

SECTION I:

OVERVIEW OF DEPARTMENTAL OPERATIONS

Overview of Departmental Operations

INTRODUCTION

This is the fourth Accountability Report for the U.S. Department of Health and Human Services (HHS), and the third as an official member of the U.S. Chief Financial Officer Council pilot program being conducted under the auspices of the Government Management Reform Act (GMRA) of 1994.

This report covers the period of October 1, 1998 through September 30, 1999, Fiscal Year (FY) 1999, and contains a high level overview of

- what we do,
- what we did with the federal funds entrusted to us, and
- how well we managed them.

It is our report to our “stockholders,” the American public, and as such we are accounting for the return on the taxpayer’s investment.

To substantiate what we say the report also contains the Department’s FY 1999 audited financial statements that discuss our financial condition as well as the auditors’ opinion that is an independent, objective assessment of how accurately we have represented our financial condition. Also this comprehensive report contains many other streamlined reports required under various statutes that make us accountable for our financial, management, and program performance. It contains new information that better explains how we managed federal funds and the actual costs of our programs.

By synthesizing all of this information into this single report, we hope to provide a more complete, accurate and useful understanding of the Department. Some of our components also are issuing their own Accountability Reports; these will give the reader more detailed program and finance information.

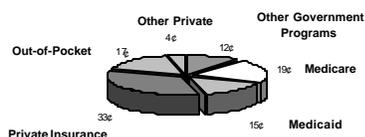
*Our mission is to enhance
the health and well-being
of Americans
by providing for effective
health and human services
and by fostering strong,
sustained advances in the
sciences
underlying medicine,
public health, and social
services.*

WHO WE ARE AND WHAT WE DO



Children are the focus of many HHS programs.

The Nation's Health Care Dollar 1998



Source: HCFA/OACT

The Department of Health and Human Services (HHS) is the United States government's principal agency whose mission is to enhance the health and well being of Americans. HHS accomplishes its mission by providing leadership in the administration of programs to improve the health and well being of Americans and to maintain the United States as a world leader in biomedical and public health sciences.

The Department manages more than 300 programs covering a wide spectrum of activities that impact all Americans, whether through direct services, the benefits of advances in science, or information that helps them to live better and to make healthy choices. These programs include:

- Conducting and sponsoring medical and social science research,
- Preventing outbreak of infectious disease including immunization services and eliminating environmental health hazards,
- Assuring food and drug safety,
- Providing health insurance for elderly and disabled Americans, health insurance for low-income people, and health insurance for children,
- Providing financial assistance and employment support/services for low-income families,
- Facilitating child support enforcement,
- Improving maternal and infant health,
- Ensuring pre-school education and services,
- Preventing child abuse and domestic violence,
- Preventing and treating substance abuse and treatment and
- Providing services for older Americans, including home-delivered meals.

In addition to the services they deliver, the HHS programs provide for equitable treatment of beneficiaries nationwide, and they facilitate the collection of national health and other data for research and publication.

Many of the goals, objectives, and activities of programs administered by HHS are shared within HHS and they also complement those of other federal agencies, and many state and local governments, as well as private organizations. Often the people being served are the same or similar. Because of this shared purpose, HHS works closely with its partners to accomplish its programs.

- HHS is the largest grant-making agency in the federal government, providing over 59,000 grants to states, among others, in the amount of more than \$158 billion per year (per the latest FY 1998 information). This is nearly 60% of all Federal grants awarded annually.
- More than \$8 out of every \$10 appropriated to a leading medical research organization of HHS funds more than 50,000 investigators that are affiliated with some 2,000 university, hospital and other research facilities.
- A nationwide network of 700 community and migrant health centers plus programs for the homeless and residents of public housing, served 8.7 million uninsured, underserved Americans as of 1998.
- Another nationwide network includes the states, 655 Area Agencies on Aging, 225 Indian Tribal organizations, and 2 organizations serving Native Hawaiians. It is responsible for assessing the needs of older persons, coordinating existing resources with the more than 27,000 service providers and developing new resources to meet local priorities for services to the elderly.
- Nearly 40,000 providers of health care are certified to provide Medicare services and 21,500 employees of 56 Medicare contractors have primary responsibility for processing Medicare claims.
- Some 1,327,000 community volunteers now help to provide comprehensive development services for low-income, preschool children ages three to five.

The Department collaborates and coordinates on common issues and problems with other federal agencies, for example:

- Coordination on the Medicare and Medicaid programs with Social Security Administration (SSA),
- Coordination with the Departments of Agriculture and Education for health insurance enrollment outreach and the Department of Justice on health insurance integrity issues,
- Coordination on drug control with the Office of National Drug Control Policy and Departments of Education, Justice, Treasury, Housing and Urban Development, and Transportation,
- Collaboration between HHS and Labor to implement Welfare to Work, and
- Cooperation on the Head Start program with Education.

	1997	1998
Poverty Rate for the United States	13.3%	12.7%
Number of Poor People	35.6 million	34.5 million
Number of Poor Children under age 18	14.1 million	13.5 million

Source: U.S. Census Bureau

HEALTH STATISTICS					
	1990	1995	1996	1997	1998
National Health Expenditures (\$billions)	699	994	1,043	1,092	NA
Persons without Health Insurance (percent)	3.91	15.4	15.6	16.1	16.3
Days of Hospital Care per 1,000 persons	792	630	606	NA	NA

Source: U.S. Census Bureau 11/99
 NA = Not Available

HOW WE ARE STRUCTURED TO ACCOMPLISH OUR MISSION

Two key concepts are critical to understanding of the HHS financial story. Expenses are one of the ingredients of the financial statements that are in Section IV. **Expenses (or Costs)** are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivable and accounts payable on determining annual income. **Outlays** refer to the issuance of checks, disbursements of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. **Budget outlays** are important because they are used to identify budget surpluses or deficits. Both concepts are important in understanding the financial condition of HHS.

The Net Budget Outlays that appear for each OPDIV are derived from the U.S. Treasury Year-End Report and September monthly Treasury statement.

The Consolidated Net Cost figures that appear for each OPDIV are derived from the HHS Consolidated Statement of Net Cost.

Because of the complexity and importance of the many issues involved in our mission, and consistent with the intention of congressional legislation, 13 HHS Operating Divisions (OPDIVs) administer the Department's programs. The Agency for Toxic Substance and Disease Registry is reported with the Center for Disease Control. Therefore this report refers to 12 OPDIVs. Leadership is provided by the Office of the Secretary (OS), which is also considered one of the 13 OPDIVs and five staff divisions headed by Assistant Secretaries, including the Assistant Secretary for Management and Budget (ASMB) who is responsible for this report. HHS is also active in ten regions throughout the United States, to coordinate the crosscutting and complementary efforts that are needed to accomplish our mission. Offices of the Inspector General (OIG), General Counsel, Civil Rights, Departmental Appeals Board (DAB), and Intergovernmental Affairs (IGA) also support this mission across the Department. The FY 1999 net budget outlay for providing this leadership was \$377 million. The FY 1999 net cost of the OS activities was \$490 million.

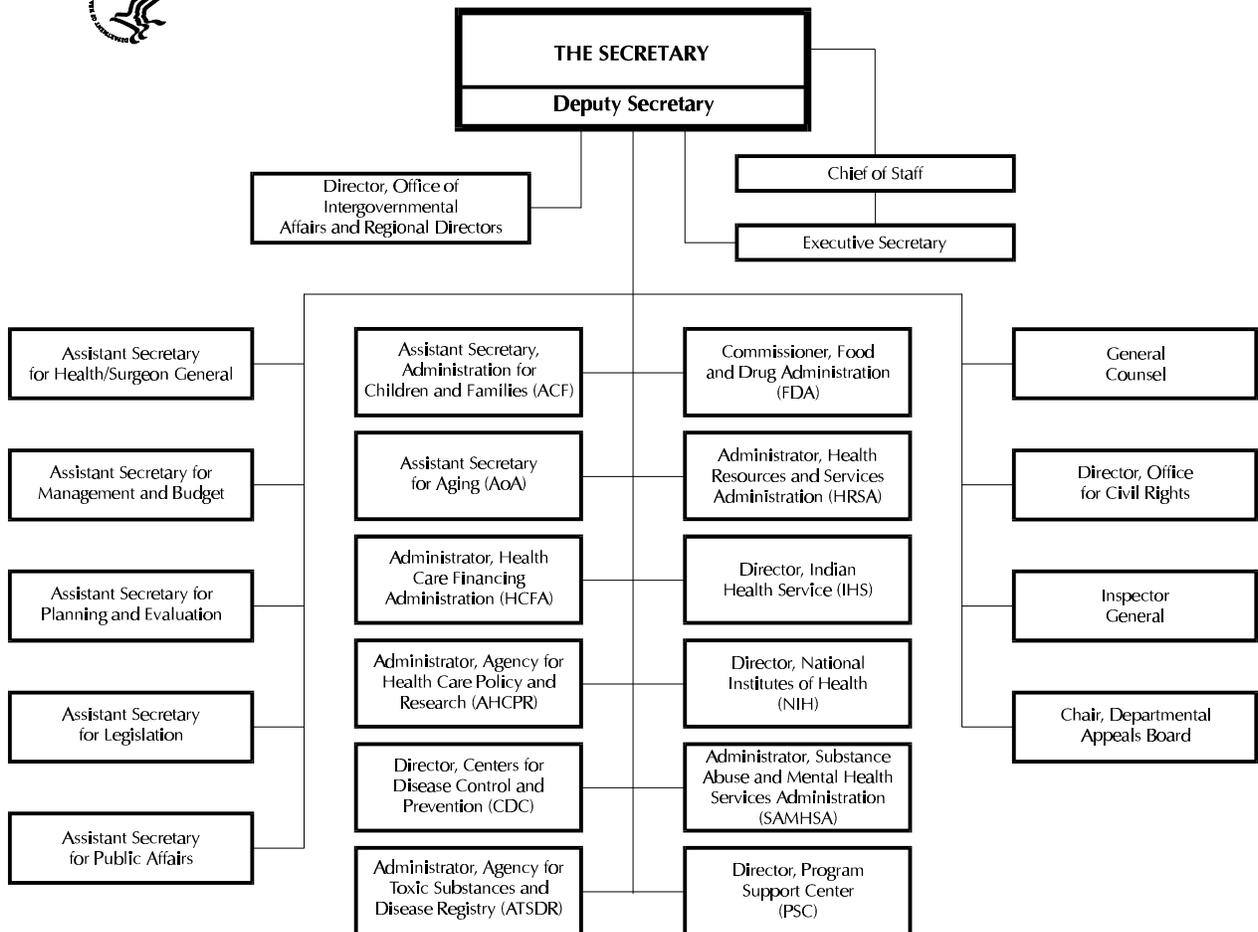
A chart of the current organizational structure of HHS follows. There was no significant organizational change in HHS in FY 1999. In December 1999 the name of Agency for Health Care Policy and Research was legislatively changed to Agency for Healthcare Research and Quality so this change will be reflected in next year's report. HHS Headquarters is located at 200 Independence Avenue, S.W., Washington, D.C., 20201.

SECRETARY: Donna E. Shalala

HHS FY 1999 NET BUDGET OUTLAYS: \$359.7 Billion

HHS FY 1999 CONSOLIDATED NET COSTS: \$358.4 Billion

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



HHS OPERATING DIVISIONS

The HHS OPDIVs are presented in the descending order of their budget outlays (rounded) for FY 1999.

Health Care Financing Administration (HCFA)

HCFA is the largest purchaser of health care in the world. HCFA administers the Medicare and Medicaid programs, which provide health care coverage to about one in every four Americans. In FY 1998 a major new health insurance program for children was implemented cooperatively by HCFA and the states to provide health insurance, preventive health care, and other important health services to children in need.

Outlays for Medicare and Medicaid, including state funding, represent 33.7 cents of every dollar spent on health care in the United States. Medicare provides health insurance for 39.5 million elderly and disabled Americans. Medicaid, a joint federal-state program, provides health coverage for 41.9 million low-income persons (48% of enrollees are children). In FY 1999 the Federal matching rates for various State and local benefits costs averaged 57% and administration costs averaged 56%. Medicaid also pays for nursing home coverage for low-income elderly, covering almost half of total national spending for nursing home care. HCFA operates from Baltimore, MD, Washington, DC, and ten regional offices. HCFA was established in 1977, incorporating the pre-existing Medicare and Medicaid programs.

ADMINISTRATOR: NANCY-ANN MIN DePARLE

FY 1999 NET BUDGET OUTLAY: \$299 billion

FY 1999 CONSOLIDATED NET COST: \$294 billion

Administration for Children and Families (ACF)

ACF is responsible for almost 50 programs that promote the economic and social well being of families, children, individuals, and communities. With its partners, ACF administers the new state-federal welfare reform program, Temporary Assistance to Needy Families (TANF) providing assistance to an average of 6.88 million persons monthly as of June, 1999. ACF administers the national child support enforcement system collecting some \$14.4 billion in 1998 in payments from non-custodial parents referred for collection follow-up. It also administers the Head Start program serving around 835,000 pre-school children.

ACF provides funds to assist low-income families in paying for childcare and supports state programs to provide for foster care and adoption

assistance. It also funds programs to prevent child abuse and domestic violence. ACF is organized into 8 program offices and five staff offices that operate in Washington, DC and ten regional offices. Five regions also act as hub sites for activities that affect several regions. ACF was established in 1991, bringing together several pre-existing programs.

ASST. SECRETARY FOR CHILDREN AND FAMILIES:
OLIVIA A. GOLDEN, Ph.D.
FY 1999 NET BUDGET OUTLAY: \$33.6 billion
FY 1999 CONSOLIDATED NET COST: \$35.6 billion

National Institutes of Health (NIH)

NIH is the world's premier medical research organization supporting some 35,000 research projects nationwide in diseases such as cancer, Alzheimer's, diabetes, arthritis, heart ailments, and AIDS. The NIH consists of 25 Institutes and Centers (ICs) that improve the health of all Americans by advancing medical knowledge and sustaining the nation's medical research capacity in disease diagnosis, treatment, and prevention. More than \$8 out of every \$10 appropriated to NIH flows out to the scientific community at large. NIH's research activities extend from basic research that explores the fundamental workings of biological systems, to studies that examine disease and treatments in clinical settings, to prevention, and to population-based analyses of health status and needs.

To accomplish its mission and these research activities NIH provides scientific leadership and establishes research priorities, funds the best research in the scientific community at large, conducts leading-edge research in NIH laboratories, effectively disseminates scientific results and information, facilitates the development of health-related products, ensures a continuing supply of well-trained laboratory and clinical investigators, sustains the nation's research facilities, and collaborates with other federal agencies. NIH is located in and near Bethesda, MD. NIH was established in 1887, as the Hygienic Laboratory, Staten Island, NY.

DIRECTOR: HAROLD E. VARMUS, M.D. (until January 1, 2000)
FY 1999 NET BUDGET OUTLAY: \$13.8 billion
FY 1999 CONSOLIDATED NET COST: \$14.4 billion

Health Resources and Services Administration (HRSA)

HRSA is the nation's health safety net provider; HRSA improves the nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA and their state, local, and other partners, work to eliminate barriers to care and eliminate health

disparities for the estimated 44 million Americans who are underserved, vulnerable, and special need populations. They also assure that quality health care professionals and services are available.

HRSA works to decrease infant mortality and improve maternal and child health. It provides services to people with AIDS through the Ryan White CARE Act programs and oversees the organ transplantation and bone marrow donor systems. HRSA also works to build the health care workforce and maintains the National Health Service Corps. HRSA uses a structure of four bureaus, centers, and special policy and support offices to accomplish its mission. Its headquarters are in Rockville, Md. HRSA was established in 1982, bringing together several pre-existing programs.

ADMINISTRATOR: CLAUDE EARL FOX, M.D., M.P.H.
FY 1999 NET BUDGET OUTLAY: \$3.86 billion
FY 1999 CONSOLIDATED NET COST: \$4.1 billion

Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR)

CDC is the "Nation's Prevention Agency"; it is the lead federal agency responsible for promoting health and quality of life by preventing and controlling disease, injury, and disability. CDC helps to save lives and health costs by working with partners throughout the nation and the world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthy environments, and provide public health leadership and training.

CDC is well known for its response to disease outbreaks and health crises worldwide. CDC's personnel are stationed in its national headquarters in Atlanta, in 18 locations throughout the United States and territories, and in more than 37 foreign countries and in 47 state health departments, and numerous local health agencies. CDC also provides immunization services and national health statistics. CDC was established in 1946, as the Communicable Disease Center.

DIRECTOR: JEFFREY P. KOPLAN, M.D, M.P.H.
FY 1999 NET BUDGET OUTLAY: \$2.4 billion
FY 1999 CONSOLIDATED NET COST: \$2.6 billion (including ATSDR)

ATSDR helps to prevent exposure and adverse human health effects and diminished quality of life associated with exposure to hazardous substances. ATSDR is a unique component of HHS

because it is funded and therefore accountable for those funds through the EPA Superfund account. However, ATSDR reports to the Director of CDC because of its complementary functions. Because of this the CDC financial statements include ATSDR. ATSDR conducts public health assessments, health studies, surveillance activities, and health education training in communities around waste sites on the U.S. Environmental Protection Agency's National Priorities List. ATSDR also has developed toxicological profiles of hazardous chemicals found at these sites. ATSDR's headquarters are in Atlanta, GA. ATSDR was established in 1980.

ASST. ADMINISTRATOR: HENRY FALK, M.D.

FY 1999 NET BUDGET OUTLAY: \$72.9 million (reported through EPA)

FY 1999 CONSOLIDATED NET COST: \$ 75.5 million

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA works to improve the quality and availability of substance abuse prevention, addiction treatment, and mental health services. There are conservatively estimated to be over 51 million adults and 8 million children that experience some form of mental disorder. An estimated 13.6 million Americans are current users of illicit drugs in 1998. SAMHSA provides funding through block grants to states for direct substance abuse and mental health services, including treatment for over 340,000 Americans with serious substance abuse problems. It helps improve substance abuse treatment through its Knowledge Development and Applications grant program.

SAMHSA also monitors the prevalence and incidence of substance abuse and mental illness. SAMHSA carries out its work through 3 centers and 6 offices that coordinate effort on certain special issues. SAMHSA headquarters are in Rockville, Md. SAMSHA was established in 1992. (A predecessor agency, the Alcohol, Drug Abuse and Mental Health Administration, was established in 1974.)

ADMINISTRATOR: NELBA R. CHAVEZ, PH.D

FY 1999 NET BUDGET OUTLAY: \$2.2 billion

FY 1999 CONSOLIDATED NET COST: \$2.3 billion

Indian Health Service (IHS)

The IHS is the principal Federal health care provider and health advocate for Indian people, who experience the lowest life expectancies in the country for both men and women. In partnership with American Indians and Alaska Natives from more than 557 federally recognized Tribes, IHS's mission is to raise the

physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS and the Indian Tribes serve 1.5 million American Indians and Alaska Natives through direct delivery of local health services.

The IHS funds 49 hospitals, 209 health centers, 6 school health centers, and 279 health stations, which are administered by Indian Tribes or IHS itself. There are also 34 health programs operated by urban Indian Health Organizations that provide various services to American Indians and Alaska Natives living in urban areas of the country. When unavailable from IHS or the Indian Tribes, medical services are also purchased from other providers to ensure that needed care is received. IHS headquarters are in Rockville, MD, and its twelve area offices are further divided into service units for reservations or a population concentration. IHS was established in 1924 (mission transferred from the Department of Interior in 1955.)

DIRECTOR: MICHAEL H. TRUJILLO, M.D., M.P.H., M.S.

FY 1999 NET BUDGET OUTLAY: \$2.2 billion

FY 1999 CONSOLIDATED NET COST: \$2.2 billion

Food and Drug Administration (FDA)

FDA is one of our nation's oldest consumer protection agencies.

It assures the safety of foods and cosmetics, and the safety and efficacy of human and animal drugs, biological products (vaccines and blood products), and medical devices - products that represent 25 cents out of every dollar in U.S. consumer spending. To carry out this mandate, FDA monitors the manufacture, import, transport, storage, and sale of \$1 trillion worth of products each year. The average cost of this effort to the taxpayer is about \$3 per person.

FDA's primary strategy is to ensure that safety is built into a product before a product goes on the market and that products are honestly and informatively labeled. Sound scientific analysis, regulatory standards, and communication help to ensure that industry does this. The standards are also enforced in postmarket surveillance. FDA operations are headquartered in Rockville, MD and are organized into six centers and five regions throughout the United States to accomplish its purpose. FDA was established in 1906.

COMMISSIONER: JANE E. HENNEY, M.D.

FY 1999 NET BUDGET OUTLAY: \$950 million

FY 1999 CONSOLIDATED NET COST: \$1.0 billion

Administration on Aging (AoA)

AoA is the federal focal point devoted exclusively to representing the needs and concerns of older people and their families and the policy and program development, planning, and service delivery to those persons in need. Through a nationwide service delivery infrastructure, AoA funds are leveraged to deliver comprehensive in-home and community services, including approximately 240 million meals for older individuals each year. AoA funds also make legal services, counseling and ombudsmen programs available to elderly Americans. AoA accomplishes this mission in collaboration with its partners – state and area agencies on aging, Tribal organizations, and the providers of services that comprise the aging network. AoA headquarters are in Washington, DC. AoA was established in 1965.

ASSISTANT SECRETARY FOR AGING:

JEANETTE C. TAKAMURA, Ph.D.

FY 1999 NET BUDGET OUTLAY: \$879 million

FY 1999 CONSOLIDATED NET COST: \$923 million

Program Support Center (PSC)

PSC is a self-supporting operating division of the Department that provides administration services for HHS and other federal agencies. The PSC is organized to provide competitive services on a service-for-fee basis in three key areas: financial management, human resources, and administrative operations. PSC provides these services to at least 13 other executive branch departments, 18 independent federal agencies, and the General Accounting Office. Activities and services of PSC are supported through the HHS Service and Supply revolving fund. Though PSC's services are fee-based and self-sustaining, the Statement of Net Cost shows the largest cost is for Retirement Pay and Medical Benefits for Commissioned Officers. PSC is located in Rockville, MD. PSC was established in 1995 as a business enterprise from various administrative support units of HHS.

DIRECTOR: LYNNDA M. REGAN

FY 1999 NET BUDGET OUTLAY: \$280 million - Reimbursable.

FY 1999 CONSOLIDATED NET COST: \$717 million

Agency for Health Care Policy and Research (AHCPR)

AHCPR acts as the catalyst for improving the quality, effectiveness, accessibility, and cost of health care as a result of its research and sharing of information. AHCPR conducts and supports the research needed to guide decisionmaking and improvements in both clinical care and the organization and financing of health care. AHCPR also promotes the incorporation of its and other research-based information into effective choices and treatment

in health care by developing tools for public and private decisionmakers and by broadly disseminating the results of the research.

Recent legislation in December 1999 changed the name of Agency for Health Care Policy and Research to the Agency for Healthcare Research and Quality (AHRQ). AHCPR/AHRQ operates six centers as well as its special policy and information offices. AHCPR is located in Rockville, MD. AHCPR/AHRQ was established in 1989.

DIRECTOR: JOHN M. EISENBERG, M.D.

FY 1999 NET BUDGET OUTLAY: \$79 million

FY 1999 CONSOLIDATED NET COST: \$174 million



We are the People's Department.

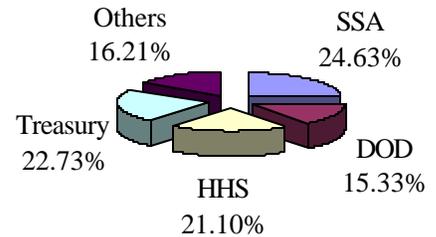
HIGHLIGHTS OF OUR BUDGETARY OUTLAYS

In FY 1999, HHS had net outlays of \$359.7 billion, representing 21.1% of all Federal net outlays. This represents an increase from \$350.6 billion (21.2% of Federal net outlays) in FY 1998. Only the SSA (which became independent from HHS in 1995) and the Department of the Treasury exceeded HHS spending in FY 1999.

The portion of the Federal budget allocated to HHS has grown significantly over the last three decades. The nature of the HHS entitlement programs is the reason for the growth in spending. We cannot limit the number of enrollees in our programs; every individual who meets the programs' criteria must be enrolled. Nine out of every ten HHS dollars are now spent on entitlements.

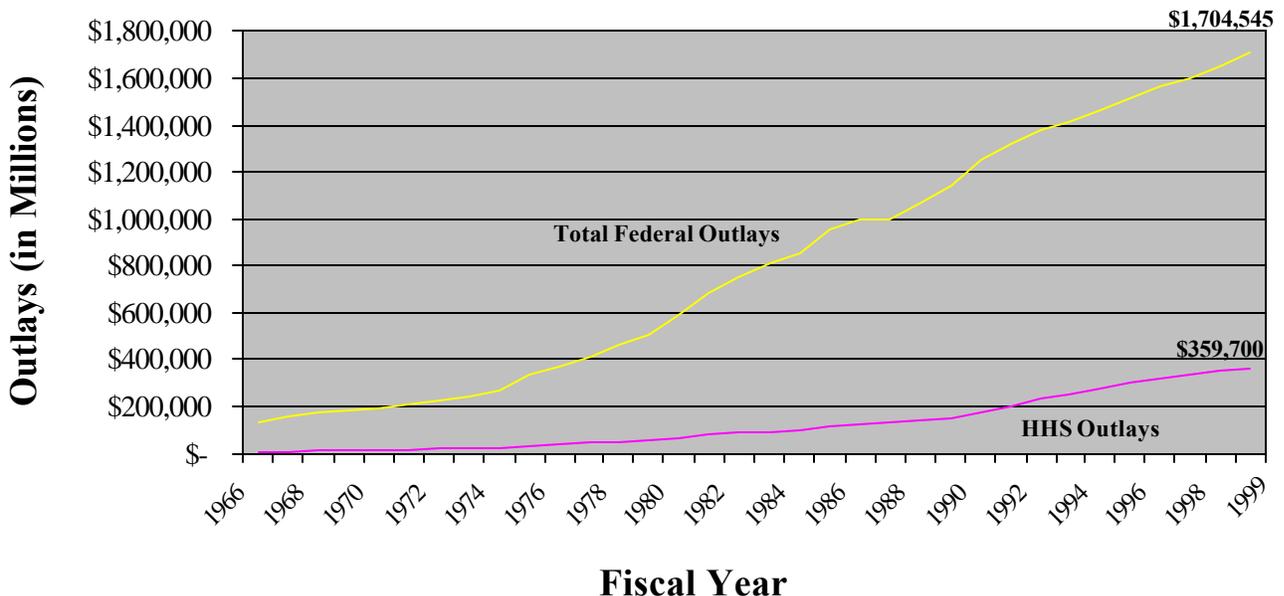
When the Medicare and Medicaid entitlement programs were enacted in 1966, HHS net outlays accounted for only 4% of Federal net outlays. As the ranks of the enrollees and beneficiaries of these entitlement programs has swelled along with the increasing costs of health care treatment, the impact on the Federal budget has been quite significant. The net outlays for Medicare alone now account for 11% of the Federal budget.

Federal FY 1999 Outlays by Agency



Source: Final Monthly Treasury Statement of Receipts and Outlays of the United States Government. (Treasury includes interest on Federal debt.)

HHS and Total Federal Net Outlays FYs 1966-1999



Source: Historical Tables, Budget of the United States Government Fiscal Year 2000, Executive Office of the President

HHS FY 1999 Net Outlays by Budget Function and OPDIV
 (In Thousands)

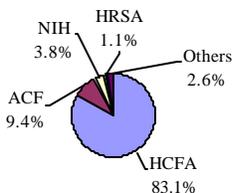
OPDIV	Education, Training, Employment, and Social Services	Health	Medicare	Income Security	Administration of Justice	TOTAL	HHS FY 1999 Net Outlays by OPDIV %
	Health Care Financing Administration		\$ 108,572,992	\$ 190,440,645			\$ 299,013,637
Administration for Children & Families	\$ 12,657,584			\$20,896,446	\$ 69,618	33,623,648	9.35%
National Institutes of Health		13,802,146				13,802,146	3.84%
Health Resources and Services Administration		3,859,672				3,859,672	1.07%
Centers for Disease Control & Prevention		2,380,432			47,758	2,428,190	0.68%
Substance Abuse and Mental Health Svs. Adm.		2,213,905				2,213,905	0.62%
Indian Health Service		2,193,221				2,193,221	0.61%
Food and Drug Administration		950,140				950,140	0.26%
Administration on Aging	879,268					879,268	0.24%
Office of the Secretary		376,730				376,730	0.10%
Program Support Center *		280,125				280,125	0.08%
Agency for Healthcare Research and Quality		79,375				79,375	0.02%
HHS SUBTOTAL	\$ 13,536,852	\$ 134,708,738	\$ 190,440,645	\$ 20,896,446	\$ 117,376	\$ 359,700,057	100.00%

* Though PSC's services are fee-based and self-sustaining, net outlays shown include \$201,689 thousand for Retirement Pay and Medical Benefits for Commissioned Officers with the remainder attributable to the HHS Service and Supply Fund and miscellaneous trust funds.

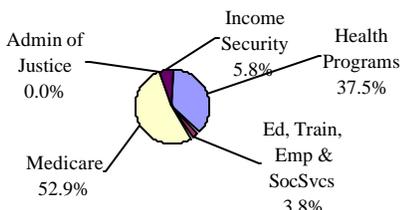
Source: Treasury Year End Report. Proprietary receipts from the public and intrabudgetary transactions have been allocated to each HHS OPDIV based on detailed amounts in the September monthly Treasury statement.

Note: The FY 1999 financial statements' supplemental schedules present data under six budget functions, rather than just the 5 shown here. This is because ATSDR's expenditures under the Natural Resources budget function are included in HHS financial statements, but excluded from HHS outlay figures; they are included in EPA's outlay figures.

HHS FY 1999 Net Outlays by OPDIV



HHS FY 1999 Net Outlays by Budget Function



HHS dollars are allocated to the OPDIVs across budget functions. The accompanying matrix chart of "HHS FY 1999 Net Outlays by Budget Function and OPDIV" details this distribution and facilitates the identification of concentrations of outlays. The largest single budget function is Medicare (which has a category all its own), with \$190.4 billion in spending. The second largest functional category, at \$134.7 billion, is Health where most of the funds are spent by HCFA (for Medicaid) and by NIH (for research). ACF has the bulk of responsibility for budget function dollars categorized as Education, Training, Employment and Social Services, and also for Income Security through the Temporary Assistance for Needy Families and Child Support Enforcement programs.

Measured by program spending, HCFA is by far the largest of the HHS OPDIVs, followed by ACF, then NIH, HRSA, CDC, SAMHSA, and other OPDIVs. The relative portion of total HHS net outlays by OPDIV is illustrated in the accompanying pie chart.

Outlays by budget function are largely concentrated in the Medicare and Health (which includes Medicaid) budget functions.

Readers will note in Section IV that the Statement of Net Cost, which was a new principal financial statement for FY 1998, allocates costs by OPDIV and by budget function. Costs reported will be concentrated in a similar fashion as the budget figures, noted above, for net outlays reported in this section of the Accountability Report.

OUR KEY ASSET: OUR EMPLOYEES

HHS, like any organization, cannot accomplish its mission without its employees. They provide the necessary direct services, coordinate with partners, award grants and contracts, and develop policy. The following chart shows the employment level distribution within HHS. The Full Time Equivalent (FTE) measure gives a better picture of total staffing than a count of the number of people at HHS, since some work full-time and some work part-time.

WORK FORCE PLANNING

In its simplest terms workforce planning is getting “the right number of people with the right skills, experiences, and competencies in the right jobs at the right time.” This definition covers a comprehensive process that provides managers with a framework for making staffing decisions based on an organization’s mission, strategic plan, budgetary resources, and a set of desired workforce competencies.

Many models for workforce planning have been developed, but all rely on comparing the present workforce to that needed in the future; determining the gaps and surpluses between the present and future in terms of knowledges, skills, abilities, and competencies; then developing strategic plans for workforce transition.

In 1999 the Office of the Assistant Secretary for Management and Budget (ASMB) published Building Successful Organizations: Workforce Planning in HHS, a workforce planning guide for the Department. An ASMB team is now working with OPDIV budget and human resources staff to help them refine workforce planning data to support fiscal year 2002 budget requests and then to institutionalize the workforce planning process.

HHS FY 1999 FTE

OPDIV	FY 1999 Actual	FY 1999 Percentage
FDA	8,910	15.1
HRSA	2,014	3.4
IHS	14,586	24.8
CDC	7,491	12.7
NIH	15,329	26.0
SAMHSA	632	1.0
AHCPR	253	.4
HCFA	4,219	7.2
ACF	1,509	2.6
AoA	120	.2
OIG	1,273	2.2
OCR	210	.4
DM	1,313	2.2
PSC	1,071	1.8
<i>Total Employment</i>	<i>58,930</i>	<i>100%</i>

* Total includes 187 statutorily exempt FTE. Those employees designated statutorily exempt are exempt due to Congressional statutes. An example statute is Public Law 100-140, the “Federal Physicians Comparability Allowance Amendments” of 1987. Other statutes may be authorized to achieve government’s recruitment and retention efforts in areas requiring highly specialized occupations.

WHAT WE ARE WORKING TOWARD

Healthy and productive individuals, families, and communities are the very foundation of the nation's security and prosperity. Through our leadership in medical sciences and public health, and as guardian of critical components of the nation's health and safety net programs, HHS has a responsibility and the opportunity to work to improve the health and well-being of our nation. The HHS strategic plan reflects this commitment in the following six strategic goals. Strategies and objectives have also been developed for each of these goals to ensure that steady, broad-based improvements result from our efforts. We are also measuring our progress toward these goals; these results are reflected in the HHS GPRA annual performance report summary and key performance results are also discussed in this Accountability Report.

HHS Strategic Goals

GOAL 1. Reduce the major threats to the health and productivity of all Americans.

GOAL 2. Improve the economic and social well-being of individuals, families, and communities in the United States.

GOAL 3. Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.

GOAL 4. Improve the quality of health care and human services.

GOAL 5. Improve public health systems.

GOAL 6. Strengthen the nation's health sciences research enterprise and enhance its productivity.

HOW WELL WE PERFORMED ON KEY PROGRAMS

PERFORMANCE INFORMATION FOR KEY HHS PROGRAMS

In this section we discuss the performance information for key programs and initiatives of HHS including some program performance goals and measures.

Financial management performance information and measures are discussed in the section titled Overview of Financial Management. Other useful performance information is contained in the Reports and Other Information section of this report. The performance information that follows is consistent with the Government Performance and Results Act of 1993 (GPRA) requirements and it supports and is aligned with the HHS strategic goals and selected strategic objectives under each goal. This information is also consistent with those GPRA programs discussed in the OPDIV-level financial statements as we begin to associate a program's performance with its costs. Performance information from other reliable sources was used as well. The source of the information is either cited or included in the listing of references in Appendix C.

Data on the results of our performance in various programs may be available on a limited basis and lag in time for several reasons. The data may be gathered infrequently due to cyclical reporting or may not be required because of legislative intent; the reliance on third parties to provide the data, including grantee reports; the cost of gathering the information; and the nature of the data, such as research results. The availability of performance data is also discussed under the Challenges section of this report and the validation/verification of the data is discussed more fully in the individual OPDIV performance plans and reports. Therefore, some of the performance information in this FY 1999 report is for prior years because that is the most current information that is available or because that information became known during FY 1999. Trends of our performance can eventually be determined by a comparison of annual trends in Accountability Reports from year to year.

For more comprehensive GPRA results, see the HHS FY 1999 GPRA Performance Report Summary and individual OPDIV GPRA Reports that will appear under <http://www.hhs.gov/progorg/asmb/budget/plans.html>

A key purpose of GPRA is to improve the confidence of the American people in the capability of the federal government by systematically holding Federal agencies accountable for achieving program results.



= In areas where we have met or exceeded the FY 1999 target we have noted that with a bullseye.

GOAL 1: REDUCE THE MAJOR THREATS TO THE HEALTH AND PRODUCTIVITY OF ALL AMERICANS.

Good health lies at the heart of the nation's well being. A healthy work force is more productive; a healthy student body is ready to learn; and healthy people are able to build a better society. HHS investments in reducing or eliminating behavioral threats to life and good health can pay off heavily in improved health and productivity of the American people.

For every \$1 spent on tobacco, drug, alcohol and sexuality education, \$14 are saved in avoided health care costs.

❖ **We took steps to reduce tobacco use especially among youth.**

Every day, 3000 teenagers start smoking, and 1 out of 3 will die of smoking-related diseases.

Between 1991 and 1997 tobacco use among youth increased from 27.5 percent to 36.4 percent. In response to this disturbing trend HHS established an initiative to reduce tobacco use among minors.

CDC's Heart Disease and Health Promotion program seeks to prevent tobacco use. SAMHSA collects youth smoking rates as part of its National Household Survey on Drug Abuse (NHDSA) and administers the Synar Amendment to support programs for compliance to reduce the sale of tobacco to minors and measures changes in youth smoking. FDA efforts emphasize its regulatory role and aim to increase the number of compliance checks performed at retail shops to enforce the requirement that minors do not purchase tobacco products.

The Department will measure the impact of its activities for FY 1999 through CDC's and the Office of Public Health Services' goal to stop the increase in youth smoking. The FY 1999 target for this goal is based on the FY 1997 levels of the biennial Youth Risk Behavior Survey. In the future the Department will use the SAMHSA National Household Survey on Drug Abuse to measure the impact of its activities.

In FY 1999 CDC began funding all 50 states and the District of Columbia to develop and maintain tobacco control programs — an increase of 18 states above last year. Baseline performance data is being developed. CDC also developed and released a set of "best practices" to help states assess their options for tobacco control programs and local funding priorities.

Also, under the Synar regulation states are to reduce the availability rate of tobacco sales to minors to 20 percent or less by the end of FY

**Percentage of Teenagers
 (In Grades 9-12) Who Smoke**

FY 1997	36.4%
FY 1995	34.8%
FY 1993	30.5%
FY 1991	27.5%

Source: CDC Youth Risk Behavior Survey

2002. SAMHSA assists in this effort through technical assistance and sampling studies in the states funded through the Substance Abuse Block Grant — a portion of which must be applied to prevention efforts.

The yearly targets were established with the initial implementation of the Synar regulation, based on the perceived amount of effort required in the state to reduce the sales to minors. For example, States with initial rates above 60 percent were given 2 years to reduce their rates to 40 percent and an additional 3 years to achieve 20 percent. The achievements above expectations resulted in the aggressive goal of 36 states for FY 2001.

In October 1999 SAMHSA announced that average retailer sales rates of tobacco products to minors dropped significantly from 40 percent in 1997 to 24 percent in 1998. This substantial decline reflects the growth of effective state tobacco enforcement programs established as a result of legislation and regulations.

FDA also contributes to this effort by entering into contracts with states to perform compliance checks in order to reduce the number of retailers who sell tobacco products to minors. The increase in compliance checks reflects the increase in participating states from 10 in 1997 to all 50 in FY 1999.



❖ **We helped to improve the diet and the level of physical activity of Americans.**

Lack of a good diet, or *nutrition*, along with physical activity contributes to at least four of the 10 leading causes of death and disability. The costs associated with diet-and activity-related health conditions, including direct health care and lost productivity are estimated at \$71 billion a year, according to a U.S. Department of Agriculture paper. Older Americans are particularly vulnerable to poor nutrition.

To combat this problem in FY 1999 \$504 million was provided to states, area agencies, and tribes which are part of the Administration on Aging's nationwide Aging Network for meals served in *congregate (group or community) settings*, and *home-delivered meals and other community-based services*. The Aging Network comprises 57 State Units on Aging, 655 Area Agencies on Aging, 225 Indian Tribal organizations, and 2 organizations serving Native Hawaiians.

Goal: (SAMSHA) Assure services availability for Synar Amendment implementation activities.

1. FY 1999 Target: 8 states have a violation rate of tobacco sales to minors at or below 20%

FY 1999 Actual: Exceeded the target; 21 states have a rate at or below 20%.

FY 1997 Baseline: 4 states, FY 1998 12 states



2. FY 1999 Target: SAMHSA provides technical assistance to help all states implement the regulations.

FY 1999 Actual: Met the target.

FY 1997 Baseline: 12 states



For every \$1 of federal congregate funds, \$1.70 additional funding is leveraged; for every \$1 of federal home-delivered funds, \$3.35 additional funding is leveraged. The average cost of a meal, including the value of donated labor and supplies, was \$5.17 for a group meal and \$5.31 for a home-delivered meal.

Compliance Checks Conducted

FY 1999	106,186
FY 1998	40,234
FY1997	6,464

Goal: Provide Home-Delivered Meals
FY 1999 Target: Maintain level of service provision at 119 million home-delivered meals.
FY 1999 Actual: Actual performance data will be available in September 2001.
Trend: FY 1996: 119 million meals, FY 1997: 123 million meals

Goal: Provide Congregate Meals
FY 1999 Target: Maintain level of service provision at 123.4 million congregate meals.
FY 1999 Actual: Actual performance data will be available in September 2001.
Trend: FY 1995: 123.4 million meals, FY 1996: 118.6 million meals, and FY 1997: 113 million meals.

Rates for reported primary and secondary syphilis	
1998	2.6 per 100,000
1990	20.3 per 100,000

CDC 1998 Sexually Transmitted Disease Surveillance Report

The Network leverages funds received from AoA to provide meals and other community-based services. These meals provided 40 percent to 50 percent of a client's daily intake from one meal per day according to the 1996 program evaluation.

The congregate meal trend is decreasing while the trend toward home-delivered meals is increasing. This is consistent with the pattern of states transferring funding from the congregate meals to the home-delivered meals programs. The FY 1999 targets were set based on the 1995 data available at that time. AoA has adjusted its GPRA targets for future years as a result and will use the FY 1997 actuals as the baseline for both measures in the future.



❖ **We actively promoted the reduction of unsafe sexual behaviors.**

About 12 million new cases of *sexually transmitted diseases* (STDs), 3 million of them among teenagers, occur annually. The annual direct and indirect costs of selected major STDs are approximately \$10 billion (\$17 billion if sexually transmitted HIV infections are included).

Unsafe sexual behavior can result in sexually transmitted diseases and contributes to some of the most rapidly spreading diseases in the country. The U. S. leads industrialized countries in rates of sexually transmitted diseases (STDs). In addition, unsafe sexual behavior among teens can result in unintended pregnancies and potentially life-damaging consequences of adolescent sexual experimentation. HHS has addressed the spread of STDs by prevention activities, surveillance, and research.

Syphilis disproportionately affects a small percentage of the population, particularly African-Americans living in poverty. Syphilis elimination efforts that focus on populations in areas where syphilis persists will help close one of the most glaring racial gaps in health status. CDC will measure the effectiveness of its effort to eliminate syphilis in project areas using an indicator of racial disparity. Beginning in FY 1999 CDC has set targets to reduce racial disparity in syphilis by 15 percent each year over the FY 1998 baseline of 34.2 percent.



To help prevent and control the spread of the deadly AIDS virus, in FY 1999 CDC continued to fund local prevention activities, helped HIV prevention programs to improve their services by applying effective behavioral interventions, and supported researchers to help identify successful approaches that community HIV programs can use. HIV surveillance guidelines were also developed in FY 1998. CDC efforts help state and local education agencies implement HIV prevention programs in schools nationwide to reduce risky behaviors among the 50 million young people who attend school.

In October CDC reported that AIDS fell from the top 15 causes of death in the United States declining an estimated 21 percent from 1997 to 1998, a rate of 4.6 deaths per 100, 000 — the lowest rate since 1987. HIV mortality has declined more than 70 percent since 1995.

CDC is also providing assistance to state and local health agencies and community-based organizations to implement effective surveillance of the incidence of HIV and AIDS. HIV reporting data are increasingly necessary to monitor the effect of the epidemic.

CDC published Guidelines for National Human Immunodeficiency Virus Case Surveillance, including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome in the MMWR Recommendations and Reports (December 10, 1999/Vol 48/No. RR-13).



In October 1999 HHS announced that the *teen birth rate* fell for the seventh straight year and reached its lowest level since 1987. We also released a new guide to help local communities and non-profit organizations establish successful teen pregnancy prevention programs.

In addition to the prevention efforts of CDC, grants such as the Maternal and Child Health Block Grant plus the Abstinence Education program, and the Adolescent Family Life demonstration activities in FY 1999 promoted and tested promising interventions to reduce teenage pregnancies.

HHS awarded \$100 million in new bonuses to four states and the District of Columbia for achieving the nation's largest decreases in out-of-wedlock births between 1994 and 1997.



Goal: (CDC) Improve the ability of the Nation's HIV/AIDS surveillance system to identify incidence and prevalence of HIV infection. (CDC)

FY 1999 Target: Update current HIV surveillance guidelines for security and confidentiality to include minimum performance standards for state, local and HIV/AIDS surveillance systems.

FY 1999 Actual: 100% of the states adopted the confidentiality standards.



Number of AIDS Cases Reported During 12 Month Period

Through June 1999	47,083
Through June 1998	54,140
Through June 1997	64,597
Cumulative Total as of June 1999	711,344

CDC HIV/AIDS Surveillance Report, Table 2, Vol.11, No.1 1999

❖ **We worked to curb alcohol use and reduce the use of illicit drugs.**

An estimated 13.6 million Americans were current users of illicit drugs in 1998, meaning that they used an illicit drug at least once during the 30 days prior to the interview for the 1998 National Household Survey on Drug Abuse. SAMHSA issued the results of the survey in 1999. Although this number is slightly less than the 13.9 million estimate for 1997 the difference is not statistically significant. By comparison, the number of current illicit drug users was at its highest in 1979 when the estimate was 25.0 million.

The 1999 Monitoring the Future study of overall drug use among 8th, 10th, and 12th graders also found that use generally remained unchanged since the 1998 survey. The NIH National Institute on Drug Abuse funds the study.

The use of illicit drugs remains at unacceptable levels. HHS and its partners actively deal with these problems through prevention, intervention, and treatment. In addition to the states, one of HHS's partners is the Office of National Drug Control Policy (ONDCP) which coordinates overall federal efforts through strategic goals and objectives. The first ONDCP strategic goal is to educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

To work with states in substance abuse prevention and treatment for youths and others, SAMHSA awarded \$1.56 billion in block grants in FY 1999. SAMHSA strives to improve how states spend their substance abuse prevention dollars by encouraging them to promote six prevention strategies: information dissemination, education, alternative activities, problem identification and referral, community mobilization, and environmental activities.

Drug abuse prevention programs are effective in changing individual characteristics that predict later substance abuse. SAMHSA's ongoing prevention intervention studies on predictor variables support the ONDCP strategic goal and will generate new empirical knowledge about effective approaches for changing the developmental path of children at risk for substance abuse. Although the outcomes of the interventions are not available yet, preliminary findings show significant improvement in the children in the intervention group. The goals of the interventions are to decrease the use of alcohol and tobacco by 10 percent and of marijuana by 5 percent by the end of the program.

To promote the adoption of best practices in reducing alcohol and drug abuse the SAMHSA National Clearinghouse for Alcohol and

Use of Any Illicit Drug In a Year		
	1998	1999
8 th Graders	21.0%	20.5%
10 th Graders	35.0%	35.9%
12 th Graders	41.4%	42.1%

University of Michigan 1999
 Monitoring the Future Survey

“For the past two years we have been cautiously optimistic as a series of encouraging reports seemed to indicate a leveling off and even a possible decline in drug use among teens after years of dramatic increases. While it looks like we have turned the corner...we must not rest.”

**Donna Shalala, Secretary of HHS
 August, 1999**

Goal (SAMHSA): Assure availability of services.
FY 1999 Target: 80% of states spend prevention funds in each of the six strategy areas.
FY 1999 Actual: Exceeded the target; 90% of states spent prevention funds in each of the six categories.



Drug Information (NCADI) distributes public information on prevention, intervention, and treatment. NCADI has experienced tremendous growth in the number of requests that it receives for information. In 1999 SAMHSA dramatically exceeded its target of a five-percent increase from its 1997 baseline. NCADI had a 129 percent increase, an average of 40,285 requests for information per month.



Prevention, intervention and treatment reduce drug abuse.

NCADI's toll free telephone number is 1-800-729-6686.

Goal (SAMHSA): Bridge the gap between knowledge and practice.
FY 1999 Target: 5% increase in number of NCADI information requests per month over FY 1997 baseline.
FY 1999 Actual: 129% increase over baseline.
Trend: FY 1997 Baseline: 17,600 requests per month; FY 1998: 25,289; FY 1999: 40,285.



Effectiveness of Treatment: In its 1996 National Treatment Improvement Evaluation Study (NTIES), SAMHSA found a clear linkage between the provision of substance abuse treatment services and improved life outcomes for both children and adults. The following are examples of NTIES findings on treatment effectiveness:

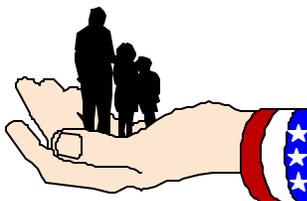
- 78 % reduction in the percentage of individuals engaging in both the sale of illicit drugs and violent crimes;
- 19 % increase in the rate of employment;
- 42 % decrease in the percentage of individuals who were homeless;
- 53 % decrease in alcohol and other drug-related medical visits;
- 28 % decrease in inpatient mental health visits; and
- 34-56 % decrease in "high risk" sexual behaviors associated with the transmission of HIV.

Cornell University researchers in a study of 6,000 students in NY State found that the odds of drinking, smoking, and using marijuana were 40% lower among students who participated in a school-based substance abuse program in grades 7-9 than among their counterparts who did not.



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

Each person, regardless of age, sex, physical ability, or racial/ethnic background, should have the opportunity to lead an economically and socially productive life. With its partners, HHS supports strategies that create opportunities for individuals, families, and communities to be economically and socially productive.



❖ **We worked to increase the economic independence of families on welfare.**

Under the *Temporary Assistance to Needy Families* (TANF) program, whose net cost was \$15.475 billion in FY 1999, states have extensive flexibility in designing programs that promote work, responsibility, and self-sufficiency. Almost every state requires personal responsibility contracts and 32 states expect clients to work within six months. In August 1999, data was released that showed all 50 states and the District of Columbia met the overall work participation rates for all families in 1998 — the first full year of the new welfare reform law. Welfare caseloads are at their lowest level since 1967 and the welfare rolls have fallen by nearly half since 1994. Nationwide the rolls have fallen by 49 percent and from 14.2 million to 6.9 million.

TANF WORK PARTICIPATION RATES FOR FY 1998	
All Family Rates	Two-Parent Family Rates
35.4%	42.3%
<small>Source: ACF Data & Statistics</small>	

Twenty-seven states received high performance bonuses totaling \$200 million for excellent performance in moving welfare recipients into jobs. The performance bonus program was authorized by law. The states placed 1.3 million welfare recipients into new jobs in 1998. Eighty percent of working recipients remained employed for an average of three months. In addition, their earnings rose from \$2,100 in the first quarter of employment to \$2,650 in the third. A recent General Accounting Office report found that between 63 percent and 87 percent of adults have worked since leaving the welfare rolls. These results are similar to state studies funded by HHS.

States also reported a new record percentage of parents on welfare that are working. Data released in 1999 shows that 35 percent of all adult welfare recipients were working, looking for employment or enrolled in work preparation activities in 1998. The percentage of employed recipients reached an all-time high at 23 percent compared to less than 7 percent in 1992 and 13 percent in 1997. Similarly, the proportion of recipients who were working, including employment, work experience, and community service reached 27 percent which is nearly a fourfold increase over the 7 percent recorded in 1992.

ACF's goal under the National Performance Review's (NPR) "High Impact Agency" initiative was to increase self-sufficiency for low-income families by moving one million welfare recipients into new employment by 2000. In FY 1999 ACF reported that the goal was achieved earlier than anticipated with 46 states reporting 1.3 million job entries for FY 1998.



CHANGE IN WELFARE CASELOADS SINCE ENACTMENT OF NEW WELFARE LAW			
Total TANF Families and Recipients (in thousands)			
	Aug-96	June-99	Percent Change
Families	4,415	2,536	- 43%
1,879,000 fewer families			
Recipient s	12,241	6,889	- 44%
5,352,000 fewer recipients			

Source: ACF Data & Statistics

TANF helps to increase the self-efficiency for low-income families.



As part of the same NPR initiative and consistent with ACF's *child welfare* activities and the Administration's adoption goal for 2001, ACF adopted a goal of increasing the number of children who are adopted from the public foster care system to 51,000 by FY 2001. Adoptions have increased from 28,000 in FY 1996 to 36,000 in FY 1998. In 1999 ACF awarded \$20 million in the first adoption bonuses to 35 states that had increased the number of children adopted from foster care.

Child Care and Development fund grantees have many efforts underway to address affordability and access to child care for low-income families. ACF work continues in partnership with states to increase and identify the number of children served by the grants. On

Goal: (ACF) Increase parental responsibility.
FY 1999 Target: Collect \$16.3 billion in child support collections.
FY 1999 Actual: \$15.5 billion (preliminary)
Trend: FY 1996: \$11.9 billion collected, FY 1997: \$13.38 billion collected, FY 1998: \$14.3 billion collected.

October 19, 1999 the Secretary of HHS released a report indicating that nationally, in an average month of 1998, 1.5 million low and moderate-income children eligible for this grant assistance from states received help through the program.

❖ **We helped to increase the financial and emotional resources available to children from their noncustodial parents.**

The *Child Support Enforcement Program* (CSE) obtains support for children by locating parents, establishing paternity, and establishing and enforcing support orders. The national employment database, known as the National Directory of New Hires, more than doubled its success in its first year by matching selected state cases and found over 2.8 million delinquent parents.

Paternities establishment rose to 1.5 million in 1998, a more than three-fold increase from 516,000 in 1992. The Passport Denial program collected more than \$2.25 million in lump sum child support payments and is currently denying 30-40 passports to delinquent parents per day.



❖ **We supported the improvement of the healthy development and learning readiness of preschool children.**

Head Start is the nation's premier early childhood development program for low-income children and families. Head Start has grown from 714,000 in 1993 to 835,000 children in FY 1999 who were enrolled in programs to enhance children's growth and development; strengthen families, and provide children's educational services.

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



Head Start helps to give children a good foundation for learning.

Head Start also emphasizes the importance of the early identification of health problems. Every child is involved in a comprehensive health program, which includes immunizations, medical, dental, and mental health, and nutritional services. ACF wants to assure that Head Start children are able to receive medical treatment when they are identified as needing medical services.

In FY 1999, ACF was just short of its goal of 88 percent, with 87 percent of Head Start children receiving care after being identified as needing services. It is important to bear in mind that Head Start has a predictable turnover rate, that is, children leave the program during its course for various reasons and so while a referral may have been made programs may not have follow up information for those children. Nevertheless, Head Start has chosen to increase targets of performance in future years.

The American Customer Satisfaction Index is a national economic indicator of customer satisfaction with the quality of goods and services available to household consumers in the United States. In December 1999 the partners that produce the ACSI released the result of customer evaluations of various federal agency services and products. The parents of Head Start students rated the program 87 out of 100 points; the highest rating received for the federal programs evaluated.



Children are our Nation's future.

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

Without insurance, access to health services is severely compromised. With its partners HHS broadens access to services and maximizes the number of low-income or special-needs populations served. HHS also prevents waste, fraud, and abuse of its entitlement and safety net programs, particularly Medicare and Medicaid because of their size and their impact on the total health care system.

Goal (HCFA): Decrease the number of uninsured children by working with states to implement SCHIP and increase enrollment of eligible children in Medicaid.
FY 1999 Target: Establish target and baselines.
FY 1999 Actual: Met.
Trend: FY 1997: 22.7 million in Medicaid; none in SCHIP



Healthy children mean a healthy future and lower health cost.

❖ **We are helping to bring about an increase in the percentage of the Nation's children who have health insurance coverage.**

Nearly 11 million children in the United States—one in seven—are uninsured because their families cannot afford private insurance and therefore are at significantly increased risk for preventable health problems.

In 1999 HHS continued to work diligently with its partners to develop and implement plans to extend health care coverage to millions of uninsured children. On September 8, 1999, HHS announced that the *State Children's Health Insurance Program* (SCHIP), which was passed in the Balanced Budget Act of 1997 and amendments, had been approved in all 56 states and territories in the country. Under the program, Congress and the Administration agreed to set aside \$24 billion over five years to help expand health insurance to children whose families earn too much to qualify for traditional Medicaid, yet not enough to afford private health insurance. States are improving their processes to achieve these enrollment levels.

HCFA met its target of developing a FY 2000 objective for decreasing the number of uninsured children by enrolling eligible children in Medicaid and SCHIP. The target is to enroll 1 million more children each year than the prior year.

In FY 1999, SCHIP enabled the states to serve many more women and children because community Health Centers are responding aggressively to the opportunities offered through SCHIP. HRSA and its Health Center grantees recognize that ongoing and intensified outreach and educational efforts will be necessary to assure that all the children who are eligible under SCHIP are enrolled.



❖ **We increased the availability of primary health care services.**

There is mounting evidence that access to a usual and regular source of care can reduce and even eliminate health status disparities among subsets of the population. The high quality primary health care received in HRSA's Health Centers has been shown to reduce hospitalizations and emergency room use, reduce annual Medicaid costs, and helps prevent more expensive chronic disease and disability for these populations.

Community Health Centers and the National Health Service Corps (NHSC) combined provides primary health care services to approximately 11.5 million low income, underserved patients. This represents one-fourth of approximately 44 million persons (according to 1998 data) in more than 4,000 communities across the nation who lack access to a primary care provider. For health centers, the patients include 3.52 million uninsured persons, of whom more than 1.2 million are children. This is a 59 percent increase since 1990. To help meet patient needs, 60 percent of the NHSC 2,526 physicians, nurses, dentists, and other primary care providers work in underserved communities throughout the country, in addition to the 40 percent who work in health centers. In FY 1999 they served 4 million of the total patients served.

In FY 1999, 52 new and expanded community health center were funded. The awards increased access to primary and preventive health care for approximately 200,000 underserved people.



To assure a health professions workforce that meets the health care needs of the American people, HRSA's **Health Professions Programs** operate more than 40 grant and student assistance activities focused on improving the diversity and distribution of the nation's health care practitioners. Thirty-three percent of family practice residents and 40 percent of nurse trainees, nurse practitioners, and midwives from HRSA-funded programs practice in medically underserved communities. In FY 1999 HRSA created a federal-state NHSC loan repayment partnership with 35 states to obtain the services of health professionals by repaying their educational loans using matching funds.



Goal: (HRSA) Increase utilization of health care for underserved populations.
FY 1999 Target: Increase to 8.9 million the number of uninsured and underserved persons served by health centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program
Trend: FY 1997: 8.3 million, FY 1998: 8.7 million.

Goal: (HRSA) Assure access to preventive and primary care for minority individuals.
FY 1999 Target: 65% of population served are minority individuals
Trend: FY 1997: 65% of population served at Health Centers, FY 1998: 64% of population served at health centers.

Goal: (HRSA) Assure access to preventive and primary care for uninsured individuals.
FY 1999 Target: 42%
Trend: FY 1997: 39% of population served at health centers, FY 1998: 41% of population served.

Data for all three goals will be available in May 2000. Percents for the last two goals will include NHSC patients.

On June 4, 1999, the Health Resources and Services Administration announced that two students enrolled in Howard University's Nursing Careers for the Homeless Program are the first to complete their bachelor of science in nursing degree programs. This program was launched in 1993 and since then 96 students were enrolled and are either enrolled in college-level nursing programs or employed in entry-level nursing positions.

Source: HRSA News Brief issued June 4, 1999.

Goal (SAMHSA): Assure services availability/meet targeted needs.

FY 1999 Target: Increase referrals from non-mental health agencies for mental health services by 10%.

FY 1999 Actual: Increased referrals to 80.1%.

Trend: FY 1997: 75%, FY 1998: 79.7%.

Although the target was not achieved, the results are moving in the direction of the target.

FY 1999 Target: Increase percent of client children attending school 75% of the time by 10%.

FY 1999 Actual: Exceeded the target. 88.9% attending at 12 months.

Trend: FY 1997 Baseline: 70%, FY 1998: 78.8% (12% increase)



Every year, more than 51 million adult Americans experience diagnosable mental disorders. Of them, more than 6.5 million are disabled by severe mental illness, including as many as 4 million children and adolescents.

Community mental health services block grants improve community-based systems of care in order to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious disturbances. SAMHSA awarded \$288.8 million in community mental health grants in FY 1999. An estimated 151,000 clients were served in systems receiving funds in FY 1999. Performance indicators are still being discussed with the states. A significant problem is the development and use of comparable definitions for the proposed measure. However, for children and their families who receive services at grantee sites under a comprehensive community mental health program, results are demonstrated by measures such as interagency collaboration and client outcomes.



In response to the severe and ongoing crisis regarding **HIV/AIDS**, HRSA's goal is to provide access to state-of-the-art HIV clinical care for those who have HIV/AIDS and approximately 250,000 HIV-positive people who know their status but are not under care. HRSA awarded \$710 million in formula grants to 50 states, the District of Columbia and U.S. territories to improve access to HIV/AIDS primary care, support services, and medications for people living with HIV/AIDS and their families. This amount includes \$461 million earmarked for state **AIDS Drug Assistance Programs**, ensuring that more than 100,000 low-income individuals living with HIV/AIDS receive life-saving and life-sustaining drug therapies.

Goals for the six Ryan White Care Act programs focus on increasing access to health care services and anti-retroviral therapy and reducing perinatal transmission. The programs have also established goals to serve women and minorities in proportions that exceed their representation in overall AIDS prevalence by a minimum of five percent. Despite the reduction seen in overall AIDS morbidity, the proportion of AIDS cases among women and minorities continues to increase. The benefits provided by new combination drugs have not uniformly reduced the incidence of AIDS. The performance noted below reflects significantly increased efforts across all of the programs to target communities of color.

- *Access to primary medical, dental, mental health, substance abuse, rehabilitative, and home health care:* HIV Emergency Relief Grants: Providing the core response in metropolitan areas hardest hit by the AIDS epidemic. Title I grantees reported 2.79 million visits in FY 1998, moving towards the FY 1999 target of 2.88 million visits. Also in FY 1998 the program exceeded its FY 1999 targets to serve 30 percent women and 64 percent minorities, serving 30.7 and 67.7 percent respectively.
- *HIV Care Grants to States:* In FY 1998 Title II programs reported 1.45 million visits, a 26.2 percent increase over FY 1997 and exceeding the FY 1999 target by approximately 230,000 visits. The program also exceeded its FY 1999 targets for serving minorities and women in FY 1998: 29.4 percent program beneficiaries in FY 1998 were women and 64.1 percent minorities, compared to the FY 1999 targets of 27 percent women and 59 percent minorities served.
- *Access to Primary Care:* In FY 1998 the Title III Early Intervention program exceeded its FY 1999 target of 90,433 clients receiving primary care services. A total of 105,398 persons received primary care services in FY 1998, a 9.3 percent increase compared to FY 1997. In addition, the program provided services to 72,242 minorities in FY 1998, an increase of 14 percent (8,819 minority clients) over FY 1997. The program has exceeded its 1999 target to serve 60,000 minorities for the past two years.
- *Access to Anti-retroviral Therapy:* In FY 1999, an average of 64,500 persons received anti-retroviral therapies each month through the AIDS Drug Assistance Program (ADAP). While an average of 9,500 additional clients were served per month in FY 1999 compared to FY 1998, because of data collection system revisions, the program did not meet its FY 1999 target to serve an average of 78,088 persons per month. The FY 1999 target was set prior to the full implementation of the data collection system for this measure in FY 1999.

Proportion of Women and Minorities served by Emergency Relief Grantees and State Grantees Compared to the Proportion of the U.S. Population with AIDS

Year	Proportion of AIDS patients who are women	Proportion of AIDS patients served by HRSA-funded programs who are women	Proportion of AIDS patients who are minorities	Proportion of AIDS patients served by HRSA-funded programs who are minorities
1996	15.3%	30.3%	53.8%	64.2%
1998	15.8%	30.0%	55.4%	68.0%

HRSA. Note: Source data contain duplicated client/beneficiary counts.



Of special concern also are health care services for mothers and children of low-income or isolated populations, who otherwise would have limited access to care. In 1999 the safety net for women and children was significantly expanded.

The **Maternal and Child Health Services (MCH)** provided \$576.2 million in funds to 59 States and jurisdictions in FY 1999 under a matching formula that takes into consideration the percent of the nation's low-income children residing in each. Since MCH is a block grant, the states have discretion in how they spent funds to meet the goals of the program. HRSA will use the aggregated state core measures that states report on, to assess the overall performance in FY 2001. In FY 1999 the program established baselines for the measures and set targets for FY 2001. Selected MCH goals include:



Prenatal health care is important to both mother and child.

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

Healthy Start was launched in 1991 to reduce infant mortality in areas with extremely high infant mortality and low birth weight babies. In FYs 1998 and 1999 HRSA focused on replicating the Healthy Start successes. Fifty-five new communities are replicating infant mortality reduction strategies from other communities.

INFANT MORTALITY RATES IN THE UNITED STATES (DEATHS PER 1,000 LIVE BIRTHS FOR INFANTS UNDER 1 YEAR OLD)					
	1960	1970	1980	1990	1997 *
Infant (All Races)	26.0	20.0	12.6	9.2	7.2**
White	22.9	17.6	10.9	7.6	6.0
Black	44.3	33.3	22.2	18.0	14.2
Hispanic	-	-	-	7.8	6.0

Source: Tables HC 1.1.A & 1.1.B- 1999 Trends in the Well-Being of America's Children & Youth (HHS)
 * Preliminary Data
 ** In 1997, the infant mortality rate for American Indians/Alaskan Natives was 8.7 and for Asian/Pacific Islanders was 5.0.

The ***National Immunization Program*** focuses on several major programmatic areas to achieve its goals, including childhood immunization, adult immunization, and global polio eradication. State and local health agencies play a primary role by using federal grant funds for a wide variety of immunization activities including surveillance. As a result, information shows that immunization coverage levels for adults in the United States have increased for influenza and pneumococcal disease. Progress is still needed among African-Americans and Hispanics.

CDC and HCFA share complementary goals to increase the number of annual influenza and lifetime pneumococcal vaccinations among selected populations aged 65 and over. For example, CDC and HCFA shared the FY 1999 goals to increase the annual influenza vaccination rate to near 60 percent. Although final data for this measure is not yet available, CDC data indicates that the rate of vaccination for influenza among persons aged 65 and older increased from 33 percent in FY 1989 to 63 percent in FY 1997.

CDC's REACH grants provide funding for adult immunization activities aimed at eliminating the health disparities. HCFA also stepped up its efforts to increase the number of minorities receiving flu and pneumonia vaccinations this year by mailing nearly 8 million postcards in four languages to remind Medicare beneficiaries to get immunized.

Also, on September 23, 1999, CDC announced that the nation's overall immunization rate for preschool children increased to a record 80 percent in 1998 attaining the highest rate ever recorded. Because childhood vaccination levels in the United States are at an all-time high, disease and death from diphtheria, pertussis, tetanus, measles, mumps, rubella and H.influenza B are at or near record lows. There was only one reported case of diphtheria, 100 reported cases of measles, and no reported cases of wild poliovirus for 1998.

Data show that cases of vaccine-preventable childhood diseases have been reduced by 97 percent from peak levels before the vaccines were available. To ensure that preschool age children continue to be vaccinated against preventable diseases, CDC and HCFA have developed complementary goals to increase the percentage of 2-year old children to receive all recommended childhood vaccinations. CDC's efforts focus on maintaining a 90 percent coverage rate among children 19-35 months for each recommended vaccine. While FY 1999 data will not be available until 2000, data from FY 1997 indicate that CDC met that goal for all but two vaccines. HCFA will continue to develop its goal to increase the percentage of Medicaid enrolled two-year-old children who are fully immunized. The first group of 16 states began developing their methods of measurement and its

Vaccination rate among persons 65 or older		
	FY 1995	FY 1997
Influenza	58%	65%
P. Pneumonia	34%	43%

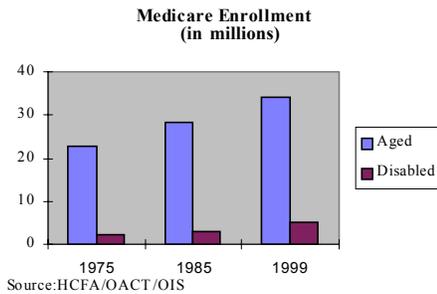
CDC National Health Interview Survey: FY 1997 data is preliminary.

Goal: Increase pneumococcal pneumonia and influenza vaccination among persons of 65 years or more.
1999 Targets: Vaccination Rates for Influenza 60%. Pneumococcal pneumonia 54%.
1999 Actuals: Data is not available yet.

For every \$1 spent on diphtheria/tetanus/acellular pertussis vaccination, \$27 is saved.



Immunization should begin at an early age.



Goal: (HCFA) Improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance.
FY 1999 Target: Work with states to establish an enrollment target for beneficiaries for FY 2000.
FY 1999 Actual: Met.




Medicare and Medicaid provide health services to many Americans.

baselines in FY 1999. They will complete setting their baselines by the end of FY 2000.

All of the national 1996 immunization coverage goals of vaccinating 90 percent of the nation’s children by aged two with the most critical doses of routinely recommended vaccines have been achieved and maintained except for Hepatitis B. Coverage for Hepatitis B in 1998 is only three percentage points short of the goal.



❖ **We protected and improved beneficiary health and satisfaction with Medicare and Medicaid.**

Medicare and Medicaid together provide health insurance coverage for approximately 75 million elderly, disabled, and economically disadvantaged Americans.

Medicare covers both hospital insurance and insurance for physician and outpatient care, laboratory tests, home health care, durable medical equipment, designated therapy services, and other services not covered by hospital insurance. A new program under Medicare, Medicare+Choice, was created in 1997 to increase health care options for beneficiaries through a greater variety of managed care and fee-for-service plans. Over the last thirty years, Medicare has significantly contributed to life expectancy, to the quality of life, and to protection from poverty for the aged and disabled. In FY 1999, Medicare costs were \$184.5 billion.

HCFA and states established a FY 2000 target of a 4 percent increase in enrollments. An additional 211,000 beneficiaries would be enrolled in a dual eligible program (i.e., for both Medicare and Medicaid).

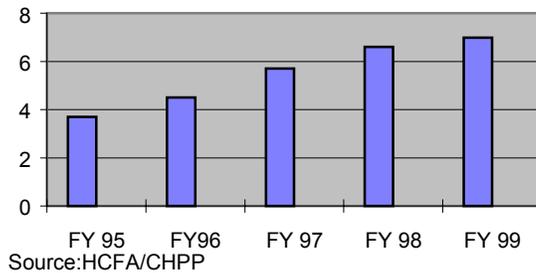
HCFA was among the 30 federal agencies that participated in the independent American Customer Satisfaction Index ratings of customer satisfaction. Recent Medicare beneficiaries were queried for their satisfaction with their HCFA contacts and they gave a rating of 71 percent satisfaction, which exceeds the aggregated federal government rating of 68.6 percent.

In FY 1999 HCFA also continued to develop an appropriate performance measurement methodology for fee-for-service arrangements and a goal for managed care plans.

In addition, HCFA set a goal and target for sustaining high quality health care options for beneficiaries. Achievement of this goal is dependent upon the marketplace and on receiving applications for managed care operations in rural areas and areas where there are no managed care organizations.

However, in FY 1999 the number of new applications or service areas did not materialize, and 45 managed care organizations terminated their contracts and 54 reduced their service area.

Managed Care Enrollment
(in millions)



The prevalence of physical restraints is an accepted indicator of quality of care and is considered a proxy for measuring quality of life for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility and other problems. Many providers and consumers still mistakenly believe that restraints are necessary to prevent residents from injuring themselves.



Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security, End Stage Renal Disease or Railroad Retirement benefits.

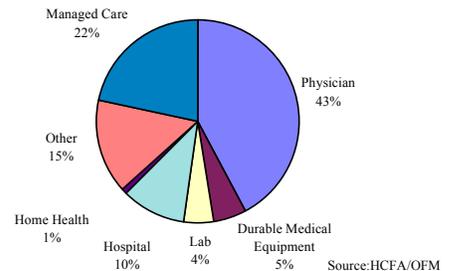
Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over, End Stage Renal Disease beneficiaries and disabled people entitled to Part A.

Goal (HCFA): Sustain health plan choices where Medicare beneficiaries have at least one managed care option/choice.
FY 1999 Target: 80% of Medicare beneficiaries have at least one managed care option/choice.
FY 1999 Actual: 76% have at least one managed care option/choice.

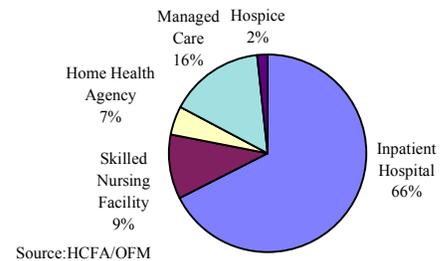
Goal: (HCFA) Decrease the prevalence of restraints in long-term care facilities.
FY 1999 Target: Decrease use of restraints to 14%.
FY 1999 Actual: Exceeded the target; 11.7%



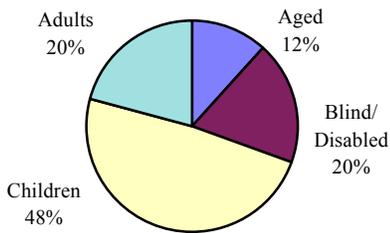
1999 SMI Medicare Benefit Payments



1999 HI Medicare Benefit Payments



1999 Medicaid Enrollees



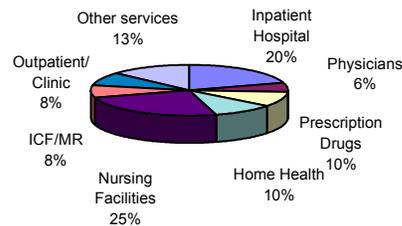
Source: HCFA/OACT

Medicaid is the primary source of health care for medically vulnerable Americans such as poor families, the disabled, and persons with developmental disabilities requiring long term care. Medicaid is administered in partnership with the States. HCFA issues the matching payment grants to states and territories for medical assistance and administrative costs. Medicaid provides health coverage for 41.9 million low-income persons. Medicaid has improved birth outcomes, childhood immunization rates, and access to preventive services, resulting in overall improvements in the health of America's children. Medicaid costs in FY 1999 were \$109.0 billion.

Goal: Provide to states linked Medicare and Medicaid data files for dually eligible beneficiaries.
FY 1999 Target: To provide data to 27 states.
FY 1999 Actual: Met the target; data is available to 27 states.



Medicaid Vendor Payments



Source: HCFA/OIS

There were approximately 6 million individuals dually eligible for Medicare and Medicaid. HCFA hopes to foster a service delivery system that is better integrated and more flexible in meeting the needs of dually eligible beneficiaries.



Twenty percent of Medicaid's vendor payments are made to inpatient hospitals.



❖ **We enhanced the fiscal integrity of HCFA programs and ensured the best value health care for beneficiaries.**

HCFA made great strides in 1999 to further define and implement its overall strategy for reducing payment errors in the Medicare and Medicaid programs. HCFA developed a comprehensive program integrity plan based on the key payment safeguard principles for fraud prevention, detection, enforcement, and coordination.

In 1999 HCFA also required more than 250 Medicare managed care risk-based plan (paid on a per-capita rate computed by actuaries) and cost-based plan (paid based on a cost report and audit) ***contractors to report on measures of performance*** on managed care programs. These measures included effectiveness of care, use of services, access to care, and other relevant areas that will provide a better understanding of the performance of the Medicare managed care plans.



Under the ***Health Care Fraud and Abuse Control Program***, HCFA, the HHS Inspector General, the Federal Bureau of Investigation, and the Department of Justice, as well as other agencies, including the Administration on Aging, are working together to detect and prevent fraud and abuse.

HHS and the Department of Justice have reported more than \$1.6 billion in fines and restitution returned to the Medicare Trust Fund during fiscal years 1997, 1998 and 1999. During these years HHS also excluded more than 8,600 individuals and entities from doing business with Medicare, Medicaid, and other Federal and State health care programs for engaging in fraud or other professional misconduct.

HHS/OIG works with HCFA to develop and implement recommendations to correct systemic vulnerabilities detected during evaluations and audits. These corrective actions often result in health care “funds not expended” (that is, funds put to better use as a result of implemented recommendations for program improvement). During FY 1999 the funds not expended on improper or unnecessary care amounted to approximately \$11.8 billion, an increase of \$1 billion above FY 1998. Much of this amount reflects savings achieved as a result of legislative amendments brought about by the Balanced Budget Act of 1996 (BBA).



HHS increased convictions in health care cases from 127 convictions in FY 1996 to 303 convictions in FY 1999.



Fraud Hot Line
Call Toll Free: 1-800-HHS-TIPS
(1-800-447-8477)
e-mail: HTips@os.dhhs.gov

During FY 1998 and FY 1999, AoA's efforts resulted in training 16,000 retired professionals and other volunteers in the Medicare and Medicaid programs. These volunteers, in turn, educated over 325,000 beneficiaries to identify and protect themselves against fraudulent, wasteful, and abusive health care practices. Where there were questionable charges for medical services, volunteers referred the cases (5,000 in FY 1999) back to health care providers, appropriate Medicare carriers, and ultimately to the HHS Inspector General.



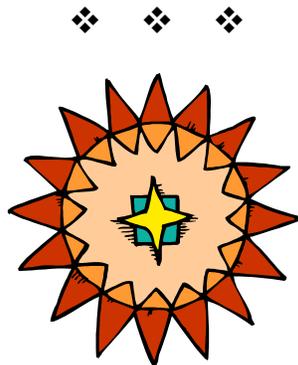
In FY 1998, HHS announced that for the first time Medicare would hire special consultants who specialize in audits, medical reviews, and internal controls for health programs as an additional effort for the Administration's fight against waste, fraud and abuse. HCFA awarded contracts in FY 1999 to thirteen Program Safeguard Contractors who will work with the **Medicare Integrity Program** to end criminal activities by fraudulent health care providers, ensure that Medicare pays only for medically necessary services, and identify honest errors that lead to improper payments.

While we have long known there are billing abuses in the Medicare program, the FY 1996 financial statement audit process gave us our first statistically valid estimated error rate in our Medicare fee-for-service program. Generally, the HHS Inspector General has found that the vast majority of claims are paid correctly based on information submitted on the claim. However, when supporting medical documentation was requested from providers and the services were reviewed the IG found errors in the claims. These errors range from inadvertent mistakes and missing documentation to outright fraud and abuse. The portion attributable to fraud cannot be quantified.

The estimated error rate is quantified in terms of ranges of both dollars and as a percent of program payments. Midpoint estimates are derived from the range figures.

Medicare Fee-for-Service Estimated Error Rates				
	FY 1996	FY 1997	FY 1998	FY 1999 Draft
Midpoint Dollar Estimate	\$23.2 billion	\$20.3 billion	\$12.6 billion	\$13.5 billion
Midpoint Percentage Estimate	14%	11%	7.1%	7.97%

As this Accountability Report goes to print, the final results on the FY 1999 error rate are not available. However, draft results indicate that the rate of improvement in the estimated error rate plateaued in FY 1999, as is indicated in the accompanying chart.



❖ **We strove to improve the health status of American Indians and Alaska Natives.**

In direct partnership with the Tribes, and in recognition of their expanding role in developing and managing the health needs of *American Indians and Alaska Natives*, (AI/AN), IHS is working to provide access to basic health services. This includes the assurance of adequate facilities and equipment for the provision of health services and adequate support services to the Tribal health delivery system.

The IHS, with the Tribes, developed and implemented a policy to ensure tribal consultation and participation in important IHS processes. The policy was in effect at the start of FY 1999. The stakeholders have elected to revisit specific consultation processes and IHS will conduct a baseline satisfaction survey after the policy is updated. IHS also continued to work with Indian Tribes exercising their



IHS provides access to health care for American Indians and Alaskan Natives.

Goal: (IHS) Reduce prevalence of diabetes among AI/AN population.
FY 1999 Target: Establish Area age-specific prevalence rates for the AI/AN population.
FY 1999 Actual: Rates are available for IHS Area and sex for 4 age groups from 0-19 to 65 and over.

self-determination rights through Tribal contracts, Tribal compacts, or continuation of services from the IHS health delivery system.

In FY 1999 under the *Hospitals and Clinics Program*, IHS and the Tribes provided essential services for inpatient care, routine and emergency ambulatory care; and support services. The program includes initiatives targeting special health conditions that affect AI/ANs.

In FY 1999 more than \$30 million was obligated for 286 grants awarded to IHS facilities, Indian Tribes/Tribal organizations and urban Indian organizations to address the prevention and treatment of diabetes. Diabetes continues to grow in epidemic proportions in Native American communities. In some AI communities, up to half of the adults have diabetes. *Diabetes* is 4-8 times more common among American Indians compared to the general U.S. population. Through these grants, diabetes prevention and treatment programs will reach more than 100,000 American Indians/Alaska Natives suffering from diabetes as well as another 30,000 to 50,000 who are at risk.



Once a facility has been completed, IHS has experienced an average increase of approximately 60% more patient visits than in the old facility. To maintain the level of service in the IHS health care delivery system over \$182 million was expended for health care facilities. A priority system determines which and when facilities are constructed.



Many Indian homes lack either a safe water supply or adequate sewage disposal system, or both. There is a demonstrated link between adequate *sanitation facilities* and reduced infant mortality, gastroenteritis, and other environmentally related diseases. IHS has undertaken a major effort to provide those facilities. These improvements will also help to reduce the related demands on the IHS health delivery system.



Under the Older Americans Act, the Administration on Aging provided funding to 225 Indian Tribal organizations representing more than 300 tribes and 2 organizations representing Native Hawaiians. Over 750,000 units of in-home services were provided to Native American older adults in FY 1999 for personal care, homemaker services health aide services, case management, and family support. A total of 600,000 rides to congregate (community) meal sites, doctor appointments, and grocery shopping were also provided. Without the transportation provided, Native Americans residing in isolated areas would not be able to conduct many activities essential to meet their everyday needs.

Goal: (IHS) Improve access to health care by construction of approved new health care facilities.
FY 1999 Target: Conduct construction of facilities scheduled for FY 1999
FY 1999 Actual: Met the target. The completion phase of construction was reached for the Hopi (Polacca), Arizona Health Center. Construction was started on Ft. Defiance, Arizona Hospital and the Parker, Arizona Health Center.



Goal: (IHS) Provide sanitation facilities.
FY 1999 Target: Provide sanitation facilities to 14,130 homes.
FY 1999 Actual: 16,571 homes received sanitation facilities.
Trend: FY 1998: 14,373 homes.



GOAL 4: IMPROVE THE QUALITY OF HEALTH CARE AND HUMAN SERVICES.

The quality of health and human services needs to improve continually to address constantly changing problems. HHS accomplishes this goal by a wide range of quality improvement activities designed to provide better ways of addressing the changing problems that confront the health care and human service delivery system, such as changes in family structures, demographics, and financing of health services.

❖ **We promoted the appropriate use of effective health services.**

Significant improvements in health, as well as reductions in costs associated with unnecessary remedial care, could be achieved by improving the extent to which physicians and other practitioners deliver the most appropriate treatments. Without a significant investment in research initiatives, there will not be enough *new knowledge produced to improve the health care system.*

To determine the funding priorities for research resources AHCPR, in FY 1999, succeeded in developing a research agenda for the future through consultations with its customers. The research agenda addresses the three AHCPR strategic research goals to improve:

- the structure and process of health care,
- the quality of that care, and
- access to care.

Consistent with these goals AHCPR awarded new research grants in the following critical areas to assess the outcomes and cost effectiveness of:

- access and outcomes of HIV care in America,
- medical outcomes in the pricing of hospital procedures,
- measuring the quality of care for diabetes, managed care and quality for children with chronic conditions, and
- improving heart failure care in minority communities.



In FY 1999 AHCPR continued to evaluate the outcomes of the investments that the agency funds. Over 3,100 articles appeared in the print media that cited the Agency and its programs; the combined circulation of the periodicals was over 253 million. Findings from at least 10 AHCPR research activities were published in major peer reviewed professional publications. Thirteen of AHCPR research activities were implemented in the health care system.

Goal (AHCPR): Initiate FY 1999 research initiatives.

1999 Target: Fund a minimum of 21 projects in:

- Consumer use of information
- Value-based purchasing
- Measure national care quality
- Vulnerable populations
- Translate research into practice

1999 Actual: 54 projects



Some Results of Recent AHCPR Research

Beta Blockers: Only 21% of heart attack patients receive beta blockers, which are more effective than calcium-channel blockers that are used 3 times as often.

Medical Errors: Adverse drug events are preventable if appropriate systems such as computerized monitoring programs are in place in hospitals.

Schizophrenia: Produced the evidence needed for the development of treatment recommendations for patients that have been used by the National Alliance for the Mentally Ill in a consumer booklet for families and patients.



We are concerned about improving the quality of health care.

Also the “Outcomes of Outcomes Research at AHCPR” report was issued in FY 1999. This evaluation study assessed the impact of AHCPR sponsored products in advancing methods to measure and improve health care. See <http://www.ahrq.gov/clinic/outcosum.htm>.

To see more findings of AHCPR research go to: Research Findings under www.ahrq.gov



In FY 1999 AHCPR also launched the National Guideline Clearinghouse <http://www.guideline.gov>, an internet-based source of information on clinical care that will help health professionals to improve the quality of care they provide to their patients. There were more than 640,000 web site visits in its first 10 months toward the end of 1999. NGC had an average of 16,000-18,000 visits per month. In addition, AHCPR’s publications clearinghouse continued to disseminate information and received 1999 customer satisfaction ratings of 97.2 percent for providing requested assistance.



❖ **We increased consumers’ understanding of their health care options.**

In 1998 HHS launched a nationwide effort to help patients rate their health plans and to help consumers choose among plans. The effort is built on a new survey tool, the *Consumer Assessment of Health Plans* (CAHPS), that provides a consumers-eye view of the care and service they receive from health plans. The survey asks how easily beneficiaries can access specialists and urgent care and seeks information on the general level of consumer satisfaction.

In FY 1999 AHCPR used its evaluation results of the CAHPS to improve the usefulness of this consumer-oriented tool. According to preliminary findings, quality affects consumer choice of health care plans. Consumers do have a favorable reaction to CAHPS reports and they do use CAHPS data when choosing a plan.



Consumers can also gain an understanding of their health care options and obtain help in making reliable personal health choices by searching several locations on the HHS web sites. In FY 1999 HHS has continued and expanded its *presence on the Internet*.

HEALTHFINDER, at <http://www.healthfinder.gov>, the gateway that links to more than 1,250 Web sites, was expanded to include: Hot Topics (top 20 topics and some perennial favorites), Smart Choices (wellness and prevention) and Just For You (age-specific links).

MEDLINE, at <http://www.nlm.nih.gov>, contains the world's most extensive collection of published medical information. It is useful for those seeking information about health conditions, research, and treatment. In FY 1999 NIH's National Library of Medicine revamped Medline for use by the public.

MEDICARE, at <http://www.medicare.gov>, offers a variety of useful information and details new choices available to beneficiaries under the Balanced Budget Act.



To help consumers make informed decisions about the medications they use and give their families, FDA issued a new regulation in FY 1999 to provide new, easy-to-understand **labeling on non-prescription drugs**. By clearly showing a drug's ingredients, dose, and warnings, the new labeling will make it easier for consumers to understand information about a drug's benefits and risks as well as its proper use.



❖ **We improved consumer protection.**

In June 1999 HCFA announced new patient protections in standards to protect the health and welfare of hospitalized patients in compliance with the Administration's **Consumer Bill of Rights**. The patient's rights regulations strengthen existing protections for patient health and safety and will assure that high quality care is provided to all patients in hospitals participating in Medicare and Medicaid. The six basic patient rights specified in the regulations include the right to confidentiality of patient records and communications, and the freedom from the inappropriate use of restraints and seclusion.



HRSA's National Practitioner Data Bank (NPDB) tracks adverse professional actions against physicians and dentists as well as medical malpractice settlements and judgments against all licensed health care professionals and can be queried by licensing, privileging, and credentialing authorities prior to granting licensure or extending clinical privileges. In FY 1999 NPDB received 399,943 queries and matched responses containing malpractice payment, adverse action, or

FDA asked principal food shoppers and food preparers in American households about the usefulness and clarity of food labeling and the usefulness of consumer alerts. In the ASCI ratings, FDA scored a rating of 66% satisfaction. As a result, FDA is going to increase public awareness of its actions to ensure food safety.

Goal (HRSA): Assure effectiveness of health care.
FY 1999 Target: Provide responses to 3,200,000 inquiries.
FY 1999 Actual: Exceeded the target; provided responses to 3,235,631 inquiries.



About 1.6 million elderly and disabled Americans receive care in approximately 16,800 nursing homes across the United States.

Goal (AoA): Protect vulnerable older Americans.
FY 1999 Target: Maintain 71.48% national resolution/partial resolution rate of complaints by Ombudsmen.
FY 1999 Actual: Data will be available in September 2001.
Trend: FY 1995 Baseline: 71.48%

exclusion report information, and 2,835,318 responses that confirmed that the named practitioner had no malpractice payments, adverse actions, or exclusions. Based on previous user surveys conducted by the OIG, an estimated 10,800 licensure, credentialing, or membership decisions were affected by these match responses during FY 1999.



HCFA also strengthened federal oversight of state enforcement of health and safety requirements at *nursing homes*. In March 1999, a final regulation was issued that allows HCFA and states to impose civil monetary penalties for each serious violation. States also must investigate any complaint that alleges harm to a resident.



To ensure the *Protection of Vulnerable Older Americans*, long-term Care Ombudsman programs in every state and 586 local areas helped to resolve nursing and board-and-care home resident's problems; provide information to residents, potential residents, and their loved ones; and advocate on behalf of these health care consumers. In FY 1998 ombudsmen nationwide handled approximately 250,000 complaints made by over 121,000 individuals and provided information to another 210,000 people. To support ombudsmen in their demanding work, the AoA has funded the National Long-Term Care Ombudsman Resource Center. The Center is operated by the National Citizen's Coalition for Nursing Home Reform in conjunction with the National Association of State Units on Aging. The Center provides on-call technical assistance and intensive annual training to ombudsmen to enhance the effectiveness of their interventions in complex situations.

In FY 1998, 82 percent of the cases closed by Ombudsman programs involved nursing homes. The five most frequent nursing home complaints concerned:

- Requests for assistance needed,
- Shortage of staff,
- Personal hygiene neglected,
- Menu, food service, and
- Accidents, improper handling.

During FY 1999 training was provided for state ombudsmen to help them better assist residents and their families. A primary area of focus was information and methods for handling the involuntary discharge of residents from nursing homes.



In FY 1999, AoA increased funding for the *Eldercare Locator*, a toll-free national telephone directory assistance service designed to link callers to Older Americans Act information and assistance programs around the country. As a result of the additional funding, the Locator served an average of 7,196 people per month in FY 1999, almost a 10 percent increase over the 6,578 served in FY 1998. As a result of the Locator, assessment, referral, and appointment services were provided to over 600 more Americans per month and 7,400 more per year.



To help ensure the protection of consumer rights to access to HHS programs, the HHS Office for Civil Rights (OCR) established goals for *compliance with non-discrimination legislation*, to assess whether there had been an increase in compliance in priority areas as a result of OCR actions. Each completed corrective action or no violation finding reported by OCR represents a provider in compliance with the law, either because the provider made changes in policies and practices or because OCR determined that there was no violation.

The levels selected for the FY 1999 Targets reflect OCR's commitment to focus its effort in high priority areas.



**Call Eldercare Locator at
1-800-677-1116.**

Goal (OCR): HHS grantees and providers found to be in compliance with Title VI in limited English proficient reviews/ investigations.

FY 1999 Target: 125 corrective actions and no violations.

FY 1999 Actual: Exceeded the target; 146 corrective actions and no violation findings.

FY 1998 Baseline: 98 corrective actions and no violations.



Goal (OCR): State and Local TANF agencies and service providers found to be in compliance with Title VI, Section 504 and American with Disabilities Act.

FY 1999 Target: 16 corrective actions and no violation findings.

FY 1999 Actual: 23 corrective actions and no violation findings.

FY 1998 Baseline: 8 corrective actions and no violations findings.

GOAL 5: IMPROVE PUBLIC HEALTH SYSTEMS.

The infrastructure of public health systems needs to be preserved and improved to conduct the interventions that save lives and ameliorate suffering. HHS contributes to an effective public health system by supporting improvements in training staff, encouraging the sharing of reportable disease information electronically, and ensuring that food and drug safety systems exist and work.

Goal: (AHCPR) Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and planners.

1. FY 1999 Target: Core MEPS public use files available through Web site and CD-ROM within 9-12 months after data collection completed.
FY 1999 Actual/Baseline year: Significant progress towards releasing public use files within a year after data collected.

2. FY 1999 Target: Customer Satisfaction from use of MEPS tapes and products rated at 85%.
FY 1999 Actual/Baseline year: Web data: 92% customer satisfaction. Publications 93-96%. CD data: 86%



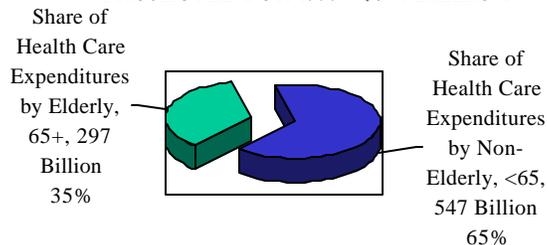
❖ **We improved the public health system’s capacity to monitor the health status and identify threats to the health of the Nation’s population.**

The *Medical Expenditure Panel Surveys* (MEPS), had \$29.3 million budgeted for FY 1999. MEPS is a household-based survey that collects detailed information regarding health care services from a nationally representative sample of Americans. It tracks the health care services use and payment from a nationally representative sample of the civilian non-institutionalized population. It tracks the health care services used by American families and individuals, the expense (including out-of-pocket expense) associated with those services, and the cost, scope and breadth of private health insurance coverage held by and available to the U. S. population. This sole and unique level of detailed information permits estimates of the impact of changes in financing, coverage and reimbursement policy, as well as estimates of who benefits and who bears the cost of a change in policy.

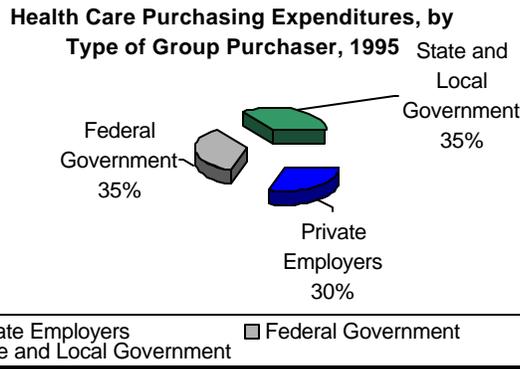
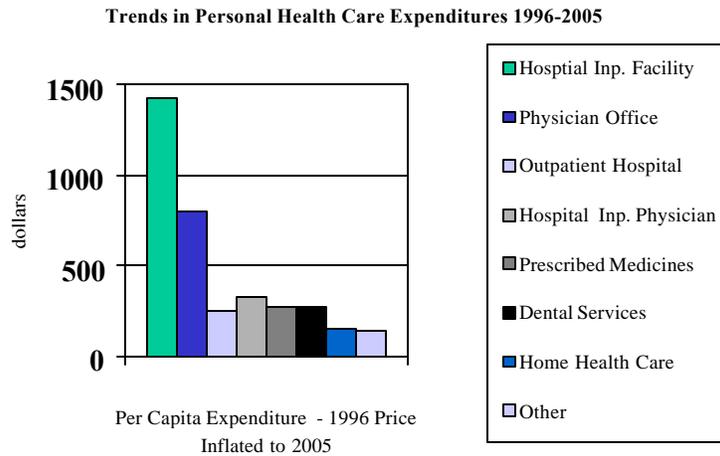
In FY 1999 the timeliness of MEPS data products and customer satisfaction with those products was the focus of MEPS performance. There were four specific products due for release in FY 1999; of those products, one was delivered in March 1999 and the rest were delivered at intervals through December 1999.

The web site for MEPS is: <http://www.meps.ahrq.gov>

SHARE OF HEALTH CARE EXPENDITURES CIVILIAN, NON-INSTITUTIONALIZED POPULATION: PROJECTED FOR 1999 - \$844 BILLION



■ Share of Health Care Expenditures by Elderly, 65+, 297 Billion
 ■ Share of Health Care Expenditures by Non-Elderly, <65, 547 Billion



Threats to the nation’s health can arise from malicious intent and from environmental toxins as well as from diseases and injuries that are discussed throughout this report. The public health system has to be prepared to monitor and respond to bioterrorism and environmental risks as well as other health risks.

To protect against *bioterrorism threats*, HHS efforts are directed especially in four areas:

- improving the nation’s public health surveillance network,
- strengthening the capacities for medical response,
- creating and maintaining a stockpile of pharmaceuticals for use if needed, and
- expanding research into the disease agents that might be released.

The initiative focuses on strengthening the public health capacity at the federal, state, and local level to respond to a terrorist event.

Goal (CDC): Increase the number of toxic substances that can be measured by CDC's environmental health laboratory to 40 new substances by the year 2002.

FY 1999 Target: Develop methods to measure human exposure to 8 new toxic substances.

FY 1999 Actual: Met the target; methods were developed for 8 new substances.

FY 1997 baseline: Methods exist for measuring 200 toxic substances in humans.



Special care must be taken to prevent exposure and adverse human effects from hazardous substances.

In FY 1999 CDC awarded \$41 million to 48 states and 3 cities for upgrading and improving their preparedness and response capabilities, laboratory services, epidemiology and surveillance systems, and electronic communication. Developing this infrastructure increases the ability to detect and respond to biological and chemical agents and bioterrorist acts in the United States. CDC achieved its FY 1999 target of creating a national pharmaceutical "stockpile" available for deployment to respond to terrorist use of potential biological or chemical agents, including the ability to protect 1-4 million civilians from anthrax attacks.



CDC has unique capabilities in the area of biomonitoring. While the Environmental Protection Agency measures environmental hazards in air, soil, and water, CDC measures human exposure to *environmental hazards*.

Environmental health monitoring was implemented in FY 1999 at the Bunker Hill Mine and Metallurgical site. It is the first site to meet all of ATSDR's criteria for a medical monitoring program. It was projected that at least two sites would be targeted for medical monitoring in the FY 1999 reporting period, but Bunker Hill was the only site that was determined to be appropriate and feasible for medical monitoring of the population affected.



In FY 1999 the HHS, Office of the Public Health Service and other OPDIVs worked actively with stakeholders to monitor the progress on *Healthy People 2000* and to develop an agenda for Healthy People 2000-2010 for disease prevention and health promotion efforts.

Healthy People is a national health promotion and disease prevention initiative that brings together national, State, and local government agencies; nonprofit, voluntary, and professional organizations; businesses; communities; and individuals to improve the health of all Americans, eliminate disparities in health, and improve years and quality of healthy life. Current "national objectives" have been referred to throughout this document. They support and exert an influence on the GPRA strategic objectives and performance plan, but are longer-term and are focused on national rather than agency achievements. The goals focus on increasing the span of healthy life, reducing health disparities, and achieving access to preventive services for everyone.

In FY 1999 the HHS, Office of the Public Health Service and other OPDIVs worked actively with stakeholders to monitor the progress

on Health People 2000 and to develop an agenda for Healthy People 2000-2010 for disease prevention and health promotion efforts.

Progress reviews were conducted in FY 1999 on the national objectives for maternal and infant health, diabetes and other chronic disabling conditions, family planning, heart disease and stroke, clinical preventive services, and physical activity and fitness. The most recent data available on the progress achieved in those areas being monitored by the Healthy People 2000 Program are found at <http://www.cdc.gov/nchs/hp2000hp.htm>



❖ **We worked to ensure food and drug safety by increasing the effectiveness of science-based regulation.**

HHS worked to ensure the safety, reliability, and efficacy of drugs and medical products. Americans have the world’s safest food supply although food-borne illnesses represent an emerging threat.

Under the *Prescription Drug User Fee Act* (PDUFA) manufacturers paid for improved processing procedures and time for new drug and biologics (the study of blood and blood products) applications. The objective of PDUFA is to expedite the application review process so beneficial drugs will be available for use quickly without compromising safety or sacrificing the quality that Americans expect. The FDA had committed to certain performance goals in response to these additional resources, and has met or exceeded these goals since FY 1995. This success occurred even with unexpected, continued growth in the number of marketing applications filed for review.

As a result, in 1997 Congress reauthorized PDUFA under the Food and Drug Modernization Act for another five years (known as PDUFA II). In 1998 90 new medicines were approved.

For all open cohorts during FY 1999 (individual application requests grouped by the fiscal year they were submitted), FDA’s Center for Drug Evaluation and Research took 185 actions on new drug applications, 77 of which were approvals. The median approval time was 11.9 months, a 1 percent decrease in median approval time compared with FY 1998. Final on-time performance information for the FY 1999 submission cohort is not yet available but FDA expects to exceed its targets.

Goals (FDA): Review and act on 90% of standard new drug applications within specified times.
FY 1999 Target: 90% within specified times
FY 1999 Actual: Final Data will be available in January 2001.



FDA regulates prescription drugs.

Fiscal Year 1998 Cohort as of 9/30/99

Submission Type	Number of Submissions Filed with CDER	Goal (months)	Number of Reviews "On Time"	Percent of Reviews "On Time"
Priority New Drug Application	30	90% in 6 months	30	100%
Standard New Drug Application	83	90% in 12 months	83	100%



FDA is responsible for blood bank inspections.

Goal: Complete biennial inspections of registered **blood banks, source plasma operations and biologics manufacturers.**
FY 1999 Target: Conduct 43% of biennial inspections
FY 1999 Actual: 64% conducted.
Trend: FY 1997 and FY 1998 biennial period: 46% conducted



Goal (CDC): Develop and strengthen epidemiologic and laboratory methods for detecting, controlling, and preventing infectious diseases.
1999 Target: Detect and investigate 23 large or unusual outbreaks of diarrheal and/or foodborne illness.
1999 Actual: Exceeded the target; 25 outbreaks were investigated.
Trend: FY 1998: 15 outbreaks were investigated; 40% of causative organism/toxin detected.




FDA is also required to conduct inspections to determine compliance with good manufacturing practices for certain products. In FY 1999 FDA exceeded its target, making a significant improvement above the last biennial period.



FDA has also exceeded its targets for ensuring that the quality and accuracy of **mammography facilities** that met inspection standards FDA conducted 9,488 facility inspections and issued 5,499 MSQA 3-year facility certificates.



The President's *Food Safety Initiative* is intended to build a national early warning system for hazards in the food supply by enhancing capacity for surveillance and outbreak investigations at the state and federal levels and by linking state health departments and federal agencies with sophisticated computer and communication systems.

The *PulseNet System* was put to work in the first year of the Food Safety Initiative to identify common sources of illnesses and speed outbreak trace back and containment. State laboratories, CDC, FDA, and USDA PulseNet systems determine bacterial subtypes with a high degree of accuracy and transmit the information digitally to a central computer at CDC. The CDC computer can match a newly submitted pathogen fingerprint to those in a databank, and can confirm whether or not disparate outbreaks are connected by a common source.

CDC helped investigate 25 outbreaks of foodborne illness in FY 1999 and was able to identify the causative organism or toxin in 48 percent of these outbreaks and the causative food in 50 percent.

According to CDC, although there has been a decline in the overall incidence of salmonella since 1996, there are about 300,000 cases of salmonella enteritis occurring each year because of undercooked eggs. In July 1999 FDA, HHS and the U.S. Department of Agriculture's Food Safety and Inspection service announced new measures to prevent illness from contaminated eggs. FDA is proposing safe handling on labels of shell eggs to warn consumers about the risks.



CDC's lab workers detect infectious diseases.

FDA has also improved food safety in FY 1999 through the *Hazard Analysis and Critical Control Point System* (HACCP) a preventive approach to a food safety that applies science-based controls all along the production chain from raw materials to finished product. Manufacturers and food preparers identify potential safety problems in the production points and take steps to prevent them. FDA sets the targets for food industries. The domestic seafood industry far exceeded its target in FY 1999. In FY 1999 proposed rules were published for the fruit and vegetable juice industry.

Goal: 50% of the domestic seafood industry will be operating preventive controls for safety as evidenced by functioning HACCP systems.
FY 1999 Target: 50% of domestic seafood industry complies.

Performance information for the goal is due in March 2000. Preliminary data indicates that the goal was met (56%).



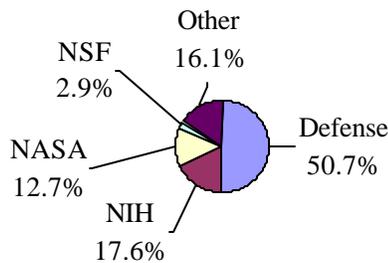
GOAL 6: STRENGTHEN THE NATION'S HEALTH SCIENCES RESEARCH ENTERPRISE and ENHANCE ITS PRODUCTIVITY.

Improvements in health are grounded in knowledge acquired through research. HHS sets the pace for the world in medical, epidemiological (incidence, distribution, and control of disease), behavioral, and health services research. We sponsor and conduct public and private research through strong, sustained public support for health sciences.

Today we are at the brink of discoveries that have the potential to revolutionize the prevention, diagnosis, and treatment of disease as well as the delivery of quality health care in America and around the world. As a Department, HHS has recognized the potential for health research advances and continues to pursue a focused and balanced approach to funding research and the infrastructure necessary to take advantage of research opportunities.

This year NIH established a formal working group of the Advisory Committee of the Director that conducted an independent assessment of NIH performance under this goal.

Federal FY 1999 Research Outlays



Source: President's Budget for Fiscal Year 2001, Historical Table 9.8

NIH accounted for 17.6% of the entire Federal research budget in FY 1999.



HHS recognizes the importance and benefit of basic research.

❖ We improved the understanding of normal and abnormal biological processes and behaviors.

This year again brought news of significant gains in biomedical research. Research findings about normal and abnormal biological functions constitute an essential knowledge base to support advances in prevention and treatment science and to determine what efforts are possible and effective across the population.

Human cancer cells were created in the laboratory by altering the expression of a defined set of genes and affecting at least four cellular pathways. The ability to introduce specific genetic alterations to transform normal cells paves the way for more precisely defining the biochemical pathways in the cell that must be disrupted in the development of cancer. This information will open new avenues for exploring the roles of various cellular pathways that become disrupted and for determining the sequence of events that must occur as cancer develops.

Studies in rodents resulted in the first evidence that adult neural stem cells can be used to *repair damage from a broad array of brain accidents/diseases where cell dysfunction is "global"* or spread throughout the brain. Other researchers demonstrated that bone marrow stem cells could give rise to liver cells and that neural stem cells become blood-forming cells. This new knowledge changes the way we think about the brain and treatment for brain disease and

injury and has obvious implications for the development of new treatment modalities for a number of devastating illnesses and injuries.

A family of *proteins (toll-like receptors) that are involved in the body's immune response* to bacteria was discovered. When these proteins detect and signal the presence of the bacteria, they trigger a severe immune reaction that can lead to septic shock. This new knowledge could facilitate development of new vaccine strategies and new approaches to the treatment of septic shock. Drugs that could interfere with the activation of toll-like receptors by bacteria during an acute infection could save thousands of lives.

The working group determined that this target was exceeded after a review of nearly 300 descriptions of research outcomes published in FY 1999.



The *human genome project* seeks to understand the genetic instructions that make us unique. Critical genomic resources continued to be developed by achieving a FY 1999 U.S. annual production rate of human genomic sequence of 173 million base-pairs, a world-wide rate of 265 million base-pairs, a total of 442 million completed world-wide and completing the sequence of the 97 million base-pairs of the *C. elegans* genome.

The *C. elegans* is a roundworm and its genetic sequencing marked a historic accomplishment since it provides biologists with a powerful tool to experiment with and learn how whole genomes function. The ability to compare the sequence of genes across multiple species and develop model systems in simpler organisms will significantly enhance the ability of researchers to identify the functional roles of the encoded proteins and thereby contribute to a better understanding of the molecular basis for human health and disease.

All of the publicly funded U.S. centers sequencing the human gene are meeting and in many cases, exceeding the standards of quality assurance for their data. The working group determined that these targets were exceeded based upon public databases.



❖ **We improved the prevention, diagnosis, and treatment of disease and disability.**

Heart disease is the nation's number one killer among men and women of all racial and ethnic groups. More than 40 percent of all deaths in

Goal (NIH): Add to the body of knowledge about normal and abnormal biological functions and behavior.

FY 1999 Target: Progress in advancing scientific understanding in key fields bearing on our knowledge of biological functions and behavior in their normal and abnormal state.

FY 1999 Actual: Exceeded the target.



Goal (NIH): Develop critical genomic resources, including the DNA sequences of the human genome, and the genomes of important model organisms and disease-causing microorganisms.

FY 1999 Targets:

- 1) U.S. annual production rate of human genomic sequence: 90 million base-pairs.
- 2) Worldwide rate: 220 million base-pairs.
- 3) Total completed worldwide at the end of FY 1999: 400 million base-pairs.
- 4) Complete the sequence of the *C. elegans* genome.

FY 1999 Actual: Exceeded the targets for 1) - 3) and met the target for 4).



Goal (CDC): Reduce morbidity and mortality attributable to behavioral risk factors by building nationwide programs in chronic disease prevention and health promotion and intervening in selected diseases and risk factors.

1999 Target: 85 % of states participating in the Behavioral Risk Factor Surveillance System communicate the findings of their annual behavioral risk factor data collected.

1999 Actual: Data is not available yet.

the United States, 900,000 each year, are directly attributable to heart disease and stroke. Associated annual costs exceed \$286 billion.

In FY 1999 CDC expanded the first state-based program for developing policies and conducting research to prevent cardiovascular disease—the leading cause of death of men and women across all racial and ethnic groups—from 8 to 11 states and strengthened the capacity of the initial 8 programs to address racial and ethnic disparities in cardiovascular disease.

In September, the National Heart, Lung, and Blood Institute and the National Institute of Diabetes and Digestive and Kidney Diseases of NIH issued an alert on the increasing importance of *diabetes mellitus* as a major risk factor for cardiovascular disease.



In addition, NIH's research program resulted in the following accomplishments in FY 1999:

- Development of a promising new technique for detecting lung cancer at an earlier and potentially more curable stage.
- Development of an improved approach for preventing mother-to-child transmission of HIV.
- Development of a new test for diagnosing a particularly devastating aggressive cancer that can involve the brain, spinal cord, and the eye.
- Identification of an effective non-surgical treatment for fistulas, a serious complication associated with the chronic inflammatory bowel disease known as Crohn's disease.
- Progress towards the Administration's goal of developing an AIDS vaccine by 2007 by increasing the number and dollar value of awards made for vaccine discovery.
- Development and implementation of the Clinical Trials database, a consolidated source of information related to federally and privately funded clinical trials for drugs used for serious or life threatening diseases and conditions.

Progress toward the various performance goals of new methods, technologies or approaches for diagnosing, preventing, or treating disease and the NIH working group also assessed disability. All FY 1999 targets were met, successfully met, or substantially exceeded. Suggestions were also provided for improving one of the goal areas.



❖ **We actively supported the research capacity of the country.**

Through its *Research Training and Career Development Program*, NIH supports a critical aspect of scientific research:

- The development of a talent base capable of producing advances in science.

To evaluate its success in attracting, developing, and retaining a diverse group of scientists, NIH has established several performance goals to assess the agency's success in attracting qualified applicants. For example, in FY 1999 NIH met its goal to maintain an application flow consistent with success rates close to historical levels of 40 percent for fellowships and 60 percent for research training grants and entry-level career awards.

NIH increased the pool of clinical researchers who can conduct patient-oriented research by issuing 85 mentored Patient-Oriented Research Career Development awards, 83 mid-career Investigator awards in Patient-Oriented research, and 35 curriculum development awards.

NIH also encouraged interest in scientific research careers by making information on training and career development opportunities widely available to students and post-doctorates (e.g., Independent Scientist Award, Minority and Disability Research supplements, Mentored Clinical Scientist Development Award).

AHCPR also supported 69 pre- and 86 post-doctoral National Research Service Award trainees to ensure that investigators will exist to perform the research necessary to improve quality and cost effective health care.



NIH supports *construction of facilities* on the NIH campus, as well as grants to fund facility improvements at institutions outside of NIH.

- Completed 56.4 percent of Louis Stokes Laboratory Building although the FY 1999 target was 65 percent completion. The NIH assessment revealed that this shortfall could be attributed to the need to make space adjustments to support current and projected research requirements. Construction is expected to be complete in December 2000, rather than the end of FY 2000.
- Completed design and over 66 percent of the construction for the Dale and Betty Bumpers Vaccine Research Center.
- Made major progress in the design and site work for the Mark O. Hatfield Clinical Research Center.



*Research capacity must keep pace
with research priorities and
technological advances.*

Challenges We Are Addressing

Our Nation faces enormous challenges to the health and well-being of our citizens. The challenges we face are both programmatic and administrative. The programmatic issues may get more public attention, but the administrative infrastructure issues are vital to the efficient delivery of health and social services. We face myriad challenges, and we list a few below.

Programmatic Challenges

- Responding to the threat of bio-terrorism.
- Responding to the threat of cyber-terrorism.
- Advancing our medical knowledge about treating and preventing infectious diseases such as HIV/AIDS.
- Promoting healthy lifestyles and non-smoking to prevent chronic health problems such as cancer and heart disease.
- Providing health care to the uninsured and underinsured.
- Ensuring the privacy of medical records.
- Ensuring safe, quality childcare for parents who work.
- Ensuring Medicare trust fund solvency.
- Working to reduce the incidence of deaths and injuries from drug interactions and medical errors.

Administrative Challenges

- Planning for workforce changes in the short term, when a significant portion of the workforce is eligible for retirement.
- Enhancing our information systems capabilities and electronic commerce interfaces.
- Obtaining “clean” financial statement audit opinions in future years.
- Continuing our advances in electronic commerce.
- Overcoming data issues for measuring performance such as the complexity of data systems, the timeliness of data, lack of resources for data, vast range of sources of data and the inherent variability of the programs.

Using the Internet to Transact Business

The Internet has changed the way the world lives and we are working to do more business and provide more customer service via this technology. We use the Web to provide a great deal of programmatic information to the public and to facilitate our administrative work. There are many Web sites identified throughout this document. Here are some examples.

Programmatic Uses of the Internet

- FDA's MedWatch collects and provides information about dangerous drug interactions.
- FDA's Healthfinder is a clearinghouse of consumer information on health.
- NIH's online medical research library provides information in all areas of medical research.
- CDC's Home Page has Travel Alerts providing information about foreign disease outbreaks.
- NIH's web site provides both the general public and NIH staff with significant amounts of information pertaining to the policies, practices and funding opportunities of NIH granting and training processes.
- SAMHSA's Knowledge Exchange Network (KEN) provides Americans with free information about mental health and mental illness as well as referrals to community mental health organizations and self-help groups.
- HCFA's State Children's Health Insurance Program provides information on how to apply for a state-run SCHIP program.

Administrative Uses of the Internet

- The HHS Office of Finance established a web site for HHS travelers to provide information about travel policy as well as links to other important travel-related web sites.
- The HHS Office of Grants and Acquisition Management posts contracting opportunities on the web.
- HHS job postings are available on the web.
- The HHS Office of Finance established a web site to collect program information for the Catalog of Federal Domestic Assistance.
- HHS now uses an internet application to collect data for the preparation of the Department's consolidated financial statements.
- HHS fact sheets are available on the World Wide Web at: <http://www.dhhs.gov>.
- HCFA's www.medicare.gov website was designed with the beneficiary in mind and offers easy to read information about the Medicare programs, health plan options, costs, benefits, performance and satisfaction, nursing homes, publications including Spanish and Chinese versions, and wellness information.
- HCFA's www.medicare.gov website has an important contact database that has over 3,000 phone numbers for Medicare-related agencies and partners across the United States. A Beneficiary Outreach Calendar allows beneficiaries, and those who act on behalf, to search for information about local events, health affairs, or educational meetings.