonella causes an estimated 1.3 million illnesses in the US, including fever and diarrhea, and between 400 and 500 deaths. *Salmonella Enteritidis* (SE), a subtype of Salmonella, is the second most common type of Salmonella in the U.S. and accounts for approximately 17% of all Salmonella cases in humans. The most significant sources of foodborne SE infections are shell eggs (FDA-regulated) and broiler chickens (USDA-regulated). Preventing *Salmonella* infections depends on actions taken to reduce contamination of food by regulatory agencies, the food industry, and consumers, as well as actions taken for detecting and responding to outbreaks. FDA published a final egg rule, "Prevention of *Salmonella Enteritidis* in Shell Eggs During Production, Storage and Transportation", on July 9, 2009. This rule requires shell egg producers to implement controls to prevent SE from contaminating eggs on the farm and from further growth during storage and transportation. The regulation also requires egg producers to maintain records concerning their compliance with the egg rule and to register with FDA. The final rule is expected to reduce SE-associated illnesses and deaths by reducing the likelihood that shell eggs are contaminated with SE.

FDA seeks to decrease the rate of SE illness in the population by 10%. The baseline, provided by CDC, is the average annual rate of SE illness in the population from 2007 through 2009. The target is a 10% reduction in that rate, which would result in a rate of 2.3 cases per 100,000 by the end of calendar year 2011. CDC will provide the data to report progress on this goal. The FY 2010 actual data will be available in June 2011.



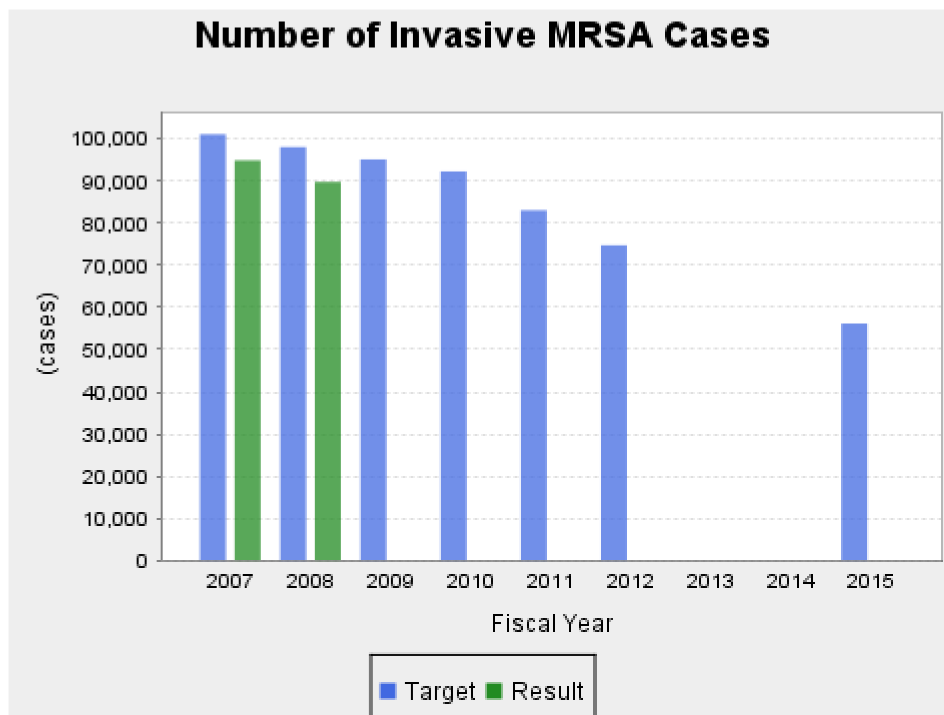
Also Supports: This measure also supports Healthy People 2020.

3.E.2 Reduce the estimated number of cases of invasive MRSA infection.

Methicillin-resistant Staphylococcus aureus (MRSA) is an antibiotic resistant bacterium that causes emerging infections of national and international importance. Staph infections, including MRSA, occur most frequently among persons in hospitals and healthcare facilities (such as nursing homes and dialysis centers) and are known as healthcare-associated MRSA.

The multidrug-resistant organism module in the National Healthcare Safety Network (NHSN) provides surveillance data from participating facilities on multidrug-resistant organisms, including MRSA, to monitor the impact of MRSA prevention in healthcare settings. Data from this source is used to estimate the number of invasive MRSA cases.

The estimated number of people developing their first serious MRSA infection (i.e., invasive) in 2007 was approximately 94,897 persons; approximately 16,118 of those persons died during the hospital stay for their MRSA infection. In 2008, the number of people developing their first serious MRSA infection was reduced to approximately 89,785 persons.



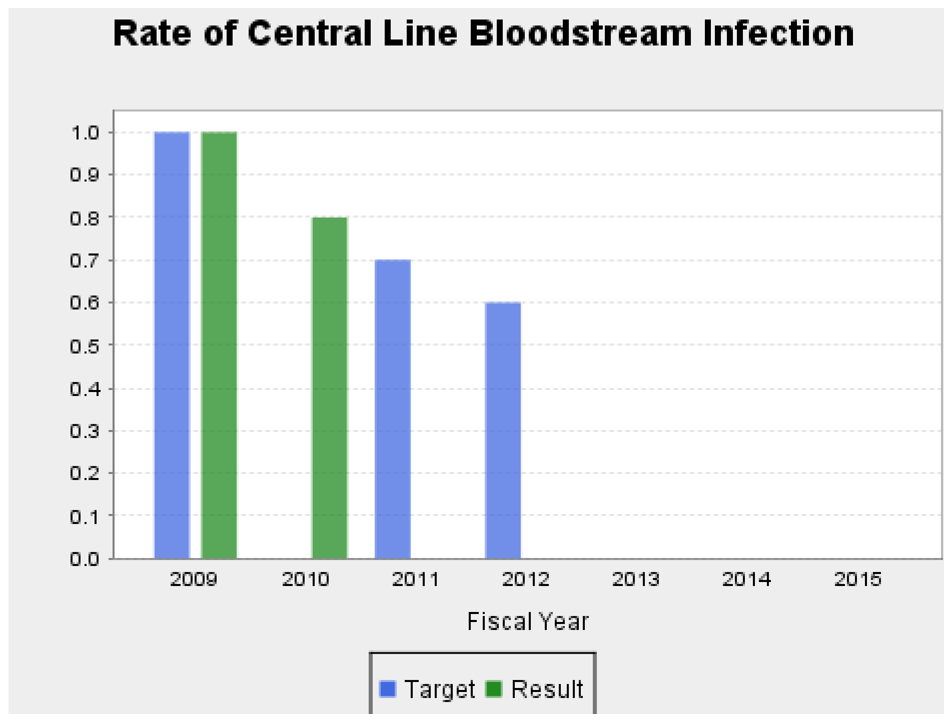
Data Source: Emerging Infections Program / Active Bacterial Core Surveillance/Emerging Infections Program Surveillance for Invasive MRSA Infections

Also Supports: HHS Strategic Plan 1.B; Healthy People 2020 Objectives: HAI-2; HHS Action Plan to Prevent Healthcare Associated Infections

3.E.3 Reduce the CLABSI standardized infection ratio (SIR).

CDC has provided leadership in preventing central-line associated bloodstream infections (CLABSI) by developing evidence based guidelines for prevention of these infections, providing technical assistance to healthcare organizations and state health departments to coordinate and facilitate implementation of these guidelines, and by working with the Centers for Medicare and Medicaid Services (CMS) to implement the Value Based Purchasing program related to bloodstream infections. CDC OVERSEES THE National Healthcare Safety Network, the source of the data provided and a surveillance system currently collecting data from approximately 2,500 hospitals and other healthcare facilities.

CDC uses the Standard Infection Ratio (SIR) to monitor trends in CLABSI reduction with a baseline SIR of 1.0. The 2010 results show a reduction to an SIR of .8



Data Source: National Healthcare Safety Network (NHSN)

Also Supports: HHS Strategic Plan 1.B; Health People 2020 Objective: HAI-1; HHS Action Plan to Prevent Healthcare Associated Infections

3.E.4 Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served.

Even though new HIV infections among racial/ethnic minorities overall have been roughly stable, compared with non-racial/ethnic minorities they continue to account for a higher proportion of cases at all stages of HIV – from new infections to death. The proportion of the Ryan White program's service population that comprises racial/ethnic minorities is an indicator of access to treatment for populations disproportionately impacted by HIV/AIDS.

The goal for this measure is that the proportion of racial and ethnic minorities in Ryan White HIV/AIDS-funded programs served exceeds their representation in national AIDS prevalence data, as reported by the Centers for Disease Control and Prevention (CDC), by 5 percentage points. In FY 2009 73% of the Ryan White HIV/AIDS program clients were racial/ethnic minorities. The CDC AIDS data for comparison is not available as of this writing. In FY 2008 73% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities, compared to 65.9% of CDC-reported AIDS cases. In FY 2007 72% of clients served in Ryan White HIV/AIDS-funded programs were racial/ethnic minorities, compared to 64.1% of CDC-reported AIDS cases. The Ryan White HIV/AIDS Program has historically seen a greater proportion of racial/ethnic minorities than are represented in CDC AIDS data.

Data Source: HRSA HIV/AIDS Bureau's Ryan White HIV/AIDS Program Services Report

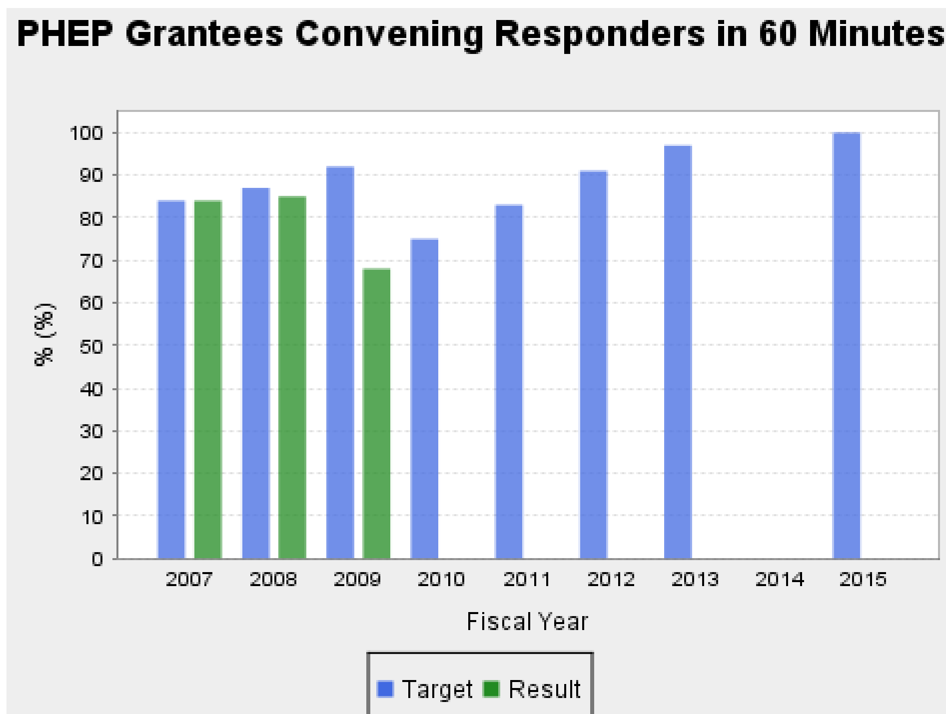
Also Supports: This measure supports the following Healthy People 2020 objective:Reduce HIV Incidence among adults and adolescents(HIV-2).

Goal 3: Advance the Health, Safety and Well-Being of the American People
Objective F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies

3.F.1 Percentage of public health agencies that directly receive CDC Public Health Emergency Preparedness (PHEP) funding that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners.

This measure stipulates that public health agencies must be able to rapidly convene key management staff (within 60 minutes of being notified) to integrate information and prioritize resource allocation to ensure timely and effective coordination within the public health agency and with key response partners during an emergency response.

As of FY 2009, this measure was updated from a pervious version and the baseline recalculated, accordingly. Unlike the previous measure, this new measure requires all reported examples of staff assembly to be unannounced, whereas the previous measure allowed reporting of both announced and unannounced examples. Given that many emergencies provide little to no notice but require a rapid response nonetheless, this requirement was added to ensure that all states are able to convene staff without having provided advance notice. For FY 2009, 70% of grantees convened necessary staff within 60 minutes of notification. FY 2010 results will be available by March 31, 2011.



Data Source: Self-reported data as part of required progress reports

Also Supports: Healthy People 2020 Objectives: PREP-2

3.F.2 Increase the number of new CBRN and emerging infectious disease medical countermeasures under EUA or licensed.

ASPR's Office of Biomedical Advanced Research and Development Authority (BARDA) manages the procurement and advanced development of medical countermeasures for chemical, biological, radiological, and nuclear agents(CBRN); Project BioShield procurements; and the advanced development and procurement of medical countermeasures for pandemic influenza and other emerging infectious diseases.

Currently there are (8) FDA-licensed seasonal, (7) pandemic H1N1 and (1) H5N1 influenza vaccines available commercially or stockpiled by BARDA. Additionally, there are FDA-licensed vaccines for smallpox and anthrax, and anti-chelating agents for radiation exposure in the SNS. Two anthrax antitoxins, a botulinum antitoxin, and a smallpox vaccine for immunocompromised persons, are in the SNS and accessible under emergency use authorization (EUA). BARDA will continue to initiate, monitor, and evaluate programs using established and advanced HHS procurement and program management procedures.

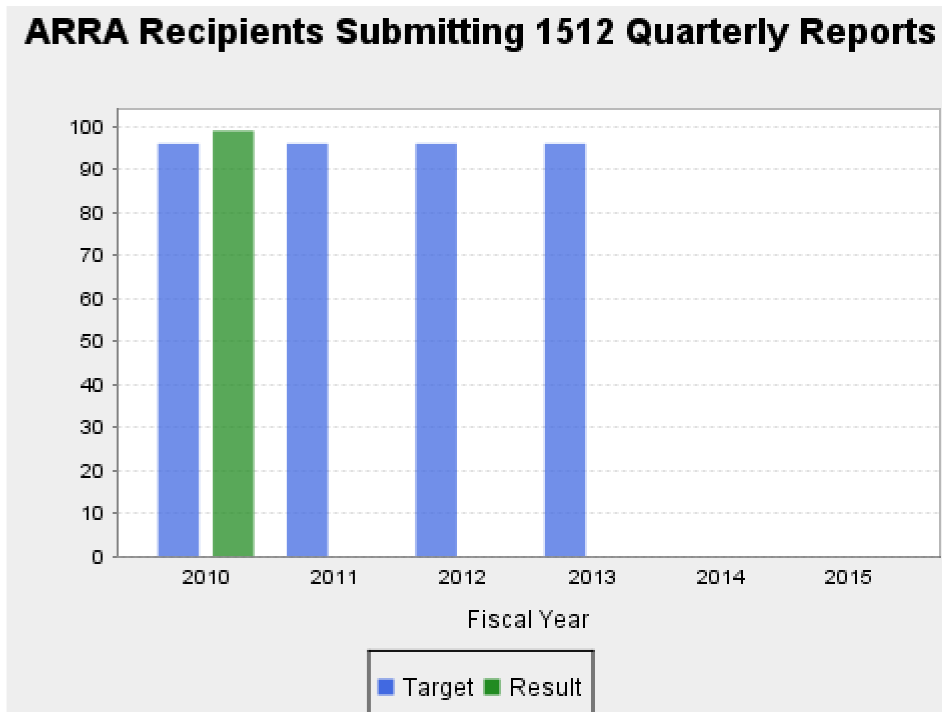
Data Source: ASPR contract files

Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs
Objective A: Ensure program integrity and responsible stewardship of resources

4.A.1 Ensure 1512 Quarterly Reports Filed.

The Recovery Act was enacted in 2009 and made available $22 billion in discretionary HHS grants and contracts to State and Local Communities through September 30, 2010. All recipients of discretionary Recovery Act funds are required by Section 1512 of the Recovery Act to submit quarterly reports that detail activies and financial information. This information is submitted electronically via www.federalreporting.gov and is made available at the end of each quarter at www.recovery.gov

During the first reporting quarter of October, 2009 98% of HHS recipients submitted their Recovery Act Reports. In every quarter since then 99% of HHS ARRA funded entities submitted their reports.

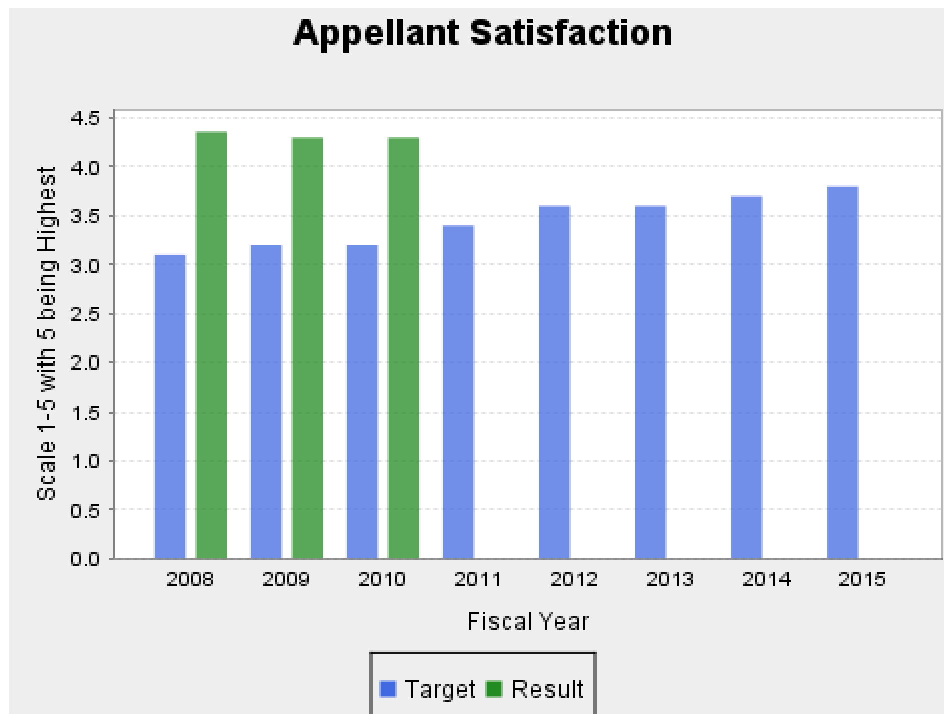


Data Source: ARRA recipients submit their reports to www.federalreporting.gov and data is available to the public on www.recovery.gov

4.A.2 Average survey results from appellants reporting good customer service on a scale of 1 - 5 at the ALJ Medicare Appeals level.

As part of its program assessment, the Office of Medicare Hearings and Appeals is evaluating its customer service through an independent evaluation that captures the scope of the Level III appeal experience. This measure will assure appellants and related parties are satisfied with their Level III appeals experience based on beneficiary survey results.

Survey results are reviewed on an annual basis. On a scale of 1 – 5, 1 represents the lowest score (very dissatisfied) and 5 represents the best score(very satisfied). In FY 2010, OMHA achieved a 4.30 level of appellant satisfaction nationwide, exceeding the 3.20 performance target level. This result indicates the vast majority of appellants were either somewhat or very satisfied with OMHA services, from initiation of cases through closure, as well as with the hearing formats used to adjudicate their cases.



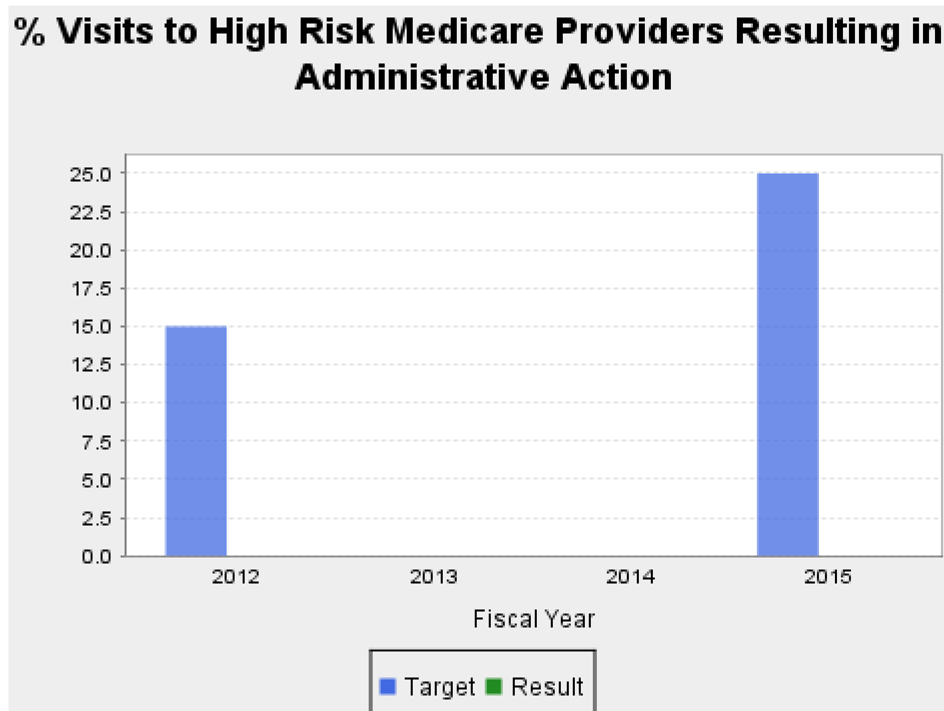
Data Source: The most recent version of the survey was administered by a third party contractor using a stratified random sample of appellants whose cases were closed within fiscal year 2010.

Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs
Objective B: Fight fraud and work to eliminate improper payments

4.B.1 Increase the percentage of Medicare enrollment site visits to "high-risk" providers and suppliers that result in administrative actions.

The Centers for Medicare and Medicaid Services (CMS) must ensure that correct Medicare payments are made to legitimate providers for covered, appropriate and reasonable services for eligible beneficiaries. Since there is a linkage between billing fraud and enrollment fraud, CMS will perform enhanced provider enrollment reviews to prevent and detect Medicare fraud and to reduce waste, abuse and other improper payments. This goal will measure the proportion of the number of "high-risk" provider site visits that result in administrative action to the number of "high-risk" provider site visits conducted.

By conducting enrollment site visits to "high-risk" targeted providers and suppliers and by taking appropriate and timely administrative actions, our contractors will focus their activities toward the areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk assessment-based approach increases contractors' efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those with higher risk assessments.



Data Source: Developmental. In *"CMS-6028-FC: Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*," CMS finalized three levels of risk, Limited, Moderate and High. Provider types were assigned to these risk levels based on reports from the HHS Inspector General, the Government Accountability Office, and

CMS's own analytic work and experience. The provider types assigned to these risk levels would receive oversight and review that increases with the level of risk of fraud—the greater the level of risk, the greater the level of oversight and review. For example, all providers and suppliers in the moderate risk level would receive site visits, and all provider types in the high risk level would receive site visits, criminal background checks, and fingerprinting (once those latter two screening provisions are implemented via subregulatory guidance).

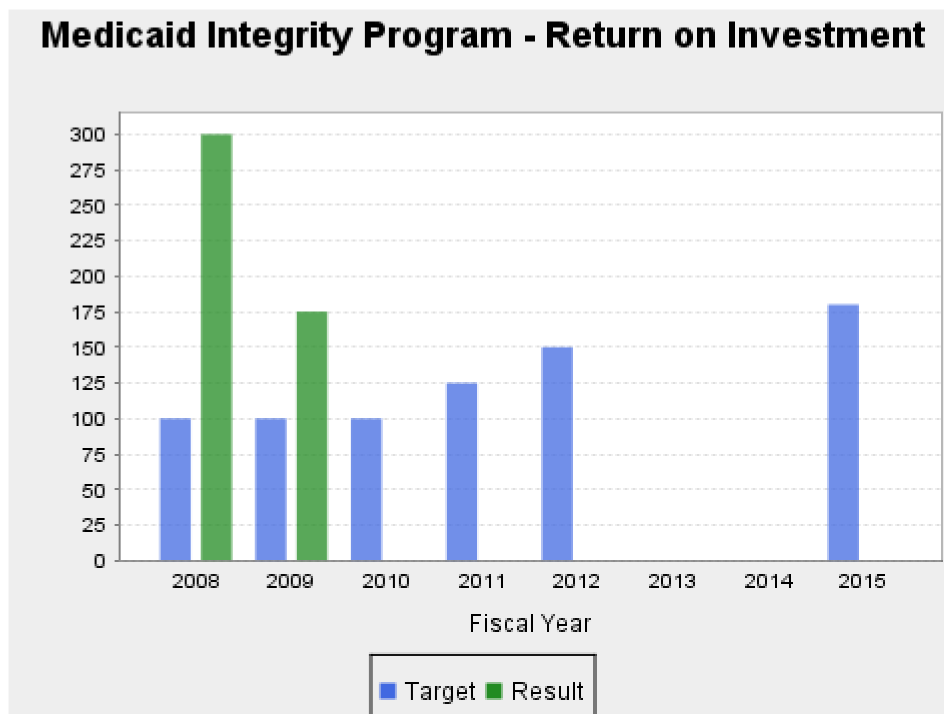
Medicare contractors will utilize CMS-developed reporting requirements to compile the data on the numbers of site visits conducted for provider types included in the high risk level, and the percentage of the site visits that resulted in administrative action(s). Contractors will also track and report the results of the administrative actions (e.g., dollars denied as a result of prepayment review). While the goal is national, based on the aggregate number of high-risk level enrollment site visits conducted, individual contractors will be strongly encouraged to meet and exceed the national goal to the extent appropriate for the provider population in their jurisdiction.

Also Supports: CMS is partnering with HHS' Office of General Counsel and the Office of the Inspector General, the Department of Justice's Office of the US Attorney and the Federal Bureau of Investigation to implement the full spectrum of administrative actions ranging from educational intervention through referral to the powerful tools of law enforcement to assist CMS in protecting the integrity of the Medicare Trust Fund.

4.B.2 Medicaid Integrity Program, Percentage Return on Investment.

The Centers for Medicare & Medicaid Services (CMS) is committed to combating Medicaid provider fraud, waste, and abuse, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients. The Medicaid Integrity Program is the first comprehensive Federal strategy to prevent and reduce provider fraud, waste, and abuse in the Medicaid program. CMS has two broad responsibilities under the Medicaid Integrity Program: to hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues and to provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse. The Medicaid Integrity Program Return on Investment (ROI) is one measure of the success of the Medicaid Integrity Program.

In FY 2008, the numerator included annual total Federal dollars identified as overpayments in accordance with the relevant Medicaid overpayment statutory and regulatory provisions. The denominator included the annual Federal funding of the Medicaid Integrity Contractors. Our FY 2008 result measured the Return on Investment for a three-month period. CMS exceeded its target and reported an actual Return on Investment of 300 percent. For FY 2009, the numerator included overpayments identified in FY 2009, the denominator included the annual Federal funding of the Medicaid Integrity Program for FY 2009. The FY 2009 target was for ROI to be greater than 100 percent. CMS exceeded the target with an actual result of 175 percent. Future targets are for ROI to be greater than 125 percent in FY 2011, greater than 150 percent in FY 2012, and greater than 180 percent in FY 2015.



Data Source: 1) The Medicaid Integrity Contractors (MICs) will compile the data on audits where overpayments are identified and States were instructed to recoup; (2) Results from State payment system audits identifying overpayments using algorithms; (3) Activities that are characterized as achieving cost avoidance of improper payments through the Medicaid Integrity Group's support and assistance to States.

Also Supports: CMS GPRA plan.

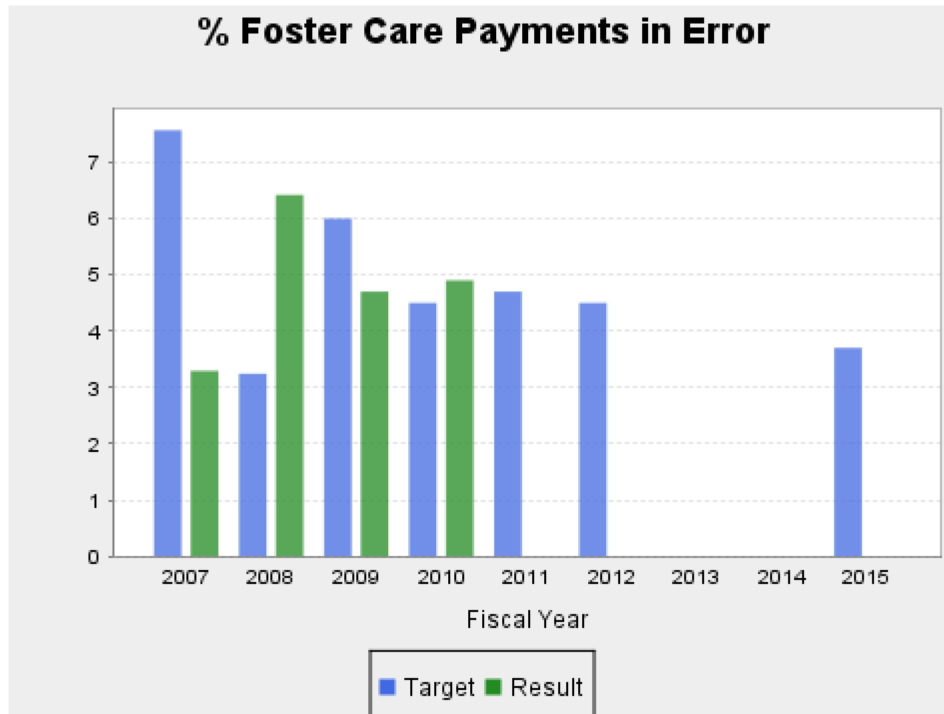
4.B.3 Decrease improper payments in the title IV-E foster care program by lowering the national error rate.

Strategic plan measure 4.B.3 focuses on reducing erroneous payments in the title IV-E foster care program. The Children's Bureau calculates a national payment error rate and develops an improvement plan to strategically reduce, or eliminate where possible, improper payments under the program. State-level data generated from the title IV-E eligibility reviews are used to calculate the error rate. Eligibility reviews are routinely and systematically conducted by the Children's Bureau in each of the 50 states, the District of Columbia, and Puerto Rico to ensure that foster care maintenance payments are made only for program-eligible children. The eligibility review determines a state's level of compliance in meeting the federal eligibility requirements and validates the accuracy of a state's claim for reimbursements of foster care payments. Each eligibility review specifies the number of cases in error, underlying error causes, and amount of payment in error determined from the examination of a sample drawn from the state's overall title IV-E caseload for an identified six-month period under review. The fiscal accountability promoted by these reviews leads to reductions in case errors and program improvements. Since FY 2000, the Children's Bureau has systematically conducted more than 155 regulatory foster care reviews, with over 14,500 foster care cases reviewed.

In early FY 2005, the Children's Bureau determined the baseline estimate of a national error rate as part of its ongoing efforts to ensure the proper use of title IV-E foster care maintenance funds and to assess the success of ongoing efforts to reduce improper payments in the title IV-E Foster Care program. The national error rate is determined by using the data collected in the most recent foster care eligibility review conducted for each state during the review cycle and extrapolating from individual case-level data on errors and improper payments from each state review sample for a specified period under review. Due to the regulatory three-year cycle of title IV-E foster care eligibility reviews, the national error rate estimate is based on a three-year rolling estimate ("rolling" because as new state reviews are conducted, the new review data will replace the case improper payment data from the state's previous review). Using this methodology, the Children's Bureau annually establishes targets for future improper payment levels that incorporate the latest available review data on each state, develops strategies for reaching the targets and monitors progress in reducing improper payments. The estimated composite baseline IV-E payment error rate of 10.33 percent was based on data obtained from fiscal years 2002-2004. For FY 2005, the estimated national error rate (based on the three year average from fiscal years 2003-2005) was 8.6 percent, for FY 2006 the error rate was 7.68 percent, and for FY 2007 the error rate was 3.30 percent, representing a reduction of over two-thirds since establishing the baseline.

The reported error rate for FY 2008, however, is not comparable to previous years, as that year's update reflects a transition to a refined methodology for estimating state improper payments. While the previous methodology extrapolated the average improper payments per case for the sample to the number of cases in the state, the refined methodology extrapolates the dollar error rate of the sample (i.e., sample Period Under Review [PUR] improper payments divided by sample PUR total payments) to the total PUR payments for the state. Using this new methodology, for FY 2008, the Foster Care estimated national payment error rate was 6.42 percent. This represented an increase over the FY 2007 error rate due in part to the revised

methodology and in part to an increase in eligibility errors for several large states reviewed in FY 2008. In FY 2009, the error rate declined to 4.7 percent. For FY 2010, ACF reported an error rate of 4.9 percent, a very slight increase over the previous year's rate. As a result, ACF, in consultation with OMB has adjusted out-year targets for fiscal years 2011 through 2013 (4.7 percent, 4.5 percent and 4.5 percent respectively). By FY 2015, ACF expects to reach the goal of 3.7 percent.



Data Source: Regulatory title IV-E Foster Care Eligibility Reviews conducted by the Children's Bureau in each of the 50 states, the District of Columbia, and Puerto Rico

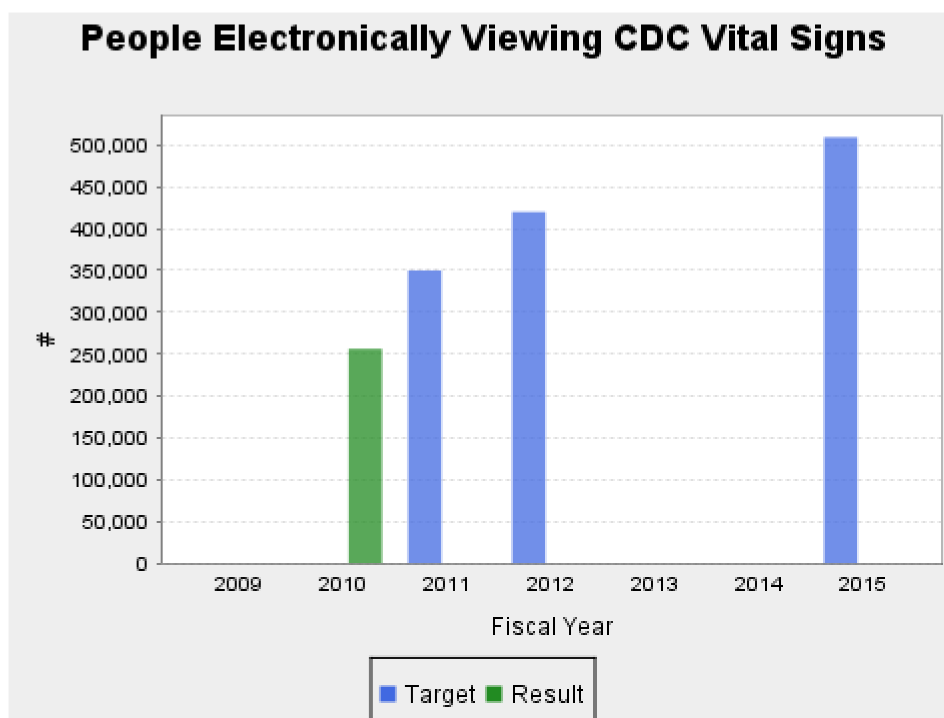
Also Supports: HHS Strategic Objective 4.B.3, fight fraud and work to eliminate improper payments.

Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs
Objective C: Use HHS data to improve the health and well-being of the American people

4.C.1 Increase the electronic media reach of CDC Vital Signs through the use of mechanisms such as CDC.gov and social media outlets

CDC Vital Signs is an innovative project at the intersection of science, policy, and communications. The public health indicators to be addressed in the monthly issues of CDC Vital Signs are related to the leading causes of morbidity and mortality in the United States. This includes the five leading causes of death—heart disease, cancer, stroke, chronic lower respiratory diseases, and unintentional injury—and contributing causes of death such as tobacco use, binge drinking, and obesity. These five causes of death combine to represent 85 percent of deaths from the 10 leading causes.

The concept for *CDC Vital Signs* was developed late in 2009 and the first issue was published on July 6, 2010. Three issues of the publication were released in Fiscal Year (FY) 2010, and baseline data reflects three months of data collection.



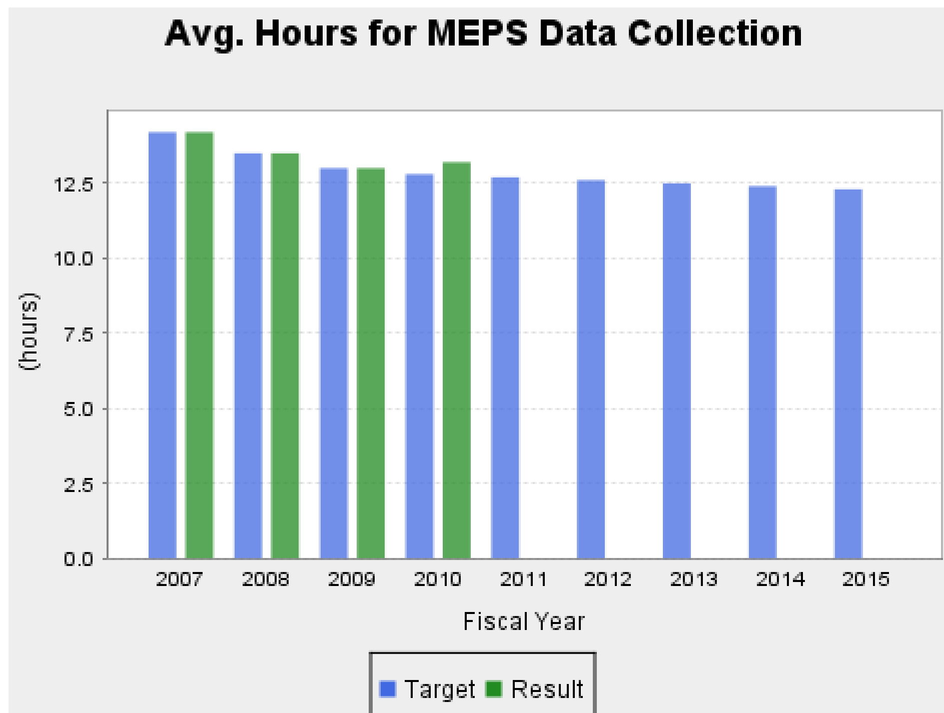
Data Source: The data source for this measure is Omniture® web analytics, which is a software product that provides consolidated and accurate statistics about interactions with CDC.gov and social media outlets as individuals seek and access information about *CDC Vital Signs.*

Also Supports: HHS Strategic Plan 2.D and 3.D; Healthy People 2020 Objective HC/HIT 13.1

4.C.2 The average number of field staff hours required to collect data per respondent household for the MEPS.

At the heart of data collection is the interaction between the interviewer and respondent (interviews take place face-to-face in the respondent's home). As cooperation by the respondent is paramount to the success of MEPS, it is important to complete the interview in as short a time as possible. In addition, all operations related to data collection (travel and data transmission) are to be minimized in order to keep costs within budgetary constraints. This contributes to an efficient use of field staff and minimize field staff hours.

Currently, the average field staff hours required to collect data from a respondent is 13.2 hours. This total entails the actual interview time (varies between one and four hours depending on the size of the household and the complexity of respondent health care utilization and characteristics) and all supportive activities required to complete an interview. Such activities include, but are not limited to: travel to and from the interviewer's residence to the respondent's residence (interviewers are located in vicinity to the respondents); telephone contacts with the respondent; and time to transmit data collected to the home office for data processing.



Goal 4: Increase Efficiency, Transparency, and Accountability of HHS Programs
Objective D: Improve HHS environmental, energy, and economic performance to promote sustainability

4.D.1 Percent employees on telework or AWS

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

Increasing the percentage of Tele-working employees reduces the vehicle miles traveled, which reduces GHG and other pollutants in our air, soil and water, which can be harmful to human health. Typical commuting causes employee stress and decreases the amount of time employees can devote to other health activities such as physical activity, planning and preparing healthy meals and developing social capital by spending time with family or in the community. Widespread telework coupled with office sharing and swing space can reduce overall facilities costs in rents, waste removal, waste-water treatment and energy use.

This is a new goal for 2015 and baseline data is being collected

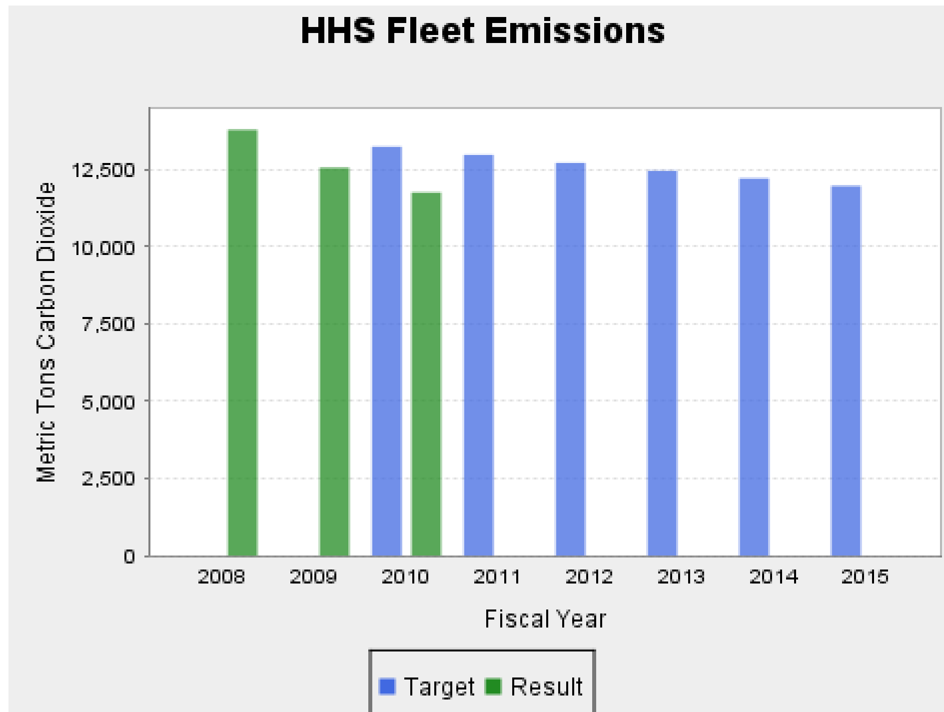
Data Source: HHS personnel records

Also Supports: HHS strategic goal 5.D

4.D.2 Percent reduction of HHS fleet emissions.

HHS is committed to replacing gasoline-powered vehicles with alternative fuel vehicles (AFV) in accordance with GSA acquisition guidelines. As a result, the fleet's petroleum consumption and the amount of carbon dioxide released into the atmosphere will decrease.

This is a new HHS performance measure. Interim targets are being developed to support the achievement of the 2015 target of annual reductions of 2%.

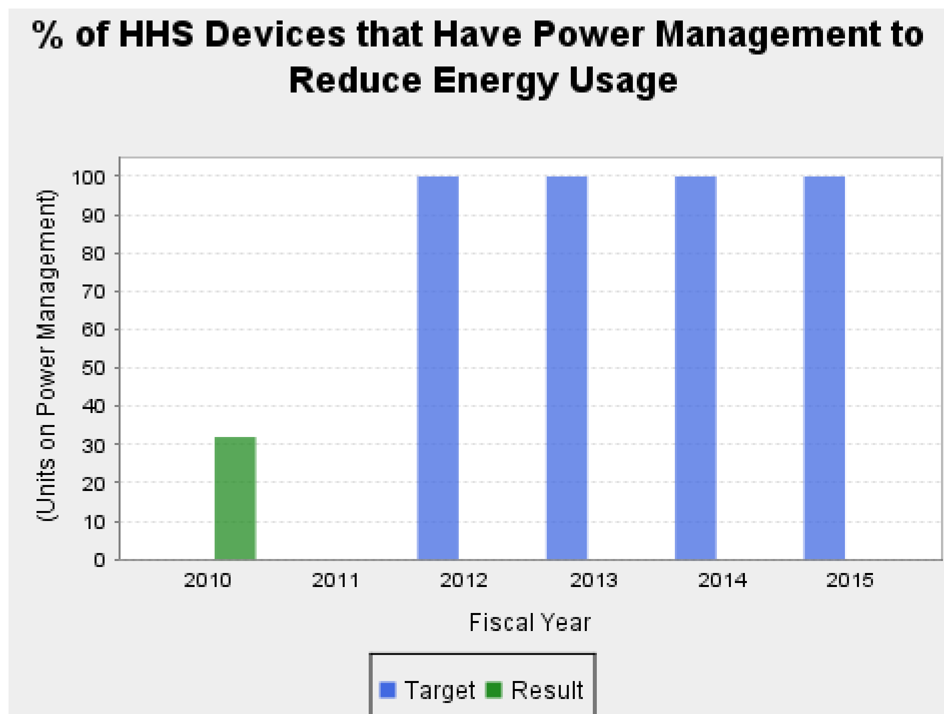


Data Source: FAST (Fleet Automated Statistical Tool)

4.D.3 Ensure Power Management is enabled in 100% of HHS computers, laptops and monitors

HHS is committed to implementing power management for eligible computers, laptops and monitors by, among other things, including power-saving protocols in the standard configuration for employee workstations. Consistent application of power management will decrease the amount of electricity used by HHS facilities. This is part of HHS' strategic initiative to be good stewards of our energy resources.

This is a new performance measure. HHS has agressive goals to move from the 2010 level of 32% of devices with power management enabled to 100% of devices with power management by 2012, continuing through 2015.



Data Source: HHS administrative data.

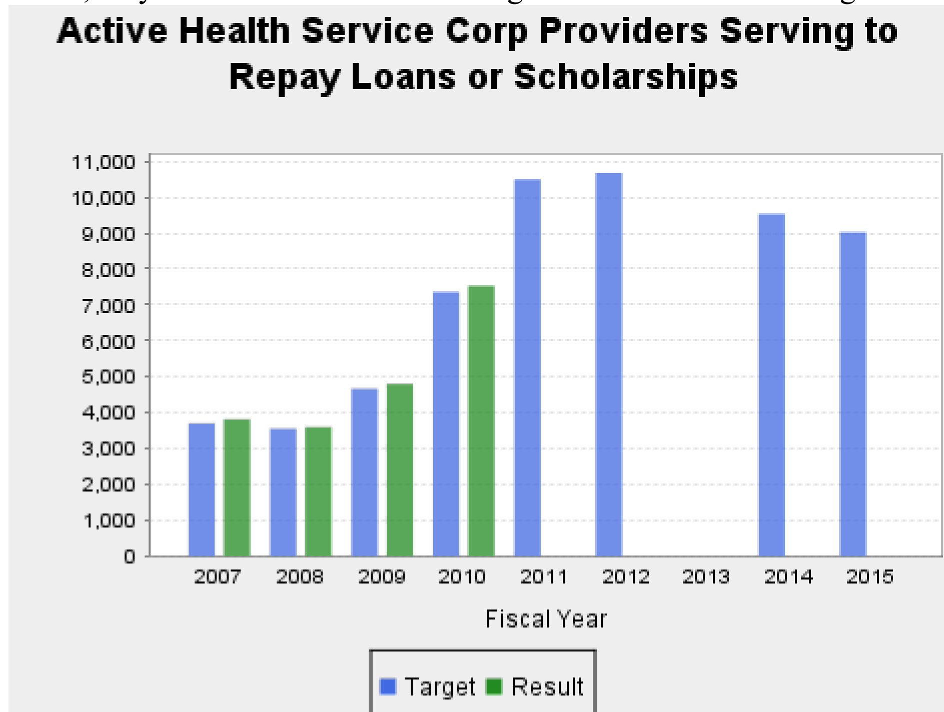
Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce

Objective B: Ensure that the Nation's health care workforce can meet increased demands

5.B.1 Field strength of the NHSC through scholarship and loan repayment agreements.

The National Health Service Corps addresses the nationwide shortage of health care providers in health professional shortage areas (HPSAs) by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. The NHSC field strength indicates the number of providers fulfilling active service obligations with the NHSC in underserved areas in exchange for scholarship or loan repayment support.

In FY 2010, the NHSC field strength of 7,530 primary care providers, more than doubled the 2008 field strength of 3,601. The FY 2010 field strength was boosted by 2009-2010 Recovery Act funding. Field strength is generally dependent upon variables such as the level of available funding, the number of qualified applicants, and the mix of scholarship and loan repayment support provided. Scholarship recipients do not appear in the field strength while in academic training; however, they do count toward field strength once their service obligation commences.



Data Source: HRSA Bureau of Clinician Recruitment Service's Management Information Support System (BMISS)

Also Supports: The NHSC field strength supports the following Healthy People 2020 goals: AHS-3, AHS-5, and AHS-4. It also supports HHS Strategic Plan objectives 1.C and 1. E.

5.B.2.a Number of primary care physicians who complete their education through HRSA's Bureau of Health Professions programs supported with FY 2010 Prevention and Public Health funding.

This measure tracks efforts, supported by FY2010 Prevention and Public Health funding, to add to the supply of primary care providers. Primary care is a cornerstone of high quality and cost-effective health care services. The need for primary care providers is growing due, in part, to demographic changes and expansions in health insurance coverage. Three categories of primary care providers whose training is supported by Prevention and Public Health funding will be monitored with a physician residents goal of 500 completers by FY 2015.

Grants in these programs were made in late September, 2010; therefore there are no performance results at this time. The first reports of program completers will be received in August, 2011. The first nurse practitioner completers will be reported in August 2011, the first physician assistant completers in August 2012, and the first physician residency completers in August 2013.

Data Source: Grantee Reports to HRSA Bureau of Health Profession

Also Supports: Aligns with Healthy People 2020 developmental measure: Increase the number of practicing primary care providers (AHS-4).

5.B.2.b Number of physician assistants who complete their education through HRSA's Bureau of Health Professions programs supported with FY 2010 Prevention and Public Health funding.

This measure tracks efforts, supported by FY2010 Prevention and Public Health funding, to add to the supply of primary care providers. Primary care is a cornerstone of high quality and cost-effective health care services. The need for primary care providers is growing due, in part, to demographic changes and expansions in health insurance coverage. Three categories of primary care providers whose training is supported by Prevention and Public Health funding will be monitored with a physician assistants goal of 600 completers by FY 2015.

Grants in these programs were made in late September, 2010; therefore there are no performance results at this time. The first reports of program completers will be received in August, 2011. The first nurse practitioner completers will be reported in August 2011, the first physician assistant completers in August 2012, and the first physician residency completers in August 2013.

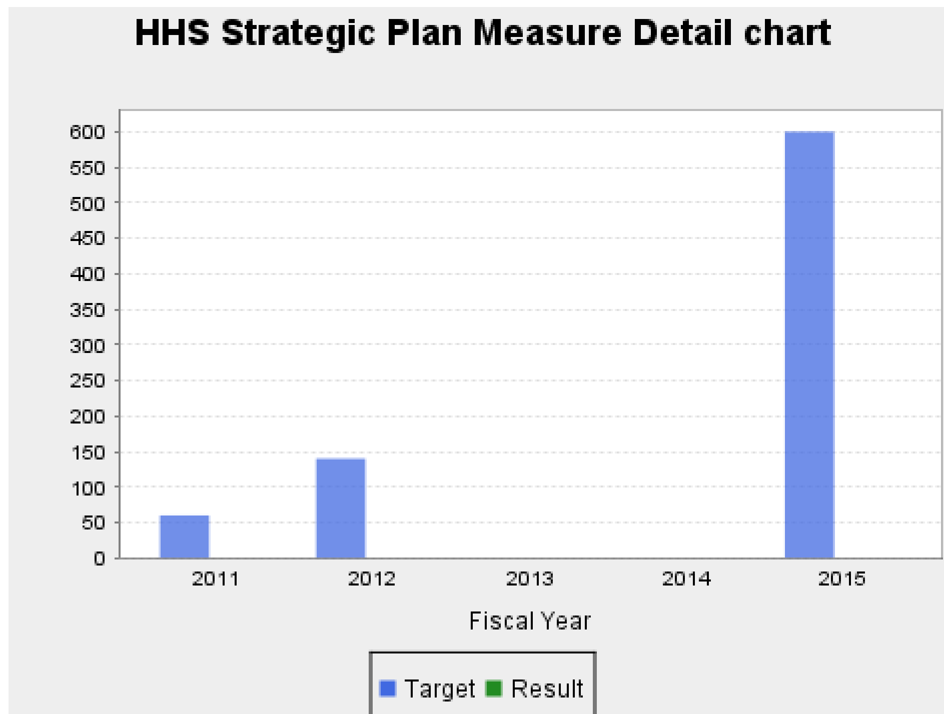
Data Source: Grantee Reports to HRSA Bureau of Health Profession

Also Supports: Aligns with Healthy People 2020 developmental measure: Increase the number of practicing primary care providers (AHS-4).

5.B.2.c Number of nurse practitioners who complete their education through HRSA's Bureau of Health Professions programs supported with FY 2010 Prevention and Public Health funding.

This measure tracks efforts, supported by FY2010 Prevention and Public Health funding, to add to the supply of primary care providers. Primary care is a cornerstone of high quality and cost-effective health care services. The need for primary care providers is growing due, in part, to demographic changes and expansions in health insurance coverage. Three categories of primary care providers whose training is supported by Prevention and Public Health funding will be monitored with a nurse practitioners goal of 600 completers by FY 2015.

Grants in these programs were made in late September, 2010; therefore there are no performance results at this time. The first reports of program completers will be received in August, 2011. The first nurse practitioner completers will be reported in August 2011, the first physician assistant completers in August 2012, and the first physician residency completers in August 2013.



Data Source: Grantee Reports to HRSA Bureau of Health Profession

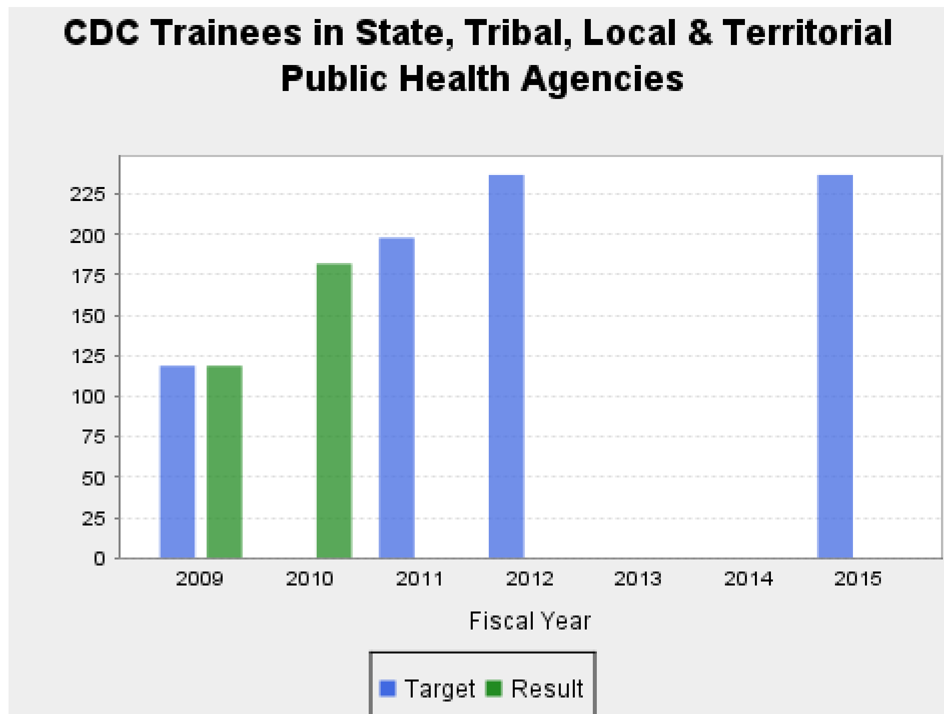
Also Supports: Aligns with Healthy People 2020 developmental measure: Increase the number of practicing primary care providers (AHS-4).

Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce
Objective C: Enhance the ability of the public health workforce to improve public health at home and abroad

5.C.1 Increase the number of CDC trainees in State, Tribal, Local, and Territorial public health agencies.

This measure tracks the annual number of CDC public health workforce trainees who are assigned to State, Tribal, Local, and Territorial (STLT) public health agencies, filling critical workforce needs in the field while they are in training for careers in public health. In 2009, this measure included the Epidemic Intelligence Service (EIS), Preventive Medicine Residency/Fellowship (PMR/F), Public Health Prevention Specialists (PHPS), and the Public Health Associate Program (PHAP), formerly known as the Public Health Apprentice Program; the Public Health Informatics Fellowship Program (PHIFP) was added in 2010; the new Health Prevention Corps (HPC) will be added in 2012.

In 2009, there were 119 CDC public health workforce trainees assigned to STLT public health agencies; in 2010, that number grew to 182.



Data Source: Data are compiled annually on November 15 to count the total number of fellows in field assignments in state, tribal, local, and territorial public health agencies. In 2009, this measure included the Epidemic Intelligence Service (EIS), Preventive Medicine Residency/Fellowship (PMR/F), Public Health Prevention Specialists (PHPS), and the Public Health Associate Program (PHAP), formerly known as the Public Health Apprentice Program;

the Public Health Informatics Fellowship Program (PHIFP) was added in 2010; the new Health Prevention Corps (HPC) will be added in 2012.

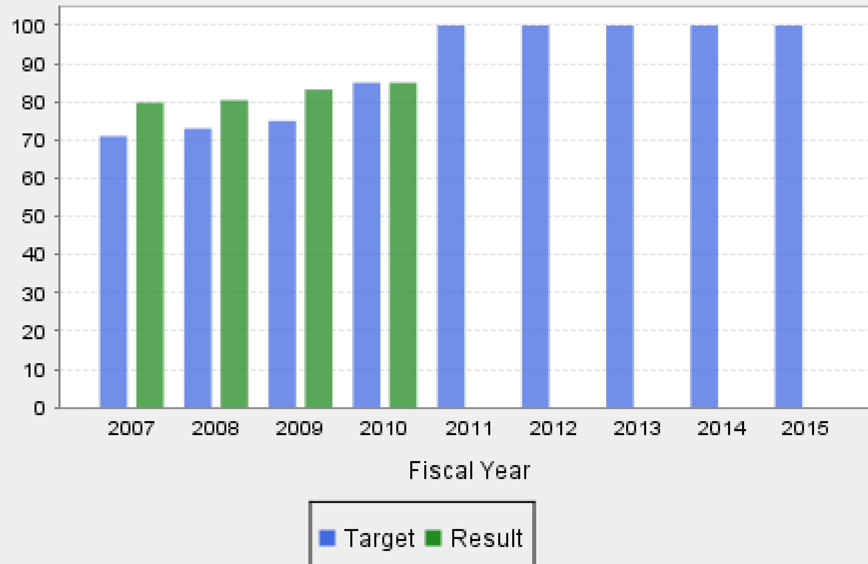
Also Supports: HHS Strategic Plan 5.E; Healthy People 2020 Objectives: PHI-13

Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce
Objective D: Strengthen the Nation's human services workforce

5.D.1 Increase the percentage of Head Start teachers with AA, BA, Advanced Degree, or a degree in a field related to early childhood education. (outcome)

Head Start grantees are required to develop plans to improve the qualifications of staff. Head Start has shown a steady increase in the number of Head Start teachers with an AA, BA, or advanced degrees in early childhood education and has exceeded the FY 2009 target. The Head Start reauthorization requires that all Head Start preschool center-based teachers have at least an AA degree or higher with evidence of the relevance of their degree and experience for early childhood education by October 1, 2011, thus the goal for FY 2015 is to reach 100 percent. Based on the most recent data as of December 2010, the Program Information Report (PIR) showed that in FY 2010, 85 percent of Head Start teachers had an AA degree or higher, meeting the target of 85 percent. More Head Start teachers have degrees than ever before, and are better equipped to deliver quality instruction to Head Start children. Of the 46,033 Head Start teachers in FY 2010, 39,121 have an AA degree or higher; of these degreed teachers, 14,848 have an AA degree, 20,127 have a BA degree, and 4,146 have a graduate degree. Not included in the percentage are an additional 5,678 teachers with a Child Development Associate (CDA) or state credential (no degree) and 444 teachers who do not have a degree but are enrolled in Early Childhood Education (ECE) degree programs. Of the teachers with a CDA or state credential, 47.9 percent are enrolled in ECE degree programs. The total FY 2010 figure represents an increase of 2,082 degreed teachers over the previous year.

In April of 2008 the Office of Head Start (OHS) made available to grantees the opportunity to apply for $5 million in Head Start training and technical assistance funding related to meeting new staff qualifications requirements. This funding can assist staff with costs related to acquiring a college degree or a Child Development Associate (CDA) credential. In September of FY 2008, OHS made new competitive grant awards to increase career development opportunities for Head Start teaching staff seeking associate and baccalaureate degrees in early childhood education. Ten five-year grant awards, totaling $3 million per year, were made to Historically Black Colleges and Universities, Hispanic-Serving Institutions, and Tribally Controlled Land Grant Colleges and Universities. In June of 2009 all Head Start programs were provided the opportunity to apply for one-time quality improvement funds (available through the Recovery Act) for the purpose of meeting the statutory qualification requirements for teachers and teaching assistants in Section 648A of the Head Start Act.



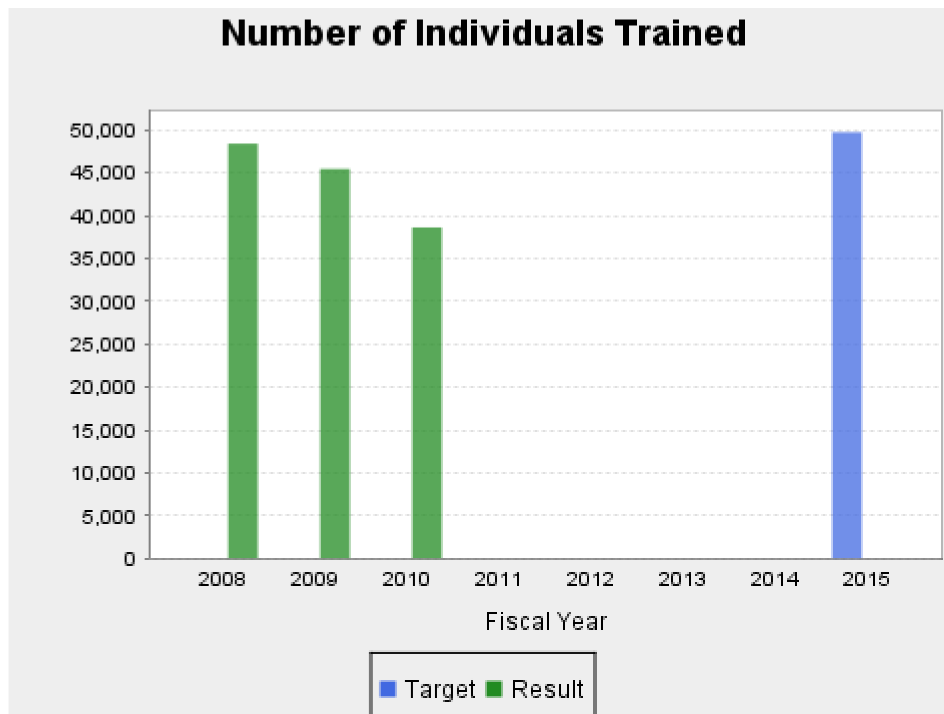
Data Source: Program Information Report (PIR)

Also Supports: HHS Strategic Plan Objective 5.D, strengthen the Nation's human service workforce.

5.D.2 Number of individuals trained by SAMHSA's Science and Services Program

SAMHSA has a number of activities that contribute to strengthening the National Health and Human Services Workforce. Of particular note are the Science and Services Activities that disseminate best-practice information to grantees and other prevention practitioners. These specific type of activities help ensure that SAMHSA's Services programs build on and/or improve service capacity in ways that are efficient, effective and as sustainable as possible. Science and Service programs are also an essential and cost-effective mechanism of increasing capacity within communities that do not receive grant funds from SAMHSA. While these programs are not always construed as direct services programs, they tend to serve many more persons at a much lower cost and, therefore, play an important role in advancing the field of substance abuse and mental illness prevention and treatment.

The measure used for this collection of activities is the number of participants trained. This measure reflects the total number of participants who attended a SAMHSA-funded training, meeting, or received technical assistance. Results obtained through this measure have remained relatively stable in recent years; however, observed fluctuations may, in part, be attributed to changes in the funding of programs, as well as a shift by some grantees to adopt a 'train the trainer' approach of providing technical assistance and training.



Data Source: SAMHSA Performance Measure Measurement System(s) (TRAC, SAIS, PMART)

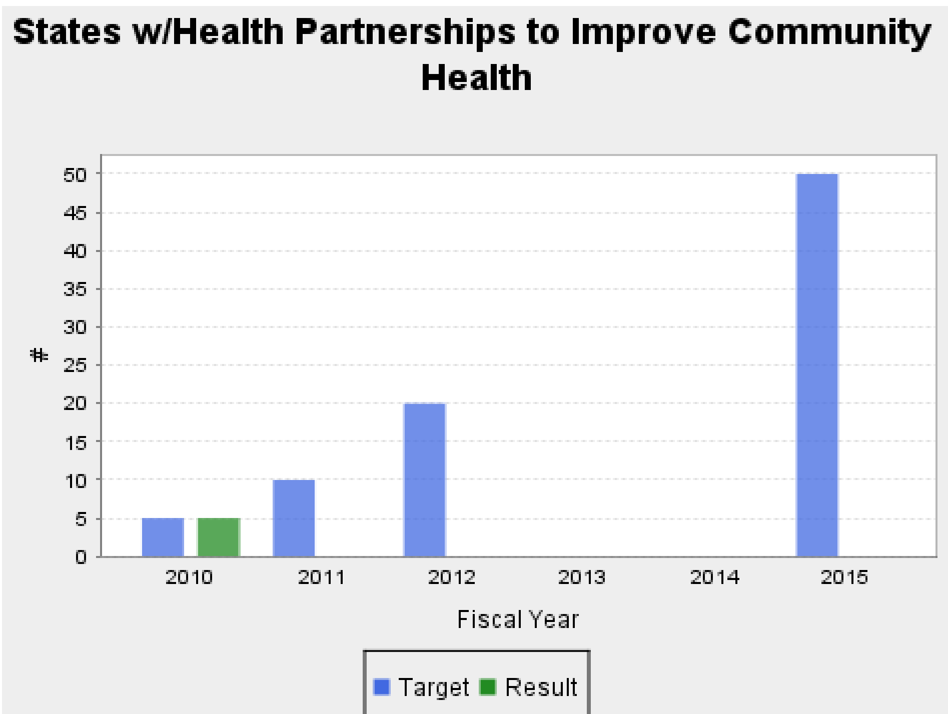
Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce

Objective E: Improve national, state, and local surveillance and epidemiology capacity

5.E.1 Increase the number of counties/communities that implement evidence-based policies/interventions as a result of their county health ranking. (MATCH County Rankings program)

The first annual *County Health Rankings – Mobilizing Action Toward Community Health (MATCH)* were released on February 17, 2010. The *County Health Rankings* is an initiative to rank the health of all counties within every state based on a summary measure of health outcomes and a related summary measure of health determinants. Providing annual rankings and consistent use of population-based health measures will allow counties to assess their progress over time as well as compare their health to other counties within their state.

The 2010 ASTHO State and Territorial Public Health Survey data provides information to establish the performance baseline. The specific data being collected for this measure is the number of states reporting they have, "Developed partnerships across multiple sectors to improve community health." For FY2010, the baseline number of states that reported developing partnerships across multiple sectors to improve comunity health was five. Future iterations of the ASTHO Survey will capture the actual number and types of actions that were implemented as a result of information conveyed by the rankings. Additionally, beginning in 2011, this measure will be supplemented with similar data from the National Association of County and City Health Officials (NACCHO) survey, which will collect information from local health departments on the use of the County Health Rankings to develop partnerships across multiple sectors to improve community health.



Data Source: Association of State and Territorial Health Officials (ASTHO) State and Territorial Public Health Survey.

Also Supports: HHS Strategic Plan 5.C (domestic) and 4.C

Developing

Measures in this area are currently in development, please check back later to see the results