1997 STRATEGIC PLAN

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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INTRODUCTION

The Department of Health and Human Services (HHS) is one of the largest federal Departments, the nation's largest health insurer, and the largest grant-making agency in the federal government. The Department promotes and protects the health and well-being of all Americans and provides world leadership in biomedical and public health sciences. HHS accomplishes these objectives through an array of programs in basic and applied science, public health, income support, child development, and the financing and regulation of health and social services. This broad range of activities is managed and delivered by the Department's component agencies (as described on the cover), in collaboration with its state, local, tribal and non-governmental partners, and with the coordination of the staff agencies in the Office of the Secretary

The Strategic Planning Process at HHS

In 1993, Secretary Donna E. Shalala initiated the Department's response to the Government Performance and Results Act (GPRA) by establishing a Department-wide planning team and a "bottoms-up" process that engaged program managers at all levels of the Department. HHS operating divisions developed strategic plans and began extensive consultations with constituencies holding stakes in the Department's activities to help focus their efforts and identify performance objectives and measures for their programs.

In 1994, two HHS programs were designated as GPRA Pilots by the Office of Management and Budget. The Child Support Enforcement program in the Administration for Children and Families and the Prescription Drug User Fee Program in the Food and Drug Administration both identified performance goals and consulted with stakeholders to develop performance indicators. The pilot programs, both of which exceeded their initial performance goals, provided valuable lessons for other HHS components in performance planning and development of goals and measures.

Over the last year, the HHS Planning Team integrated the individual efforts of its operating divisions to create a Department-level plan that incorporates their earlier planning and consultation activities. In order to allow adequate time for the Department's broad spectrum of stakeholders to review and comment on the HHS Strategic Plan, a preliminary draft was approved in early April 1997 outlining six goals and general strategies to achieve the goals. An extensive consultation process was conducted from April through June, including outreach to more than 300 organizations, 400 tribal governments, and nearly 60,000 HHS employees through a series of mailings and meetings. Meetings were held with state and local government officials, representatives of tribal governments and nongovernmental organizations, and staff from both the House of Representatives and the Senate. More than

500 individuals and organizations provided comments through the electronic comments process on the Internet, in correspondence, and in meetings. Most comments provided positive feedback on the HHS priorities and directions. A number of comments included suggestions for additional areas of emphasis and detail.

While the external consultation process was underway, the Department continued to develop performance objectives and to negotiate with stakeholders on performance measures. The Department also updated its assessment of the external and internal factors that might affect achievement of its goals. The Strategic Plan was revised to reflect the results of these actions.

The HHS Strategic Plan

The Department's Strategic Plan is the first and guiding element in HHS performance management. As designed by the Government Performance and Results Act, the cycle continues as the Department finalizes its first annual performance plan and sets annual performance targets.

The plan begins with the Department's *Mission and Goals,* shown together, followed by its *Vision for a Healthy and Productive America* and a description of the *Core Values* that guide its decision-making and management. Next is a discussion of the *Challenges* that may affect our ability to achieve the Department's goals. The six *Strategic Goals and Objectives* are then presented in detail. After the Goals, the section on *Improving Performance* includes a description of major Department-wide management improvement efforts and a summary of recent and ongoing reinvention and coordination efforts.

MISSION

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.

GOALS

The Department has established six goals that support and carry out its mission.

The first two will guide its efforts to enhance the health and well being of individuals and families:

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

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

The third and fourth guide the Department's efforts to provide effective health and human services:

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

4. Improve the quality of health care and human services

The fifth and sixth foster strong, sustained advances in the systems and sciences underlying medicine and public health:

5. Improve public health systems

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

VISION OF A HEALTHY AMERICA

Healthy and productive individuals, families, and communities are the very foundation of the nation's security and prosperity. Through its leadership in medical sciences and public health, and as guardian of critical components of the nation's health and safety net programs, the United States Department of Health and Human Services (HHS) seeks to improve the health and well-being of people in this country and throughout the world.

The Department's success should be measured against the yardstick of steady, broad-based improvements in the physical and mental health and economic well-being of individuals, families, and communities, and advances in medicine and public health that benefit the entire world. Achieving good health as individuals and communities is a shared responsibility. To realize its goals, HHS will develop the policies, tools, and resources that are appropriately national in scope. In order to realize the objectives for improving the nation's health, strengthening the social and economic fabric, and contributing to global health, HHS will form partnerships of many kinds: with state, local, and tribal governments, with academic institutions, with the business community, with nonprofit and volunteer organizations, and with its counterparts in other countries and international organizations.

In a society that is diverse in culture, language, and ethnicity, the Department manages an array of programs that aim to ameliorate disparities in health status, and access to health services and increase opportunities for disadvantaged individuals to work and lead productive lives. These programs support basic and applied science, development of knowledge and its application, public health, and child and adolescent development; foster economic self-sufficiency and help working families; and finance health and social services. In all of these, we seek to close the gaps in health status and improve economic opportunities.

Core Values

In the Department's ongoing management of its programs, and in its strategic planning process, it has been guided by the core values that define its organizational culture:

- To deliver results that are satisfactory and meaningful both to the people and communities that are directly served by the Department's programs, and to the American people who pay for these programs

- To be an accountable steward of the Department's programs and to enhance the efficiency and quality of the services provided to its customers

- To protect against discrimination in the provision of health and human services
- To focus consistently on the prevention of health and social problems
- To create new forms of collaboration in regulation, research, service delivery, and management
- To maintain a work environment that encourages creativity, diversity, innovation, teamwork, and the highest ethical standards

CHALLENGES FOR THE 21ST CENTURY

HHS stands at the epicenter of transformations in the nation's health care system, in its national approach to welfare, in its exploitation of the remarkable opportunities in medical science, in the roles of federal and state and tribal governments' management of health and human service programs, and in the impact of the global economy on the health of the American people in areas such as emerging infectious diseases and food safety. These and other changes will require continuous adaptation of the Department's strategies and programs. In addition to flexible and responsive management of its own programs, the Department must play a leadership role in helping the nation to comprehend the unfolding changes and develop successful strategies to address them.

This section of the strategic plan discusses challenges that the Department and the Nation face in the next six years and beyond. The first are external challenges that will profoundly influence the programs that we manage and the individuals and institutions that they serve. The second are challenges that will influence the Department's ability to manage its programs efficiently and with a high degree of integrity. The third are challenges relating to data needs that must be addressed if the long-term potential for program improvement and accountability offered by the Government Performance and Results Act are to be realized.

External Challenges

The following is a brief summary of the external challenges that will exert strong influence on the Department's programs and that will affect its ability to achieve its strategic goals.

Transformation into Managed Care. Since the early 1990s, the payment for health care in the United States has been in a rapidly accelerating transformation from a system based on paying for service into one that pays for responsibility for care. More than 100 million Americans are now enrolled in some form of managed care. In 1988, 29 percent of workers in private firms were enrolled in managed care; the proportion had risen to 75 percent in 1996. Some 13.3 million Medicaid beneficiaries were enrolled in managed care plans in

1996, accounting for 35 percent of the Medicaid beneficiaries. Approximately 4.3 million Medicare beneficiaries were enrolled in managed care plans in 1996--11.2 percent of the total Medicare population. The Congressional Budget Office has projected that Medicare enrollment in managed care plans will increase to 17 percent by 2002.

This set of changes has affected every aspect of the health care system -- a sector that accounts for about 13 percent of the GNP today and is projected to continue growing. Cost containment pressures have led to new ways of paying health care providers and practitioners, as well as new ways of managing patient access and delivering services. The programs managed by HHS--Medicare, Medicaid, the Indian Health Service, primary care programs for underserved populations, and the nation's medical research and regulatory enterprises--have all been significantly influenced by these changes.

Growth in the Number of Uninsured. Even though health care expenditures are projected to reach 15 percent of GNP by the year 2000, the nation still has a large and growing uninsured population. In 1995, 17.4 percent of the nonelderly population--40.3 million individuals--were not covered by health insurance. There is concern that the growth of managed care plans may further complicate the problem of providing care to the uninsured if this growth results in reduction of the resources available to safety net providers who traditionally care for the uninsured. At the same time, however, the efficiencies achieved by managed care plans are an important factor in improving the affordability of insurance. Uninsured children and adults will strain the resources of safety-net providers. To the extent that the uninsured cannot gain access to essential health services, the overall health of the nation will be compromised.

Transformation of the American Family. The American family has undergone a dramatic transformation over the past few decades. Many fewer children live with both parents. In 1940, 85 percent of children had two parents *in the home*. By 1994, only 70 percent of children were living with both parents. In part, this is driven by a dramatic increase in out of wedlock births. Between 1960 and 1992, the percentage of births that were to unmarried mothers increased from 5 percent to over 30 percent. Mothers are also far more likely to work than in the past. These changes create new challenges for the social safety net. Related challenges include:

- Poverty rates among children increased during the 1980s and remain stubbornly high at over 20 percent. Over half of African American children live in economically disadvantaged neighborhoods (where poverty exceeds 20 percent). Over six million children require and receive special education services, and nearly one million have a disability severe enough that they qualify for assistance through the Supplemental Security Income program.

- Adolescent with at-risk behaviors are also creating new challenges. The abuse of tobacco, drugs, and alcohol increased among high schoolers in the early 1990s, and more

teens are having sexual intercourse at earlier ages. Among high school students, 44 percent report having tried marijuana and 10 percent report having used cocaine. The incidence of severe emotional disturbance and mental illness have also increased among children and adolescents.

- Domestic violence and child abuse and neglect continue to victimize women and children of all socio-economic strata. Battering is a major cause of injury to women, more significant than auto accidents, rapes and muggings combined. Twenty-eight percent of adult women are likely to be the victims of abuse in intimate relationships; the long-term effects on children witnessing and experiencing abuse include depression and self-destructive behavior, anger and hostility, poor self-esteem, feelings of isolation and stigma, difficulty in trusting others, marital and relationship problems and a tendency toward revictimization.

Aging of American society. The decline in mortality rates and the aging of the baby boom cohort will produce one of the most profound social phenomena of the twenty-first century. In 1995, 35 million people were fifty to sixty-four years old — a number that will increase by nearly two-thirds to 53 million people by the year 2020. People who reach the age of 65 can now expect to live into their eighties. However, it is not likely that all those years will be active and independent ones. The very old (aged 85 and older) population is projected to be the fastest growing part of the senior population in the next century. In 1994, 3.7 million persons in the U.S. were 85 or older -- comparable numbers for the year 2050 are estimated to range from 10 to 30 million (U.S. Census Bureau projections.) History has rarely witnessed demographic change of this magnitude except in periods of crisis, like war or plague. The very scale of the change makes it difficult for most people to prepare for the myriad adaptations that must be made throughout society.

The aging of the population raises important issues:

- **The need to increase employment opportunities**: Although life expectancy has increased dramatically over recent decades, the labor force participation rates of men aged 65 or older have dropped significantly, worsening the rising "senior support ratios" as measured by the ratio of "retirement age" persons to the number of "working age" persons in coming decades. Many seniors would prefer to continue work if part-time or transitional work arrangements were available. A rethinking of the paradigm of aging and dependence will require public and private sector leadership to foster changes in the attitudes of economic and social institutions. These changes are a critical component in finding a long- term equilibrium in the support of entitlement and social safety net programs.

- **Developing cost-effective ways to treat chronic disease**: Non-communicable chronic diseases (including mental illness) have replaced infectious diseases as the most

significant burden of disease. As the population ages, developing cost-effective means of treating and managing chronic diseases will become more urgent. Options for addressing chronic illness are growing, from high-tech solutions, such as coronary artery bypass surgery or angioplasty, to low-tech solutions, such as home care and assistive devices. Advances in basic medical and behavioral research are leading to new treatments and ways to delay the onset of chronic diseases. Providing access to effective treatments—particularly for low-income and uninsured populations— will be a critical challenge of the next several decades. Moreover, it will be increasingly important to find ways of effecting permanent behavioral changes, such as reducing high-risk behaviors, and improving diet and exercise, that can delay or prevent the onset of many chronic diseases.

The Genetics Revolution. Molecular genetics is becoming an important element of medical practice and public health. The recent identification and sequencing of a portion of the estimated 100,000 human genes has fostered the development of an array of genetic tests and other technologies that hold tremendous promise for diagnosing, treating, and preventing disease and disability. Virtually all diseases of public health significance result from interactions between genes and the environment -- that is, nutritional, chemical, physical, infectious, and behavioral factors. Understanding of this complex interplay has increased to the point at which biomedical scientists and health care providers can begin to identify genetic susceptibilities and tailor subsequent diagnostic efforts, behavioral interventions, and medical treatments.

These developments will revolutionize medicine and public health. But they will also raise new ethical, legal, and social issues that require broad public attention. HHS will play a leading role in ensuring that advances in genetics research and technology are translated into methods to promote health and prevent disease. We will also help to create a legal/regulatory framework that provides protections for both individuals and society.

Bioethics. Advances in medical technology and breakthroughs in medical research have created a new set of challenges regarding the ethical and moral considerations that are associated with the pursuit of these scientific advances and their incorporation into medical practice. The cloning of Dolly, the Scottish sheep produced through somatic cell nuclear transfer, is but one example. Genetic testing is another. As more and more genetic tests become commercially available, questions arise about, for example, the desirability and utility of testing for genetic disorders for which there are currently no effective interventions, the use of genetic information as a basis for discrimination in health insurance or in the workplace, and the need for informed consent when DNA samples collected for one purpose might be used for another in future years. Therapies to reverse, arrest, or retard cognitive impairments also challenge researchers to protect individuals with such handicaps from being exploited as research subjects, even while they undertake the clinical studies on which the validation of proposed new therapies depends. Further, as effective interventions are developed, issues such as ensuring fair and equal access will present significant ethical challenges. HHS has a

responsibility not only to stimulate and support the highest quality science but also to ensure the protection of human subjects, the full and open consideration of moral and ethical issues, and the delicate balancing of risks and benefits for both individuals and society.

Privacy and Confidentiality of Information. A number of the transformations outlined in this section have stirred public concern about the confidentiality of health information and the need to develop new norms and legal protections to safeguard it. Because of the dramatic changes over only a few years in the ways health care is delivered and documented, the traditional, often informal, confidentiality controls that patients and physicians previously had over patient information have weakened. The management and transfer of medical records via networked computer systems and the advent of genetic tests providing predictive health information open unprecedented opportunities for violations of confidentiality, discrimination, and misuse. The existing legal structure is not adequate for effective control of this information. Safeguards must be developed that will ensure the privacy and confidentiality of patient information without compromising the Department's ability to conduct research and protect public health. Crafting such a system will constitute a major challenge to the public and private sectors over the next decade. HHS will provide leadership on these issues. A first statement on privacy and confidentiality recommendations will be sent to the Congress in the near future. We expect this to be the first in a series of interactions with the Congress and the American people as we consider how best to achieve the right balance of individual and societal benefits.

Emerging and re-emerging infectious diseases. Infectious diseases are growing threats to public health, both domestically and globally. Between 1980 and 1992, the death rate due to infectious diseases rose 58 percent in the United States. The emergence is due to the capacity of microbes to change and adapt in ways that make them more virulent or drug resistant, the demographic and environmental changes that place humans at increased risk from microbial infections, and the increase in travel and commerce that allow infectious organisms to spread rapidly and widely -- including through food. A substantial share of the U.S. food supply now comes from developing countries, and it is expected to increase over the coming decades. Unless the safety of the U.S. food supply is to be compromised, significant actions must be taken at the national, state, and local levels to identify foods and drinking-water supplies contaminated by infectious organisms and to prevent them from reaching consumers. Improved international collaboration and surveillance will also be critical to address public health threats of infectious diseases and protect the food supply.

Changing Intergovernmental Roles. The last five years have produced very substantial changes in the roles and relationships of different levels of government in the management of health and human services. The current trend toward devolution (from federal to state or tribal government, and from state to local levels) is fundamentally reshaping HHS programs and how they are managed. Policy-making responsibility related to HHS programs is progressively shifting from the federal government to states, tribal, and local governments or to the private sector. The most prominent example is the welfare reform legislation that

converted a long-standing program with a multiplicity of federal rules to a program of block grants with extremely broad state flexibility. Equally significant, however, are the large number of states that have been granted Medicaid waivers that offer them considerable flexibility in the design and management of their programs. The Indian Self-Determination Act created the basis for tribal governments to take over the resource base and management of health services provided to tribal members, and the Congress is considering legislation that would extend tribal management to other types of programs serving American Indians and Alaskan Natives.

As these policy and management responsibilities shift, they will call for a new paradigm for the way HHS does business. Challenges include the development of accountability models and the data systems to support them that will permit effective oversight and collaboration. HHS must substantially improve its ability to deliver responsive, customized technical assistance to state and tribal governments and communities. Doing so requires both new models of interaction with the Department's partners and a substantial investment in HHS staff to assure that they have the requisite skills and organizational support to perform these new roles.

Management Challenges

In the HHS strategic plan, a concerted effort has been made to focus Department-wide goals and objectives on programmatic issues and challenges stemming from the legislation that enables the Department to define and achieve its mission.

As indicated in the preceding discussion of the Department's external challenges, HHS must achieve its mission and goals during a time of changing expectations and resource constraints. This requires managing differently, and developing an HHS management culture appropriate for the challenges of the future. Key elements of the new HHS management culture are results- oriented management; increased cooperation and integration of efforts across organizational and functional lines; increased use of partnerships to accomplish results and a commitment to develop and support a committed, skilled, and diverse workforce. The new HHS management culture is being introduced through communication of the Secretary's and Deputy Secretary's expectations, implementation of high-priority initiatives that link program activities across HHS's operating divisions, involvement of customers and employees at all levels, efforts to improve the quality of work life at HHS, and careful attention to the requirements of the Government Performance and Results Act.

Many of the Department's most significant management challenges are program specific, and they are reflected in the goals and objectives of the plan. HHS also addresses certain significant responsibilities, as required of strategic plans by federal management legislation

and regulations. These include, for example, major responsibilities for financial management, resource management, and technology and capital planning. Detailed information on HHS commitments to management improvement and accountability for these functions is contained in other plans and reports the Department produces regularly. A summary of Department-wide management improvement plans is contained in the final section of the plan titled Improving Performance.

Data Challenges

One of the critical limiting factors in developing performance objectives for HHS programs is the absence in many cases of timely, reliable, and appropriate data. There are relatively few data sources for HHS programs that are ideal for performance monitoring, and understanding the limits of available data is important if appropriate inferences are to be drawn. In the short term, most programs will have to rely upon existing administrative data systems and population-based surveys to monitor program performance, and the achievement of strategic objectives. However, many of those data systems were designed to provide administrative or general population data, and not for monitoring specific program outcomes. In these cases, it is often necessary to "force fit" the data to new purposes; understandably, the resulting product may be less than ideal. The problems are compounded when data systems rely upon collection and reporting by states and localities, since collection methods may vary and both comparability and timeliness may present problems.

Individual program or activity areas present specific data issues, and the most important of these are discussed in this section. In addition, a number of generic problems affect multiple programs and have strongly influenced the Department's selection of measurable objectives.

Limitations of Current Administrative Data Systems. Administrative data systems were established in most cases to monitor the use of resources and to provide counts of clients and of service units and other descriptive information about the program. In some cases, these systems involve the reporting of data at the client level. In others, only aggregate data is reported to the federal agency by the states, grantees, or other entities. These systems often provide data on process or on output; but, in general, they were not designed to capture the results or outcomes of the activity.

The administrative data systems are useful for management purposes and to respond to federal accounting requirements for reports on program integrity, which have not changed with the enactment of the Government Performance and Results Act. However, many of these systems must be modified to capture outcomes, and new systems will be needed in some areas. These modifications call for costly and long-term investments, and will require the cooperation of state governments, service providers, and community-level grantees in many program areas.

Geographic and Population Detail. Many federal surveys provide national data on various characteristics, including measures of health and socioeconomic well-being, as well as participation in the larger public programs. Few surveys, however, provide state-specific data or data that permits tracking of special population groups. In addition, national averages may often mask significant variations among regions, states, and specific population groups.

Timeliness. Some key surveys are not conducted annually, and analysis of the data may require up to a year in many cases. This means that changes in access to services, risk factors, health status, or social functioning outcomes that indicate program success or failure may not be seen for several years after they occur. Similarly, baseline data against which to measure program changes are usually several years old, complicating the task of assessing change in the GPRA time frames.

Attributing Cause. Despite their widespread use and intuitive appeal, measures of health or social functioning are insufficient by themselves for monitoring the effects of a given program. Many measures that track health outcomes—such as infant mortality rates—or social functioning—such as child abuse—are affected by so many factors that changes in outcomes cannot be attributed to specific program effectiveness alone. Attribution of responsibility for outcomes becomes even more difficult when the services in question are supported by multiple funding sources or multiple providers.

Performance Objectives for Health and Human Service Programs

In the short term, many HHS health programs will rely upon existing data sources to support performance measurement, with the result that, at least initially, data collected for other purposes will be used for performance measurement. Potential data sources include administrative data, surveillance data, and survey data. Subsequently, improvements to systems and new systems will be needed to provide outcomes data.

Health programs that provide or finance health services -- for example, Medicare and Medicaid -- may be able to benefit from the development of performance measures of outcomes and quality of care in health care generally. Aggregate Medicaid reports from states on volume and expenditures can provide some initial output measures, and Medicaid claims data are available for twenty-eight states. Extensive Medicare claims data are available for certain measures in that program. Most grant assistance programs will rely on administrative data as well as on public health surveillance data for output and outcome measures. Substance abuse and mental health measures present especially difficult issues, and there is a dearth of appropriate state-level data in general. An expert panel at the National Academy of Sciences on performance measurement for public health grants with the states recently recommended that a combination of measures of health status outcome, process, and capacity be used. The panel also recommended that, because it may be impractical to measure or because so many factors affect health status outcomes, "intermediate" outcome

measures such as risk status also be used when there is a consensus that the result being measured is related to the health status outcome.

The human service programs will rely upon both administrative data as well as non-administrative data sources that meet the tests of reliability and comparability across states and program sites. Measuring the achievement of the Temporary Assistance to Needy Families (TANF) performance goals will use both aggregated data -- caseload summaries -- and disaggregated data -- by individual and family -- on a quarterly basis. The Child Welfare programs will use the Adoption and Foster Care Analysis and Reporting System (AFCARS); Head Start will supplement administrative data with child assessments, parent interviews and classroom observations; and Child Support requires that all states have a comprehensive, statewide system in place. In most cases, when the Department must rely on administrative data, there will continue to be concerns regarding consistency, validity, and uniformity.

New Investments in Data

GPRA's focus on performance measurement in public programs is a reflection of a broader shift in thinking toward accountability, results, information, and evidence-based decisions. Although initial performance measures for HHS programs will rely of necessity on existing data systems, a number of modifications will be necessary to current administrative data systems to adequately support outcomes measurement in HHS, and a number of new data systems will be needed. In addition, significant investment will be needed in HHS survey programs to generate state-level data. Moreover, special surveys and studies of client populations are likely to be necessary in order to develop appropriate performance measurement on program populations, particularly outcomes that involve long periods of observation. Because of the significant costs involved, coordinated investment strategies across HHS will be critical. Comparable investment may be needed in state infrastructure for performance measurement as well.

Potential Conflict with the Paperwork Reduction Act

These requirements for data collection are likely to come into conflict with the targets of the Paperwork Reduction Act. The Department is making strong efforts to reduce burden through survey integration plans -- including consolidation of surveys between HHS and other Departments, such as the Department of Agriculture -- simplification, prioritization, and innovations in design and methodology. Despite these efforts, the Department expects to have difficulty in achieving the required 25 percent burden reduction targets while simultaneously developing the information it will need to successfully implement the Government Performance and Results Act.

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 a healthy people is able to build a better society. Individual behavior, education, equality of opportunity, social and physical surroundings, the economy, and access to health care are all elements crucial to health, and therefore offer opportunities to promote good health.

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

Investments in programs that are effective in reducing or eliminating these behavioral threats provide a major payoff in improved health and productivity of the American people. The results--improved health status for individuals and increased life spans--are highly valued by the public. Of the Department's strategies for reducing behavioral threats to health, most employ a combination of research, prevention, public education, and regulation. All involve multiple components of the Department and rely heavily on partnerships with other levels of government and the private sector, including academic institutions, voluntary associations, and advocacy groups. Special efforts are made to help vulnerable populations, including youth, the elderly, women, minorities, and individuals with disabilities.

To integrate its activities, the Department has established a conceptual model for the nation—*Healthy People*—that sets an agenda for prevention programs in the public and private sectors and guides the Department's selection of ten-year performance targets. The objectives and strategies described below, based on research findings and developed in partnership with national health organizations, will contribute to achieving specific Healthy People objectives in the year 2000 and will build a foundation for achieving a new set of Healthy People objectives in the year 2010.

Strategic Objective 1.1
Reduce Tobacco Use, Especially among Youth

Tobacco is the leading cause of avoidable death in the United States, killing a larger number of people than AIDS, automobile collisions, suicides, homicides, fires, and illegal drugs combined. Over 400,000 tobacco-related deaths occur each year from cancer, stroke, cardiovascular disease, lung disease, low birth weight and other problems of infancy associated with maternal smoking during pregnancy, fire-related deaths, and environmental tobacco smoke. Cost of direct medical care for tobacco-related illness is estimated at $50 billion. Research shows that, by reducing the rate of tobacco use, the Department can improve the health and quality of life of the population.

Strategy for Achieving Objective

The nation's youth are at the center of HHS's strategy to prevent tobacco-related deaths because chronic, long-term tobacco use almost invariably begins in the teenage years. Thirty-four percent of 9-12 graders are cigarette users and each day approximately 3,000 young people become regular cigarette smokers. Preventing the start of this addiction is the best strategy for reducing adult tobacco use and the tragic loss of health and life associated with it. The Department is committed to achieving the President's goal of reducing tobacco use among young people by 50 percent in seven years, through a combination of research, prevention, and enforcement of existing laws and regulations.

Research. The National Institutes of Health will continue to support research to identify determinants of smoking initiation and maintenance in youth and to evaluate innovative strategies to reduce the prevalence of this high risk behavior. Research also will continue on the genetic basis of nicotine addiction, preventing and controlling tobacco use in adolescents, and risk communication and informed decision-making. The findings from these efforts will be shared with HHS agencies and other stakeholders.

Prevention. The Centers for Disease Control and Prevention (CDC) will lead a national effort to educate Americans about the health effects of tobacco use. CDC also will provide technical assistance to state health departments and education agencies to help develop the infrastructures needed to prevent and control tobacco use. Through its clinics and its school- and community-based programs, the Indian Health Service will conduct education and outreach activities for Native American populations. Similarly, the Health Resources and Services Administration will incorporate education and outreach activities into its community-based prevention and primary care programs to reach populations served by these programs.

SAMHSA will support community education and media efforts through its Prevention and Treatment block grant. Finally, the Agency for Health Care Policy and Research will provide guidance to health plans, clinicians, and consumers on effective smoking-cessation techniques.

Enforcement. The Food and Drug Administration will implement and oversee enforcement of its rule to reduce the access and marketing of tobacco products to minors. Similarly, the Substance Abuse and Mental Health Services Administration will provide technical assistance to states to implement the Synar Amendment, requiring states to have in effect legislation prohibiting tobacco sales to minors and requiring comprehensive enforcement of such laws.

Success Measures

- Rate of tobacco use among young people
- "Tobacco buy rates" in state compliance checks of tobacco sales to minors
- Smoking prevalence rate of adults
- Perceived harmfulness and perceived social disapproval of tobacco use among young people
- Number of tobacco sales to minors
- Number of states conducting random, unannounced inspections of tobacco outlets

Major New Resources

CDC and FDA will need significant new resources to carry out prevention and regulatory enforcement activities. Levels will be specified in future Department budget requests

New Legislation and Regulations

Pursuant to its current regulatory authority, FDA will regulate the use of cigarettes and smokeless tobacco as delivery devices for the drug nicotine.

Research. The National Center for Injury Prevention and Control will fund research to better understand the etiology of non-occupational injuries and the effectiveness of interventions to prevent injuries. For occupational-related injuries, the National Institute for Occupational Safety and Health will spearhead a research effort called NORA (National Occupational Research Agenda), a consensus agenda developed by the occupational safety and health community to guide research into the next century. The National Institutes of Health will continue to contribute to the research strategy by funding research on effective treatments for injuries, including rehabilitation therapies.

Training. Through its academically-based Injury Prevention Research Centers, the National Center for Injury Prevention and Control will train researchers and public health professionals in injury prevention. Training of occupational health and safety professionals to improve safety and health in the workplace will be undertaken by the National Institute for Occupational Safety and Health. These efforts will contribute to assuring a national cadre of professionals in injury prevention.

Prevention. The National Center for Injury Prevention and Control will lead injury prevention activities in the Nation, primarily by providing technical assistance to states and community injury prevention programs to help them build program capacity and implement effective injury prevention programs. The Indian Health Service, a partner in these efforts, will build tribal capacity for injury prevention, including risk identification, and health and safety services.

In the area of occupational injuries, the National Institute for Occupational Safety and Health will conduct a vigorous program to identify workplace hazards and recommend control measures to employers. A particular priority will be the evaluation of violence in the workplace and the identification of occupational injuries among teens.

Violence prevention will also be addressed by a number of other HHS agencies, focusing on prevention efforts in minority communities. The Health Resources and Services Administration will concentrate on prevention of domestic violence by making risk identification and intervention a priority objective for its Maternal and Child Health program. The Maternal and Child Health program also will concentrate on reducing unintentional childhood injuries through education activities addressed to the families it serves. The Centers for Disease Control and Prevention will evaluate community-based interventions for reducing intimate partner violence and use the findings to improve ongoing prevention programs, such as Health Resources and Services Administration's domestic violence efforts and the Administration for Children and Families' Family Violence Program.

Key External Factors

In part, vigorous state enforcement of tobacco laws will be necessary to achieve the objective. Additionally, a proposed global tobacco settlement developed by forty states' attorneys general and the tobacco industry is currently under consideration. The final outcome will strongly influence both the legal framework and resource base for tobacco use prevention efforts.

Strategic Objective 1.2 Reduce the Number and Impact of Injuries

Claiming nearly 150,000 lives each year, injury is one of the leading causes of death and disability for all age groups. The impact of injury is especially high for young Americans. Indeed, from the time a child celebrates his first birthday until he reaches age 45, injury--unintentional injury, homicide, and suicide combined--will be his or her leading risk of death.

Each year, there are an estimated 37 million injury-related emergency department visits. Three-fourths of these visits are associated with unintentional injuries and one-fourth are associated with intentional injuries. The cost of these injuries in terms of direct medical care and rehabilitation, as well as lost income and productivity, totals an estimated $224 billion a year. Each year, there are over 11 million persons aged 12 years and older who are victims of violent crimes, of which many result in injury. Racial and ethnic minority populations are at highest risk of injuries resulting from violence, thus making violence prevention one of the keys to improving the health of these communities.

Although great strides have been made in reducing occupational injuries, work place hazards continue to inflict a tremendous burden on the Nation in both human and economic costs. Each day, an average of 16 people die from work-related acute traumatic injuries. In 1995, occupational injuries cost $119 billion in lost wages and productivity, administrative expenses, health care, and other costs. Clearly, focusing on the reduction of injuries has a substantial societal benefit.

Strategy for Achieving Objective

Within the Department, the National Center for Injury Prevention and Control (at the Centers for Disease Control and Prevention) takes the lead in preventing and controlling injuries. The Department's approach to reducing injuries to Americans will include support for state-of-the-art research, training and prevention activities, and assuring treatment services that include acute care, trauma care, and rehabilitation to minimize the functional impairment of persons suffering injuries.

New Legislation and Regulations

None.

Key External Factors

Reliance on service delivery partnerships with other federal departments and state and tribal governments is essential to success in this area.

Strategic Objective 1.3
Improve the Diet and the Level of Physical Activity of Americans

During the past 40 years there has been a shift in diet-related public health problems from nutrient deficiency diseases as major problems to chronic degenerative diseases as leading causes of death. In 1995, four of the ten leading causes of death in the United States--heart disease, certain cancers, stroke, and diabetes mellitus--were diseases in which diet and physical activity play a role. Together these diseases account for more than 300,000 deaths annually. The costs associated with diet and activity-related health conditions, including direct health care and lost productivity, is estimated at $56.3 billion.

Scientific consensus has emerged around dietary and physical activity recommendations for disease prevention and health promotion. The Department's approach to improving diet and the level of physical activity is based on this consensus.

Strategy for Achieving Objective

The strategy to improve diet and physical activity will involve a combination of research, education, and regulatory activities.

Research. Through research and dissemination efforts, the National Institutes of Health will continue to investigate and inform the public and the health professions about the effects of diet and physical activity on health. The scope of NIH research is broad, including cutting-edge efforts such as the trans-NIH initiative to investigate nutrient modulation of cell integrity and repair mechanisms as well as efforts to evaluate the effectiveness of educational efforts to change behavior.

Education. Based on research findings from the National Institutes of Health, the Centers for Disease Control and Prevention, and the President's Council on Physical Fitness and Sports will lead a Nationwide campaign--in partnership with

Finally, the Department's substance abuse treatment and prevention programs, in conjunction with Health Resources and Services Administration, the Department of Education, and the Department of Justice, will support an initiative to provide communities with current information on the incidence of street and gang violence, domestic violence, and data on substance abuse and violence.

Treatment. Emergency intervention and treatment services also will be a key element of the Department's effort to ameliorate the impact of injuries. The focus of Department efforts will be on providing technical assistance to states through the Health Resources and Services Administration to improve emergency medical services for children, including emergency medical care, pre-hospital care, emergency department care, hospital care, and rehabilitation. This strategy is focused on minimizing the severity and long-term impact of injuries.

Success Measures

- Death rate from unintentional injury

- Safer communities as measured by:
  - -- Number of emergency department visits of children with bicycle-related head injuries
  - -- Percentage of child bicyclists who use bicycle helmets
  - -- Percentage of residential dwellings having at least one smoke detector present on each habitable floor
  - -- Death rate from residential fires

- Safer work places as measured by:
  - -- Rates of work-related injuries resulting in medical treatment, lost time from work, or restricted work activity
  - -- Rates of workplace violence and juvenile occupational injuries

- Number of states that require training in pediatric emergency care as a condition for recertification of EMTs at all skill levels

Major New Resources

None.

the states, school systems, and voluntary organizations--to encourage improvements in diet and greater levels of physical activity. Primary attention will be paid to reaching work places, schools and at-risk populations.

Educational messages will also be developed and delivered through primary care settings supported by the Department. The Indian Health Service and the Health Resources and Services Administration (through their health centers and maternal and child health sites) will implement programs to counsel patients on diet and lifestyle.

The National Cancer Institute will continue its "Five-A-Day" education program about the importance of eating vegetables and fruits. The National Cancer Institute will evaluate the effectiveness of this effort.

Based on research findings from the National Institutes of Health and others, the Office of Public Health and Science, in partnership with the U.S. Department of Agriculture, will revise the Dietary Guidelines for the Nation. The completed materials will be disseminated to professionals and the public.

Regulation. The Food and Drug Administration will enforce ingredient and content labeling requirements for prepared foods so that consumers can act on the dietary guidelines.

Success Measures

- Percentage of students who engage in physical activity
- Percentage of Americans with an average dietary fat intake of 30 percent of calories or less and average saturated fat intake of less than 10 percent of calories
- Percentage of schools implementing the Center for Disease Control and Prevention's guidelines on school-based physical activity
- Effectiveness of the National Cancer Institute's public-private partnership "Five-A-Day" (Number of Americans meeting the Dietary Guidelines' average daily goal of five or more servings of vegetables/fruits)
- Percentage of adults who use food labels to make nutritious food selections

Major New Resources

None.

New Legislation and Regulations

None.

Key External Factors

Changing the behavior of Americans will take a tremendous collaborative effort. HHS will depend on cooperative activities in the public and private sectors to achieve these objectives.

Strategic Objective 1.4
Reduce Alcohol Abuse

Alcohol has devastating effects on the health and quality of life of individuals and families in America. More than 100,000 people die from misuse of alcohol each year, with related health and social consequences that cost over $100 billion annually. An estimated 18 million U.S. residents suffer from alcohol dependence, and some 76 million are affected by alcohol abuse at some time during their lives.

Strategy for Achieving Objective

HHS will employ a multifaceted strategy -- consisting of research, prevention and treatment -- for reducing alcohol abuse.

Research. The National Institutes of Health will continue to conduct basic, clinical, and health services research to improve the effectiveness of alcohol abuse prevention programs and alcoholism treatment programs. NIH will investigate the genetic contributions to the development of alcoholism; the metabolism of alcohol and how alcohol causes organ damage; the effects of alcohol on the brain and the nature of alcohol dependence; identification and development of treatment pharmaceuticals; the effectiveness of behavioral treatment and combinations of medications and behavioral treatment; scientifically-based prevention strategies; and the delivery of health services to determine optimal service delivery.

Prevention. Alcohol abuse prevention activities will be carried out by the Substance Abuse and Mental Health Services Administration through its block grant program and will support education programs, programs designed especially for at-risk populations, training for community personnel, and technical assistance to states and communities for activities that promote changes to advertising, pricing, and availability of alcohol. The Administration for Children and Families will target

prevention activities on high risk groups, such as through its Runaway and Homeless Youth Program.

Complementing these direct prevention activities, the Centers for Disease Control and Prevention, through its Youth Risk Behavior Survey, will help states build the capacity to monitor alcohol problems and alcohol abuse trends in their populations.

Treatment. HHS will support a range of treatment services directed at diverse populations. The Substance Abuse and Mental Health Services Administration will support a wide range of treatment activities through its block grant, including residential treatment, intensive outpatient services and treatment programs for adolescents. Complementing the SAMHSA activities, the Health Resources and Services Administration will support treatment services for low income populations and for women served through its maternal and child health programs.

The Indian Health Service will address the treatment needs of Alaskan Natives and American Indians. Efforts to prevent and treat alcohol dependence will be a special area of emphasis for the Indian Health Service, which will work to screen women at prenatal clinics for alcohol abuse (and to treat, as needed), and to improve follow-up activities with youth discharged from adolescent treatment centers.

The Medicare and Medicaid programs of the Health Care Financing Administration will also play important roles through their financing of alcohol treatment services for beneficiaries.

Success Measures

- Death rate for alcohol-related motor vehicle crashes
- Death rate for cirrhosis
- Past month use rate for alcohol among 12-17 year olds
- Percentage of school seniors who perceive social disapproval of heavy use of alcohol
- Parental attitudes toward youth use of alcohol
- Number of "client slots" for alcohol abuse treatment and follow-up services for American Indians/Alaska Natives

Major New Resources

None.

New Legislation and Regulations

None.

Key External Factors

The success of prevention and treatment efforts depends on collaborative efforts of state and tribal governments and communities.

Strategic Objective 1.5
Reduce the Use of Illicit Drugs

Approximately 20,000 preventable deaths a year are attributable to the use of illicit drugs and the illicit use of prescription drugs. Illicit drug use and illicit use of prescription drugs contribute to suicide, homicide, motor vehicle injury, HIV infection, pneumonia, hepatitis, tuberculosis, sexually transmitted diseases, and endocarditis. While an estimated 3 million people in the United States have serious drug problems, fewer than a third of them are in treatment at any given time. Apart from the loss of life, the social costs are severe—worsening crime rates and community and family disintegration, which in turn compromise other important influences on health such as income, education, and family stability.

Strategy for Achieving Objective

The Office of National Drug Control Policy (ONDCP) is leading a cooperative effort involving fifty federal agencies to establish national performance targets and measures for achieving the President's national drug control strategy. HHS is a committed partner in this cross-cutting and labor-intensive process that has focussed the drug prevention efforts of federal agencies and that will document the contributions of individual agencies and the benefits of collaboration. HHS staff participate in ONDCP's interagency working groups and currently are involved in reviewing targets and measures for its 32 objectives. The Department's strategy to reduce the illicit use of drugs is an integral part of the national drug control strategy.

The Department's role in the national strategy consists of three elements: research, prevention, and treatment.

Research. The National Institutes of Health will continue to develop and disseminate basic, clinical, and health services research to improve the effectiveness of prevention and drug treatment programs. NIH will support research on: the determinants of drug taking behavior among youth, to better prevent experimentation and addiction; neuroscience, to better understand the brain circuitry and chemistry that "rewards" drug use; anti-addiction medication development, including the development of an anti-cocaine medication; and a wide spectrum of issues related to methamphetamine, including the development of anti-methamphetamine medication, development of prevention strategies, and improved treatment protocols, in response to a surge in popularity of this drug.

SAMHSA will complement the National Institute of Health research by supporting community-based research on changing patterns of drug use so that treatment protocols can be adapted to the community needs.

Prevention. Of special concern is the recent rise in drug use, especially marijuana use, among youth and the decline in their perceptions of the harm it causes. To address these related trends, the SAMHSA will lead the Secretarial Youth Substance Abuse Prevention Initiative to raise public awareness, mobilize public and private sector resources, and increase accountability for results. A major component in this strategy will be incentive grants to states for the development and application of effective community-based prevention efforts.

The Substance Abuse and Mental Health Services Administration also will support prevention programs for drug abuse through its prevention and treatment block grant. This effort supports a substantial number of drug abuse prevention efforts in the nation, including education programs, programs for at-risk populations, and training of community-based personnel. SAMHSA also will continue to administer the Federal Drug-Free Workplace Program, which affects almost 30 million U.S. workers.

The Health Resources and Services Administration and the Indian Health Service will use their networks of community-based providers to support drug abuse prevention activities for the populations they serve. The Administration for Children and Families will target its prevention activities on high risk groups through its Runaway and Homeless Youth Program and other relevant programs.

Additionally, the Centers for Disease Control and Prevention will help states monitor and respond to drug abuse problems in their populations through its Youth

Risk Behavior Surveys. The Centers for Disease Control and Prevention will also work with the Indian Health Service to implement a survey for American Indian and Native Alaskan youth.

Treatment. The SAMHSA will support residential treatment, intensive outpatient treatment, methadone programs, and adolescent treatment programs through its block grant program. The Indian Health Service will fund approximately 400 alcoholism and substance abuse programs that provide prevention and treatment to rural and urban Indian communities. IHS will also provide screening services in emergency rooms and prenatal clinics so that drug abuse can be identified and treated.

The Medicare and Medicaid programs of the Health Care Financing Administration will also play important roles through their financing of drug treatment services for beneficiaries.

Success Indicators

- Rate of "past month use" of marijuana among 12-17 year olds
- Rate of "past month use" of all illicit drugs among 12-17 year olds
- Parental attitudes toward youth use of drugs
- Death rate of persons aged 15-65 attributed to drug use

Major New Resources

None.

New Legislation and Regulations

None.

Key External Factors

HHS depends on cooperative activities of many federal departments and its state partners. The quality of services provided by managed care organizations will impact the success of this goal (see also goal 4).

Strategic Objective 1.6
Reduce Unsafe Sexual Behaviors

Unsafe sexual behaviors now represent some of the most rapidly increasing causes of disease in the country contributing to sexually transmitted diseases such as chlamydia, gonorrhea, syphilis, HIV infection, genital herpes, human papilloma virus and hepatitis B, and their complications (infant mortality, cervical and liver cancers, pelvic inflammatory disease, and AIDS). In addition, unsafe sexual behavior among teens can result in unintended pregnancies, a potentially life-damaging consequence of adolescent sexual experimentation.

Strategy for Achieving Objective

The Department's efforts to reduce unsafe sexual behavior will focus on prevention of sexually transmitted diseases and teen pregnancy. Research, prevention, and treatment will play important roles in the overall strategy.

Research. The Department's responses to the increase in sexually transmitted diseases will include basic, clinical, epidemiologic, and health services research conducted by the National Institutes of Health and the Centers for Disease Control and Prevention. The research will be designed to help better understand the patterns of sexually transmitted diseases and to develop effective prevention and treatment strategies. The Department will also support research on teen pregnancy, with a focus on the behavioral aspects of teen decision making and development of prevention strategies.

Prevention

- Sexually Transmitted Diseases (STDs)

  The focus of Department prevention efforts will be support for sexually transmitted disease prevention programs to reduce sexual behaviors leading to infections and their complications. These programs, supported by the Centers for Disease Control, the Substance Abuse and Mental Health Services Administration, Administration for Children and Families, the Indian Health Service, and the Health Resources and Services Administration, will support population-based prevention programs in the states (CDC), as well as counseling activities offered through health departments (HRSA), community health centers (HRSA), Indian clinics (IHS), mental health and substance abuse providers (SAMHSA), and other service sites (ACF).

- Teen Pregnancy

The primary focus of the Department strategy for preventing out-of-wedlock teen pregnancy will be a national prevention program, called *Girl Power,* directed at girls aged nine to fourteen. This program will encourage communities to develop innovative and comprehensive approaches to preventing teen pregnancy by encouraging abstinence and responsible behavior. For example, HRSA will provide grants to states for abstinence education, mentoring, and counseling for those youth most likely to bear children out-of-wedlock.

The Department also will support prevention activities that counsel sexually active teenagers on the consistent and effective use of condoms and other contraceptives. The Department will initiate demonstration projects to test and disseminate promising prevention approaches, including the involvement of young men. Improved data collection will also be a priority.

Treatment. Treatment of sexually transmitted diseases will be supported by CDC, the Substance Abuse and Mental Health Services Administration, the Indian Health Service, and the Health Resources and Services Administration through their service networks. Curative therapy is offered for diseases caused by bacterial and parasitic organisms. For many viral infections such as HIV, current treatment suppresses the infection but does not provide a cure. However, recent advances in combination therapy (i.e., protease inhibitors) dramatically reduce the amount of virus that can be detected and increase the life span of many patients.

The Medicaid program of the Health Care Financing Administration will continue to play an important role through its financing of treatment services for beneficiaries.

Success Indicators

- Incidence rates of gonorrhea, syphilis, and pelvic inflammatory disease
- Prevalence rate of chlamydia in teens and young women
- Rate of perinatally acquired HIV infection
- Pregnancy rate among teens

Major New Resources

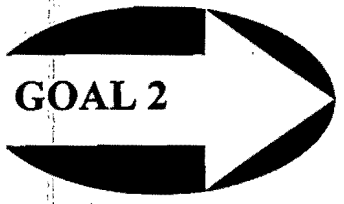
None.

New Legislation and Regulations

None.

Key External Factors

HHS's success depends on the participation of its partners in state and tribal governments and other federal departments.



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

Achieving a society in which each person, regardless of age, sex, physical ability or racial/ethnic background, has the opportunity to lead an economically and socially productive life is central to the Department's vision for the future. Realizing this vision requires that we support strategies that create opportunities for individual, families and communities--a responsibility that the Department shares with other Federal agencies, state, local and tribal governments and the private sector.

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

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

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

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

Persons With Disabilities. The Department has also identified significant barriers to independence faced by working age adults with disabilities (those aged 18-64). People with disabilities typically report that they want to work, but need personal assistance services or devices in order to do so. Others won't risk working because they cannot afford to lose the health and long-term care coverage they have under Medicaid or Medicare. Thus, while 90.7 percent of men and 74.4 percent of women without disabilities participate in the work force, for men and women with disabilities, those statistics are 67.3 percent and 52.3 percent respectively. To address this disparity, the Department will work to provide access to health coverage and a wide range of supports for daily living activities needed by persons with disabilities to facilitate their participation in the work force and full participation in community life. For those unable to work, the Department will provide similar supports necessary for independent living and integration in the community.

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

General Strategy for Achieving Goal

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

Strategic Objective 2.1
Increase the economic independence of families on welfare

On August 22, 1996, the President signed into law The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which created Temporary Assistance for Needy Families (TANF) and significantly improved and expanded the Child support and Child Care programs. These programs are important to the strategies discussed here and in other strategic objectives. TANF gives states and tribal governments unprecedented flexibility to design programs that promote work, responsibility, and self-sufficiency. It has transformed welfare from an entitlement to individuals into a variety of programs in states and counties that require work and provide time-limited assistance. The nation has an enormous stake in this new approach to public assistance. The Administration for Children and Families (ACF) will lead the Department-wide effort to help state and tribal governments as they design and implement their programs and move clients from welfare to work, while protecting the well-being of children through child care and other services.

Strategy for Achieving Objective

The Department will conduct a rigorous program of research, evaluation, and exchange of information to develop a sound knowledge base of what works well and to measure the impacts of reforms on children and families. The Department will work with states, communities and the research community to identify the most critical information needed to design and implement effective programs that promote sustained employment.

Technical Assistance. The Department will support state implementation of TANF by highlighting best practices and innovative strategies; assisting in the development of program performance measures and systems for data collection; facilitating peer-to-peer assistance; and designing ways to monitor and evaluate program.

Promoting Employment. The Department is committed to working with states to promote work, personal responsibility and self-sufficiency in ways that will strengthen families. Specifically, we will develop reliable information on effective ways to do this; we will facilitate communication across states; identify best practices; promote peer technical assistance; and offer expert technical assistance. The high performance bonus measures, which we will develop in consultation with states and national organizations, will both recognize high performance and identify areas for improvement.

A concerted effort also is underway to find jobs for welfare recipients in the Department and to challenge other agencies and the private sector to hire welfare recipients. Partnerships are being forged with health care providers and others to develop job opportunities. Attention will also be given to removing barriers to work for welfare recipients who are victims of domestic violence, who have developmental disabilities, and for others who have serious personal or family problems which interfere with their ability to work.

Improving Access to Child Care. A public commitment to providing access to quality, affordable child care is critical to achieving self-sufficiency for welfare clients. Child care subsidies also help the working poor remain self-sufficient. The Department will continue to promote expansion of child care services as a critical element in its strategy for helping families achieve economic independence. This will involve working with our partners to increase the supply of child care, develop measures of child care quality and provide information to help parents make sound child care choices. The Department also will support the development of models to help establish the conditions for child care subsidies, and to test the effects of variations in child care subsidies on labor force attachment.

In addition, partnerships between Head Start programs and child care providers are integral to serving the full day needs of low income parents who are working. As Head Start expands, the Department will encourage collaboration between Head Start programs and child care providers to meet the full-time child care needs of the families they serve.

Success Measures

- The number of states meeting the TANF work participation targets for FY 1999.
- The number of welfare recipients that are employed by the year 2000.
- Job retention rates among TANF recipients and former recipients.
- The average earnings of TANF recipients and former recipients.
- The number of TANF recipients and former recipients who are employed by HHS funded community-based programs.

Major New Resources

Significant additional resources will be needed to expand the availability of child care services for welfare recipients going to work. Specific levels will be specified in future Department budget requests.

New Legislation and Regulations

Implementing regulations for TANF will be developed and published.

Key External Factors

The primary responsibility for implementing welfare reform is now lodged in the states, with tribal governments and in a number of cases, in counties. In this decentralized environment, HHS's ability to achieve the objective depends on effectively working with state, local and tribal governments and other key stakeholders.

The health of the economy could also have a major effect on the achievement of this goal. Traditional business cycles have varying consequences across geographic areas and sectors of the economy and the currently strong economy has played a major role in the success of welfare reform to date. Historically, however, the low-wage entry level and service sector jobs that many former recipients will hold have been highly vulnerable to economic downturns.

Strategic Objective 2.2
Increase the Financial and Emotional Resources Available to Children from Their Noncustodial Parents

Parents have a responsibility for the financial, emotional and social support of their children. Financial support from non-custodial parents is essential to the economic security of the child and the custodial parent. Emotional and social support is equally essential for the child's sound growth and development. If every parent paid the child support he or she legally owes, significant reductions in the number of children living in poverty and families receiving welfare would occur. For example, the Urban Institute has estimated a $34 billion gap between the potential and actual child support collections. To address these issues, the Department is committed to working

with states to aggressively enforce payment of legally owed child support, to establish paternities, and promote the involvement of noncustodial fathers in their children's lives.

Strategy for Achieving Objective

The Department plans two major strategies to achieve this objective:

Increasing Child Support Collections. The Department will aggressively implement the child support provisions of the law. This will be achieved through a variety of means, from implementing federal policy to technical assistance, training, information dissemination, a more performance-based incentive funding structure, and federal oversight and assistance with state-based quality assurance. The Federal Parent Locator Service will be expanded to facilitate location of noncustodial parents, their employers and their assets to promote the establishment and enforcement of child support orders; the National Directory of New Hires will be operationalized and linked to the Federal Case Registry to locate absent parents across state lines; and the Department will promote implementation of administrative offsets for child support with the Internal Revenue Service.

Encouraging the Involvement of Fathers. The Department will continue efforts to increase parental responsibility, focused on the involvement of fathers in the lives of their children through: focusing attention on the positive role fathers have in improving child well-being; ensuring that the Department's research agendas pay adequate attention to the role of fathers in families and the effects of fathering on child well-being; using positive messages and language regarding fathers and fatherhood in publications and announcements; and ensuring that the Department's workforce policies encourage and enable fathers to balance work and family life responsibilities.

Success Measures

- Dollar amount of child support collections.
- Number of paternities established for children who need paternity established.
- State child support agencies' rate of child support collections.
- Number of HHS funded research and service programs that focus on encouraging father involvement.

Major New Resources

None.

New Legislation and Regulations

None.

Key External Factors

Child support enforcement is a joint federal and state effort. Many of the changes brought about by the PRWORA require the passage of strong state legislation and state implementation of the new laws. Therefore, state systems' changes and improvements are an important element in the achievement of this objective. To the extent that states are slow to develop state-wide systems, this could hinder the ability to improve child support enforcement efforts.

Strategic Objective 2.3
Improve the Healthy Development and Learning Readiness of Preschool Children

Children who reach school ready to learn -- healthy and socially and emotionally well-developed -- are likely to succeed in school and to go on to secure and productive lives. Extensive research on early childhood programs confirms the positive outcomes for children receiving high quality early intervention services. Also, recent research on brain development sponsored by the National Institutes of Health has given us new insights into the importance of children's day-to-day social interactions for healthy development, and has shown us how interconnected are emotional, social and cognitive development. Interventions in infancy and early childhood with those who are vulnerable have been shown to be cost effective and are essential to preventing more costly mental, developmental, and social problems.

Strategy for Achieving Objective

Because disadvantaged children are most at risk for problems as they grow up, we particularly will focus on improving childhood development for these children by

supporting programs to improve the cognitive, social, emotional, and physical health and development. There are three elements to the strategy:

Expanding Head Start to Serve More Children. A bipartisan consensus regarding the value of early childhood services has fueled the dramatic expansion of the Head Start program, which has a thirty-year history of providing comprehensive child and family development services to preschool children from low-income families. More recently, based on research demonstrating the critical developmental importance of the first years of life and experience with previous demonstration programs, the Early Head Start Program has begun to serve children from zero to three years of age. Expansion of Head Start and Early Head Start is underway to reach one million children by 2002, up from 752,000 children served in 1996. The Department will continue to promote this expansion.

As Head Start expands, the Department's also will work to ensure program quality. This effort will be underpinned by a strong research and evaluation agenda. Investments in measuring program performance and outcomes for children and parents also will undergird a continuous quality improvement effort. This will be done by supporting the implementation of updated and more comprehensive performance standards by all providers, newly improved systems for program monitoring and technical assistance, and the analysis and use of findings from a new national system for measuring program outcomes.

Child Care. Increasing the availability of good child care services to support the development of low income children is as important to achieving this objective as it is to achieving the Department's objective of moving welfare recipients into jobs (see objective 2.1). Therefore, the Department will promote continued expansion of quality child care services to ensure access for eligible children.

As it supports increasing the availability of child care services, the Department also will conduct an extensive program of research, technical assistance, and information dissemination to maintain and improve the quality and effectiveness of child care programs. Research partnerships among child care administrators, academics, providers, and practitioners are planned, as well as joint ventures regarding child care quality between the Child Care Bureau and other parties both within and outside the Department. These partnerships will produce important insights into statewide and local patterns of child care demand and supply, the quality of care used by low-income families, and the importance of quality care for both parents and children.

Health Care Services. To complement the cognitive, emotional, and social development of children provided by Head Start and child care services, the Department will also take steps to see that appropriate health care services are available to children in early childhood settings. This will involve providing access and linking health care services to the low income and disadvantaged children in these settings. Department programs, including Maternal and Child Health, Community Health Centers, mental health programs, and Medicaid will be involved in this effort.

Success Measures

- Children participating in Head Start will demonstrate improved learning skills, health, social behavior, and emotional well-being.
- The number of Head Start programs that partner with child care services.
- The number of states that provide health services linkages with Head Start and child care (e.g. immunization, Medicaid outreach and screening).
- Number of Head Start and child care sites having behavioral health services.

Major New Resources

The President's commitment to serve one million children in Head Start by the year 2002 will require continued budget increases. These are planned for in existing budget agreements.

Significant additional resources for child care expansion will also be needed and built into future Department budget requests.

New Legislation and Regulations

None.

Key External Factors

Although HHS's leadership will continue to be critical to achieving success under this objective, states, tribal governments and local Head Start and child care programs play a

major role in improving access and quality to these services. Their actions can significantly effect the outcome.

Strategic Objective 2.4
Improve the Safety and Security of Children and Youth

The Department is deeply committed to improving the safety and security of children served by the child welfare system. In the past twenty years, social, cultural, and economic changes such as increases in substance abuse, community violence, and poverty have increased the number and severity of family problems. Reports of substantiated, as well as suspected, cases of child abuse and neglect continue to increase. The damaging effects of child abuse and neglect on the physical, psychological, cognitive, and behavioral development of children is well documented.

At the end of 1995, over 450,000 children were in foster care, an increase of almost 42 percent since 1988. While many of these children will return home, nearly 100,000 will not. The median stay in foster care is over two years. It takes substantially longer to find permanent homes for minority children. Older children, sibling groups, and children with disabilities, irrespective of race, also have longer waits.

Strategy for Achieving Objective

The Department strategy to improve the safety and security of children is composed of five elements.

Preventing Child Abuse and Neglect. The Department will support research and demonstrations to better understand how to prevent child abuse and neglect and treat child victims and perpetrators. Transfer of new knowledge gained will lead to more successful prevention and treatment results. The Department will also study the implementation of family preservation and support services in the states and local communities to identify what has and what has not worked well. Rigorous studies of the impact of family preservation and family support services will be conducted to inform the practice community and technical assistance efforts; and technical assistance will be provided.

Providing Mental Health Treatment Services. While not all the causes of mental health problems in children are the result of the mental trauma of abuse and neglect, support

for these services is an important element in helping children overcome abuse. To address this need, the Department, through the Children's Mental Health Program, will support the development of community-based systems of care that serve children with serious emotional disturbances.

Improving Management of Foster Care and Adoption Assistance Services. The Department will work to reduce the amount of time children spend in foster care settings. This will be done by revising monitoring procedures for the title IV-E foster care and adoption assistance programs to focus on a realistic examination of the actual experiences of families and children, such as discussions with foster care children, foster and biological parents, caseworkers and judges. The Department will also support child welfare waiver demonstrations in partnership with states to test, evaluate, and disseminate more effective child welfare practices. Finally, the Department will evaluate and improve the technical assistance and training activities that it provides under the child welfare, foster care and adoption assistance programs to ensure best practices are disseminated and the technical assistance and training have relevance and utility to states and localities.

Implementing Adoption 2002. The Department will double the number of children in the child welfare system for whom adoptions or other permanent living arrangements are established by implementing the President's Adoption 2002 Initiative. To accomplish this, the Department will work with states, non-profit organizations, and local communities to identify and remove barriers to adoptions (e.g., court processes that prevent timely judicial actions to terminate parental rights).

The Department also will work with Congress to provide legislation for the implementation of several of the Adoption 2002 strategies to reduce barriers, including the authorization of incentive funds to promote the adoption of special needs children and the authorization of grants to support the reduction of adoption barriers.

Court Improvements. The Department will continue to work with state supreme courts, child protection agencies and others in the community to bring about improvements in court systems and processes to achieve more timely actions affecting children. The Department will support state supreme courts in developing self-assessments and plans for systemic improvements.

Enforcing Nondiscrimination Provisions. The Department will conduct training and provide technical assistance, through its Office for Civil Rights and ACF, to help state and local adoption and foster care providers implement the nondiscrimination

provisions of the Small Business Job Protection Act and the family recruitment provisions of the Multi-ethnic Placement Act. The purpose of this will be to ensure that race or ethnicity are not used as the basis to deny or delay placement of children into adoptive or foster care.

Success Measures

- Percentage of harmed children whose situations are investigated by child protective services agencies.
- Percentage of children with substantiated reports of maltreatment who have a repeat substantiated report of maltreatment within 12 months.
- Percentage of children who exit the foster care system through reunification within one year of placement and who exit through adoption or guardianship within two years of placement.
- Percentage of minority children who exit the foster care system through reunification with one year of placement and who exit through adoption or guardianship within two years of placement.

Major New Resources

New resources will be needed to implement the Adoption 2002 Initiative. These were specified in the President's budget request for 1998.

New Legislation and Regulations

Legislation currently under consideration in Congress would provide authority for several aspects of the Adoption 2002 Initiative which are not in current law, particularly for the provision of financial incentives to states for increasing adoptions and other permanent placements for children and the authorization of grants to reduce adoption barriers.

Key External Factors

HHS' ability to achieve permanency goals for children is dependent upon improving judicial handling of child welfare cases. We provide leadership in an environment in which the primary responsibility for decisions about the placement of children will be taken by state

courts. Major changes to assistance programs for low income families as part of welfare reform will also have an unknown impact on the child welfare system over the next several years.

Strategic Objective 2.5
Increase Opportunities for Seniors to Have an Active and Healthy Aging Experience

One of the major successes of the 20th century is increased longevity and improved health among older people. The challenge of the paradigm shift from thinking of the elderly as dependent to helping seniors remain engaged in economically and socially productive lives is an important element in the Department strategy to achieve the overall goal of improving the economic and social well-being of persons in the United States.

Strategy for Achieving Objective

To achieve this objective, the Department will pursue a dual strategy:

Conducting Research to Support Active and Independent Aging. Through the research programs of the National Institute on Aging, the Health Care Financing Administration, and the Agency for Health Care Policy and Research, the Department will conduct and disseminate biomedical, behavioral, and health services research to better understand the aging process and what contributes to healthy aging and the ability to function independently for as long as possible. Importantly, we will examine whether current declines in the disability rates of seniors persist and what factors seem to contribute to the lower rates. We will also identify which social and health factors, treatments, and approaches to organizing and delivering care contribute most to minimizing and delaying functional decline. Demonstrations that offer innovative health care options to Medicare beneficiaries and new service delivery models for those dually eligible for Medicare and Medicaid will be supported.

Providing Services Essential to Active Aging. To remain healthy and active participants in their communities, many of the elderly need a range of services that include preventive health services, in-home and community support services and nutrition services. To ensure the elderly have access to these services, the Administration on Aging (AOA) will support a national aging network of state, tribal, and Area Agencies on Aging operating in every county in the United States to deliver these services. The network also will carry out a broad range of activities including

advocating on behalf of older people, surveying the needs of the seniors in states and communities across the country, and marshaling available resources and knitting them together into a comprehensive and coordinated system of services and supports.

The Department will increase access to preventive and primary health care and chronic disease management services for seniors by increasing the outreach activities in programs of the Health Resources and Services Administration, such as the Community Health Centers. Primary health screening can detect problems such as alcohol and prescription abuse and depression.

The Office for Civil Rights will promote access by carrying out its government-wide coordination responsibilities under the Age Discrimination Act by protecting against discrimination on the basis of age in services funded by the Department and other Federal agencies.

Success Measures

- Average age of onset for the chronic diseases of old age
- Disability rates for the elderly
- Proportion of older people who are nutritionally healthy
- Proportion of older people with access to preventive health services
- Number of years of functional independence for the elderly
- Number of persons over 65 receiving preventive and primary care in HRSA programs

Major New Resources

None.

New Legislation and Regulations

None.

Key External Factors

How the baby boom generation prepares itself for retirement, both economically and in terms of lifestyle behaviors, will effect the achievement of this objective.

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

According to the recently conducted Disability Supplement to the National Health Interview Survey, disability is widespread in America, with 19.1 million people reporting that they perceive themselves or others perceive them as having a disability, 16.9 million reporting a disability that limits or prevents them from working, and 13.8 million receiving benefits from a disability program. (These groups are not mutually exclusive.)

Although most seniors are active, older people are at greater risk of needing health and long-term care services. Many seniors because of advanced age and/or severe disability, are dependent on others for even basic needs--that is services such as assistance with eating, bathing, dressing, getting in and out of bed, using the toilet, shopping, managing money, doing housework, or using the telephone.

Although disability and the need for long-term care increase substantially with age, disability is not a concern solely for the elderly. Of those with long-term care needs, half are under age 65, due in part to the fact that the oldest baby boomers are starting to reach their forties and fifties. According to recent analyses of the 1994 Disability Supplement to the National Health Interview Survey, 5.3 million working age adults need help with one or more of their daily living activities. Furthermore, people with disabilities are less likely to be employed than their counterparts without disabilities. To become employed and maintain employment, persons with severe disabilities need both supports in their daily living activities and access to health insurance to meet their medical needs.

As the baby boom generation ages, the proportion of the population likely to need long-term care will increase and the demand for long-term care and health services will also likely increase. Meeting this demand is a critical factor if we are to help the elderly and working age adults with the essential activities of daily living that will allow them to obtain and keep jobs and/or continue to be socially integrated into their communities.

There is also an additional problem that needs to be addressed as part of the demand for services. While increasing numbers of seniors and working age adults with disabilities are getting long-term care services in community based settings, many are still served in nursing homes and other public and private institutional settings. In general, people with disabilities and their family members and friends advocate for minimizing reliance on institutional care and maximizing use of services in home and community based settings that they have a role in directing. Although all the states have responded by creating Medicaid waiver programs that provide these services, and many are experimenting with new ways to provide greater consumer control in personal assistance services, more needs to be done to offer long-term supports in community settings where consumers participate in the direction of their services.

Strategy for Achieving Objective

HHS recognizes the need to support and expand the long-term care and health needs of vulnerable seniors and persons with severe disabilities by directly financing a variety of community based and residential long-term care services and providing access to health services. This will be done through a number of programs that target services for the those with the greatest financial need. Existing programs will have to be expanded if anticipated growth in demand occurs.

Also recognized is the need to empower these individuals to direct their own services. In this respect, the Department will support a strategy, including demonstrations, aimed at increasing the ability of those needing long-term care services to be involved in planning and directing those services.

Expanding Services. Medicaid is the long-term care safety net for those who cannot otherwise afford long term care and health services, expending almost 40% of its resources on long-term care, through the Medicaid personal care program, home health services, and the Home and Community Based waiver program. The Department also relies on support through Title III of the Older American's Act for a wide range of in-home and community based long-term care services for the elderly. These services include personal attendant care, home-maker and personal care, care management, transportation, respite services for family members, and home modifications and assistive devices.

Expansion to meet the growing demand for long term care and health services will be met by maintaining our support for the entitlement to services under Medicaid for the most vulnerable populations. Community Health Centers will increase the number of

Centers providing home care as part of HRSA's geriatric initiative, and provide home care in a way that can be monitored and integrated with preventive and primary care services.

Employment models for adults with serious mental illness will be enhanced by the development and evaluation of rehabilitation models, including models for supported housing services. States will also have the option of allowing certain disabled SSI beneficiaries who would lose eligibility because their earnings exceed the allowable limit to "buy in" to Medicaid, thereby overcoming disincentives to work.

The Office for Civil Rights ensure access to home health and other community-based long term care services by protecting against discrimination on the basis of race, national origin, disability, and age

Infrastructure Development. Meeting new demands for services also means having a network of community based services in place. To ensure the development of comprehensive service networks, the Department will support State Developmental Disability Councils to promote development of statewide consumer and family-centered systems. The Department will also support Developmental Disability Projects of National Significance to develop innovative national and state disability policies, programs, and protection and advocacy systems in each state and the University Affiliated Programs that provide training and dissemination of information and research on best practices and models of community service networks.

Additionally, the Administration on Aging, under the Older Americans Act, will support the continued development of the statewide home and community-based infrastructure (the aging network) to foster independent living outside institutional settings. This network provides personal care and assistance with activities of daily living (supportive and nutrition services) for elderly citizens and their caregivers. The services provided by the network are funded by a variety of federal, state and local funds.

Consumer Direction. The Administration on Developmental Disabilities will support demonstrations in the area of personal assistance to help consumers learn to hire assistants and negotiate scopes of services. An important step in providing consumers more control over their personal care services will be a Medicaid personal care regulation to enable consumers to receive less medically-oriented personal care, in both their homes and settings outside their homes. The Department will also mount a rigorous experiment to test the cost-effectiveness and quality of consumer

directed services approaches in which people with severe disabilities are given cash in lieu of services benefits so that they can select and manage their own services.

Success Measures

- The proportion of community based long-term care recipients reporting that they have control over their services and higher levels of consumer satisfaction.
- Increases in the proportion of people with disabilities who have health insurance.
- Reductions in the number of younger disabled individuals living in nursing homes.
- Increases in the proportion of working age adults with disabilities with access to attendant services.
- Percentage of persons in the community needing long-term care who receive needed services from home or community-based sources.
- Number of Community Health Centers providing home care.

Major New Resources

Passage of the Medicaid provision allowing states a "buy in" option for certain disabled SSI beneficiaries who would lose coverage because of earnings will have resource implications for the program.

New Legislation and Regulations

Extending Medicare and Medicaid to enable greater numbers of individuals to initiate or return to work will require legislative changes.

Key External Factors

States are expected to continue the trend of offering long-term care services in home and community based settings. For employment of working age adults with disabilities, jobs will need to be available for those who are qualified; this will depend, in large part, on economic conditions in states and localities.

Strategic Objective 2.7
Improve the Economic and Social Development of Distressed Communities

Strong neighborhoods and communities are the foundation supporting families in creating a healthy environment for children. Not surprisingly, research reveals a significant relationship between the quality of community life and the individual well-being of its residents. Residency in economically distressed neighborhoods is associated with negative impacts on early childhood development, educational attainment, and health indicators, as well as higher rates of violence, infant mortality, substance abuse, and teen parenthood.

Vibrant communities provide economic opportunity and social support -- jobs, education, health, housing, and safety -- the conditions in which human initiative, work, and stable families can flourish.

Strategy for Achieving Objective

HHS will achieve its objective by supporting activities that create jobs in economically disadvantaged communities, help communities develop comprehensive services networks to provide community supports for local residents, and empower residents to leverage local assets and address their needs. These activities will be enhanced by research as well as dissemination of best practices in community development.

Economic Development. HHS will assist communities to develop economically, create jobs and enable low-income individuals to access employment through a number of initiatives. The Department will support the Empowerment Zone/Enterprise Community (EZ/EC) initiative, in cooperation with the Department of Housing and Urban Development, by providing substantial funding and technical assistance for community development corporations and other organizations to create new business and employment opportunities. Additionally, the Department will use its grant programs, such as the Community Health Centers and Head Start, to employ welfare and low-income residents in distressed communities.

Infrastructure Development. HHS will support activities designed to help communities build networks of comprehensive, coordinated community support services for their residents. This will be done through the EZ/EC initiative that will provide funding and technical assistance to help establish interdisciplinary and cross-sector partnerships in communities between public and private service organizations. In

particular, the Department will provide technical assistance to assist community organizations gain access to HHS programs that support comprehensive, coordinated community services. The Department also will use the community service programs that it supports, such as the Family Violence Prevention Program, the Community Services Block Grant program, Healthy Start, Mental Health Services for Children and the Aging Network, to build coordinated service networks.

Empowerment. HHS will promote the involvement of community residents as active partners in developing and implementing local programs and services. This will be done through the EZ/EC initiative that will provide funding and technical assistance to increase leadership development and resident participation in community planning and governance. Also, the Department will use the community service programs that it supports, such as the Community Services Block Grant Program, HIV prevention programs in the Centers for Disease Control, and the Administration for Native Americans, to include community residents in the planning and implementation of services.

Research and Evaluation. Through its various research and technical assistance programs, HHS will undertake an analyses to enhance the knowledge base of effective community development practices, including collaborative and integrated services, governance processes, technical assistance delivery, technological applications, and outcome-based performance measurement.

Success Measures

- Number of jobs created for adult residents of economically-distressed urban and rural communities.

- Amount of community development investments in economically-distressed urban and rural communities.

- Prevalence of poverty-related health conditions suffered by residents of economically-distressed urban and rural communities. (Representative poverty-related health conditions include incidence of teenage pregnancy, substance abuse, depression, and malnutrition among residents of economically distressed areas.)

- Participation rates of residents of economically-distressed urban and rural communities in community planning and governance projects

Major New Resources

None.

New Legislation and Regulations

None.

Key External Factors

Many HHS programs vital to this strategy are implemented by state, tribal and local governments, and non-governmental agencies. Several other federal Departments and agencies manage projects for strengthening community-based efforts and creating economic opportunity for residents of distressed communities. In addition, our nation's overall economic climate, as well that of particular geographic regions, is a major factor in the Department's ability to achieve this strategic objective.

IMPROVE ACCESS TO HEALTH SERVICES AND ASSURE THE INTEGRITY OF THE NATION'S HEALTH ENTITLEMENT AND SAFETY NET PROGRAMS

The estimated 40 million Americans who lack any health insurance coverage, and the even larger number who are without insurance for behavioral health care services are at serious risk of going without essential health care. It is a matter of grave concern that these already large numbers are rising, and that employment-based insurance—the bedrock of coverage for working Americans— is declining. The percentage of the nonelderly population with employment-based health insurance coverage declined from 69.2 percent in 1987 to 63.8 percent in 1995 (EBRI). Without insurance, access to health services—particularly primary and preventive services—is severely compromised. Additional barriers to access include the absence of health care facilities or professionals; discrimination on grounds of race, national origin, age, or disability; and language or cultural obstacles that impede the delivery of care.

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

The Department is equally committed to the sound and fiscally prudent management of all of these programs. Because of their size and scope, the Medicare and Medicaid programs are particular targets for fraud and abuse and accordingly receive the highest priority attention. A coordinated enforcement effort—Operation Restore Trust—involving multiple components of HHS as well as the Department of Justice is expected to yield major results in the prevention of fraud and abuse in these programs. Areas of concern encompass fraud perpetrated by providers and beneficiaries as well as program payment policies that may excessively reimburse for certain types of services, and management practices that are wasteful or inefficient. The Department's program integrity strategy encompasses all of these.

General Strategy for Achieving the Goal

The Department's strategy has three components. First, HHS will work with the Congress and the states to increase access to services by reducing the percentage of children and adults who are without health insurance coverage. Second, the Department will maximize the number of low-income or special needs populations served through its programs, consistent with the level of appropriations to those programs. Emphasis will be on better integrating specialized safety net programs with Medicare and Medicaid. Third, HHS will expand its efforts to prevent waste, fraud, and abuse in all of its programs—but particularly in Medicare and Medicaid because of their size and their impact on the total health care system.

The objectives and strategies described below will guide the Department's success in meeting the goal.

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

Medicaid insures low income and severely disabled children. Almost 21 million children receive health coverage through Medicaid, which provides health care for nearly 33 percent of the nation's infants and for the overwhelming majority of all children with HIV/AIDS. Nonetheless, over 10 million children remain without any form of health care coverage. These children and their families are commonly the working poor and many rely upon federally-funded clinics or emergency rooms for their primary and acute health care needs. Children without health insurance or a regular source of health care have a higher frequency of acute medical conditions and other preventable illnesses.

Additionally, individuals may face various forms of discriminatory practices by health insurers or managed care plans due to pre-existing conditions (including genetically identified vulnerabilities, a prior history of mental illness, or substance abuse), disability, job transitions, or personal factors. These discriminatory practices increase the percentage of children and adults who are uninsured.

Strategy for Achieving the Objective

Expanding coverage to children and adults will be accomplished through implementation of the newly enacted Children's State Health Insurance Program; outreach and enrollment

of additional eligible children in Medicaid; and, along with the Departments of Labor and Treasury, implementation of the provisions of the Health Insurance Portability and Accountability Act (HIPAA). In addition, the President has proposed legislation that would prevent discrimination on the basis of information gained through genetic testing. HHS's ongoing enforcement efforts will address discriminatory practices that are covered by federal civil rights statutes.

Expanding health insurance coverage for children. Passage of the State Children's Health Insurance Program, as part of the Balanced Budget Act, is expected to substantially improve coverage for currently uninsured or unenrolled children. States will be able to choose how they participate in this initiative. Each state may choose to spend its allotment through a capped grant; or through an expansion of its Medicaid program above current state eligibility requirements for children; or a combination of both. HCFA is beginning to develop an implementation plan, and expects to work with ACF to build on the experience gained working with states in the implementation of TANF.

Medicaid Enrollment. An estimated 3 million children are eligible for Medicaid but are not enrolled. Effective outreach programs to identify Medicaid-eligible children require dynamic partnerships at all levels. State Medicaid agencies, the network of Community Health Centers, the Maternal and Child Health Programs, and the network of Head Start and Child Care programs all have opportunities to improve enrollment of eligible children. The Department plans an unprecedented effort to work with states and with institutions and organizations that reach low-income children to establish ongoing mechanisms to identify and enroll these children. For example, HRSA programs, such as community health centers, will out-station Medicaid eligibility workers on site. ACF will similarly use Head Start and child care grants to support outreach. HCFA, in collaboration with the Department of Education and ACF, is working on the development of technical assistance materials on "how to" issues such as ways for school based clinics to qualify for Medicaid payments, how states can claim the federal share of the Medicaid costs of outreach, and how child care centers can be used as vehicles for conducting outreach.

Implementing HIPAA. HHS shares responsibility with the Departments of Labor and Treasury for implementing the various insurance reform provisions of the Act. In addition, HHS and the Department of Justice share responsibility for the fraud and abuse and provisions of the law. HHS is reponsible for the administrative

simplification provisions of the law. Interim final regulations for the insurance reform provisions of the bill were published on April 8, 1997, and the responsible Departments are developing regulations, to be published in the fall, to implement the mental health parity and mothers and newborn amendments to HIPAA which were enacted after the original bill.

HCFA is developing enforcement procedures for HIPAA that will be utilized for those states that elect not to enforce HIPAA under state law. The Department is also preparing for the required evaluation to assess HIPAA and other state laws on the affordability and availability of insurance in the states.

Success Measures

- Implementation of the State Children's Health Insurance Program
- Enactment of legislation prohibiting discrimination in insurance on the basis of genetic testing
- Percentage of all children who are insured
- Percentage of adults who are insured

Major New Resources

In order to fully implement HIPAA, the Health Care Financing Administration will require supplementary funding, including funding for the required evaluation. Levels will be specified in future Department budget requests.

New Legislation and Regulations

Implementation of the State Children's Health Insurance Program legislation will require implementing regulations. Passage of legislation to prohibit discrimination on basis of genetic testing will be sought. HIPAA regulations will be forthcoming in the fall of 1997.

Key External Factors

Achieving the Department's goal of reducing the number of uninsured children depends on building strong, durable partnerships with states. Successful implementation of the

children's insurance expansion will depend on state actions.

HCFA is assuming a major new commitment in insurance reform that will require the Department to oversee state enforcement of the portability and access provisions of HIPAA, and to enforce such provisions if a state fails to do so. Currently HCFA direct enforcement is necessary in Missouri and Rhode Island and direct enforcement activities in other states are a real possibility. The Department assumes that Congress will provide adequate resources to carry out this complex new national commitment.

Strategic Objective 3.2
Increase the Availability of Primary Health Care Services

An estimated 43 million people have difficulty gaining access to primary care due to the limited availability of primary health care sites and inadequate numbers of primary health care providers, discrimination, and language and cultural obstacles that impede the delivery of care. These problems are found especially in economically disadvantaged neighborhoods and rural areas. A further problem has been the difficulty of integrating appropriate primary mental health and addictive disorders services into primary health care sites and Medicaid programs.

If Americans are to have adequate health care, a priority must be to address access barriers to primary care—including behavioral health care.

Strategy for Achieving the Objective

Improving access to primary care services will be accomplished in several ways:

Expanding community-based systems of care. HRSA's Bureau of Primary Health Care provides preventive and primary care and case management to 10 million of the nations's 43 million underserved persons through health centers and freestanding National Health Service Corps (NHSC) sites. To achieve its objective, the Department will increase the number of Community Health Centers.

The NHSC program will be used to locate providers in underserved areas. Technical assistance will be provided to communities in underserved areas to help them recruit and retain health care providers.

Improved targeting of the Health Professions Programs. Racial and ethnic minorities

(African Americans, Hispanics, American Indians and Alaska Natives) represent nearly 25 percent of the population, yet only about 10 percent of the health professions workforce. In addition, minority populations are the fastest growing segment of the U.S. population. Recent studies show that minority health care providers are more likely to locate in underserved communities and to provide health services to the most needy populations. Therefore, the Department will focus its health professions programs to increase the supply of trained minority primary health care providers.

Improving the effectiveness of the Maternal and Child Health Program. The Maternal and Child Health Block grant provides for a wide range of services, including direct medical care services, enabling services such as transportation and case management, population-based services such as immunization and newborn screening, and basic capacity building in areas such as quality assurance and training. The program is currently working with state MCH Directors to develop performance measures that would be used by all States to improve the effectiveness of MCH services. By focusing on measures such as the percentage of women receiving prenatal care in the first trimester, access to the program can be monitored and enhanced. Emphasis on performance measures will improve the effectiveness of the MCH agencies, encourage the reduction or elimination of low-priority activities, and free resources for expansion of those services that improve access to primary care.

Expanding Healthy Start The Healthy Start programs across the country have contributed to reducing the level of infant mortality in high risk communities. Phase I of the program identified nine particularly effective infant mortality reduction strategies. Some 30 communities are currently carrying out those strategies. HRSA has identified approximately 300 communities—urban and rural—with infant mortality rates at least 1.5 times the national average. The Department proposes to expand this successful program to many of these communities with high infant mortality rates.

Improving integration of treatment for mental health substance abuse and addictive disorders into primary care. Primary care is often the service of first resort for people experiencing behavioral health problems. Primary care providers can recognize, diagnose, and refer individuals to needed specialty services—the reverse type of referral is also common. Integrating these removes barriers to obtaining appropriate health care through a comprehensive assessment of a client's needs and service requirements, coordinated case management, and follow up.

SAMHSA programs test innovative models of specific combinations of services for various types of client needs and disseminate the findings to primary care and behavioral health care providers. Starting Early/Starting Smart, which measures the effectiveness of integrating behavioral health services with primary health care or early childhood service settings, is one example of this type of experiment. SAMHSA expects to test other models for different age groups and client needs.

Success Measures

- Percentage of people without access to primary care
- The number of former participants in HHS-funded health professions programs that practice in underserved areas
- The number of federally-supported health centers (including IHS and tribal) providing or linking to a full array of health services, including mental health and addictive disorder services for adults and children
- The number of persons served by HRSA primary care programs

Major New Resources

A meaningful increase in the number of adults and children receiving services at Health Centers will require a significant increase in appropriations for Centers. Increase levels will be specified in future Department budget requests.

New Legislation and Regulations

Reauthorization of Titles VII and VIII of the Public Health Service Act on Health Professions and Nursing Education and Training is necessary.

Key External Factors

Success in achieving the objective will depend on community partnerships to provide increased access to services.

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

The Department administers federal grants to states and local agencies to provide high quality prevention and clinical services for individuals who have limited access to health care services except through publicly-funded health programs. For these individuals, the Department provides support to states to provide substance abuse prevention and treatment services, mental health services, maternal and child health services (including services for children with special health needs), and HIV/AIDS services. In addition, the Health Care Financing Administration supports payment for many of these services through the Medicare and Medicaid programs.

The need for these services is growing. For example, of the 33 million children and adolescents between the ages of 9-17 in the United States, 9 to 13 percent or 3.5 to 4 million of these youngsters have a serious emotional disturbance: many will require help from HHS-funded programs. Approximately 9 percent of the adolescents surveyed in the 1966 National Household Survey had used illicit drugs in the last month. Again, many will seek treatment in HHS-funded programs. Prevention strategies for substance abuse have been discussed under Goal 1. However, improvements in service capacity and effectiveness for substance abuse programs and mental health programs are of equal concern and importance. A 1994 survey found that nearly half of those needing substance abuse treatment did not receive it. (2)

While most American children require few medical services, a significant percentage have special health care needs. Depending on the definition used, it is estimated that from 16 to 31 percent of U.S. children have a chronic physical, developmental, behavioral, or emotional condition and require health or related services beyond those typically needed by children. Children with special health needs and their families face fragmentation in the health care system and a frequent lack of organized systems of care. They also face difficulties in obtaining insurance coverage for their medical needs. It is essential that access for these children be monitored, and where problems persist, that gaps be filled.

Recent advances in the treatment of HIV/AIDS offer the opportunity for major improvements in the longevity and quality of life for persons with HIV disease. At the same time, the epidemic is becoming increasingly concentrated in minority and disadvantaged populations. Overall progress in dealing effectively with this epidemic will require new and more effective programs to support patients in primary care and in

maintaining adherence to complex medical care and drug therapies. It is estimated that the cost of combination anti-retroviral drug therapy, including protease inhibitors, is ten to twelve thousand dollars per year. At least 30 percent of individuals with HIV are uninsured, so that government efforts to increase access to these new therapies are essential.

Strategy

Improving state capacity to provide access to quality prevention and treatment for mental health, substance abuse, and addictive disorders. The Substance Abuse and Mental Health Services Administration is providing assistance and support to the state agencies that manage the substance abuse and mental health block grant programs to improve their capacity to identify priority areas of need, to monitor and assess the effectiveness of services provided under the block grants, and to establish performance measures and targets that will enable the states and the federal government to measure success in these program areas. By improving their ability to assess needs and performance, the states will know where services are needed and the most effective way to provide those services—thereby improving their ability to prioritize and improve access. Currently, in the area of mental health, five states are pilot testing performance objectives for their mental health systems overall. In substance abuse, up to twenty states will test performance indicators for their prevention activities; fourteen states are identifying performance indicators for treatment programs. To address the mental health needs of children and their families, SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families Program will help communities develop comprehensive family-driven systems of care in which mental health services are coordinated with other services such as education, juvenile justice and health services.

Improving access to care for children with special health needs. The Maternal and Child Health Program will help states build the capacity of their maternal and child health systems to improve the health of their clients, with special attention to the needs of children with special health care problems. Access to care for special needs children will be enhanced by building the capacity of local systems. In order to assess how well states are meeting these and other responsibilities under the MCH program, HRSA has collaborated with the states to develop core reporting and outcome measures to be implemented next year. The core measures will enable states and HRSA to assess areas of weakness and develop strategies to improve access to care for children with special health care needs.

Helping states meet the medical needs of persons with HIV/AIDS. The Department will provide assistance to states for the medical care and support services for families, women, and children with HIV infection. This will include financing for the latest therapeutic/pharmaceutical advances. Support will also be provided for Health Insurance Continuation Programs for low-income individuals. The Department will expand access to these key services, particularly to the Drug Assistance Program, through increased funding for drug purchases.

In addition, the Department will help states increase access to the early intervention program, which supports outpatient HIV early intervention for low-income, medically underserved people in existing primary care systems, and to the program effort which is directed at children, youth and women and families. Access will be expanded through HRSA- supported primary care systems and education programs for health care providers.

Success Measures

- Number of states that identify and report on core performance measures by which to assess the impact of substance abuse and mental health services funded by the SAMHSA block grants
- States and providers find results of SAMSHA's KDA (knowledge development activities) relevant and useful in improving program performance (measured by customer surveys, focus groups, consultations with state officials)
- States and providers find SAMHSA technical assistance and training activities relevant and useful in improving program performance (measured by customer surveys and consultations with state officials)
- Proportion of children with special health care needs who have regular sources of primary and specialty care
- Number of HIV-infected persons receiving services from Ryan White CARE Act sites and ECAs
- Number of individuals receiving appropriate anti-retroviral therapy through state ADAP programs

Major New Resources

Due to the recent advances in the treatment of HIV/AIDS, significant expansions will be necessary in the Ryan White CARE Act. Levels requested will be specified in future Department budget requests.

Investments must be made in state data infrastructure, if mental health and substance abuse programs are to develop the data systems necessary to monitor treatment access and effectiveness. Levels will be specified in future Department budget requests.

New Legislation and Regulations

The President has proposed the conversion of SAMHSA's block grant programs into Performance Partnership Block Grants. If enacted, this change would provide the framework and support within which states could strengthen data infrastructure, provide enhanced flexibility for states in program management, and require a system of outcomes reporting by states in accord with the general approach of the Government Performance and Results Act.

Key External Factors

These programs and activities are managed in partnership with states, tribal governments, and non-profit provider groups, which must implement the proposed strategies. The success of national and state efforts to reduce the supply of illegal drugs and the success of prevention efforts will strongly influence the ability of SAMHSA and state governments to meet demands for effective treatment. The future course of the HIV epidemic and the long-term effectiveness of the new drug therapies are highly important variables.

Strategic Objective 3.4
Protect and Improve Beneficiary Health and Satisfaction in Medicare and Medicaid

Medicare and Medicaid are the nation's largest purchasers of health services, providing insurance coverage for approximately 72 million elderly, disabled, and economically disadvantaged Americans. 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. 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 also pays more than 50 percent of nursing home costs.

The major structural changes taking place in the nation's health system, and in the management of the Medicaid program as states assume increasing responsibility for program design and policy, offer both risks and opportunities to beneficiaries of both these programs. For example, incentives for Medicare beneficiaries to join managed care plans have become stronger as a result of provisions in the Budget Agreement directing HCFA to develop a wider range of choices for beneficiaries. In many states, managed care is already the sole or dominant system for Medicaid beneficiaries. As these transformations unfold, the Department, through HCFA, will give priority attention to ensuring that the quality of services provided beneficiaries and beneficiary satisfaction with those services are not compromised.

Strategy for Achieving the Objective

The Department's strategy to improve beneficiary health and assure their satisfaction with their health care has four components. The Department will ensure that beneficiaries have access to high quality and appropriate services, including clinical preventive services. HHS will encourage beneficiaries to make use of preventive services and to take other actions to improve and protect their health. Second, the Department will ensure that beneficiaries have the information they need to make informed decisions about their health care. Third, HHS will use surveillance, research, and oversight to improve services.

Encouraging Use of Preventive Services. To ensure that the health care improvements brought about by Medicare and Medicaid over the last thirty years continue, HCFA will work to ensure that programs and services respond to the health care needs of beneficiaries. This includes ensuring that appropriate benefits are covered and that beneficiaries are given clear and helpful information about how to use them. In that regard, HCFA will educate beneficiaries about the role of preventive services such as immunizations and mammograms; encourage the appropriate use of home and community based services; implement program demonstrations of more flexible delivery, payment, and coverage approaches to better meet beneficiary needs and educate consumers to seek high quality, cost effective health care. For example, HCFA is mounting a large initiative to encourage regular mammograms and annually conducts a highly publicized effort to encourage flu immunizations. Other actions to improve

beneficiary health include quality control efforts described under Goal 4.

Improving Consumer Health Information. HCFA will provide clear and useful information to help beneficiaries better understand their treatment options, appeal rights, health plan choices, and health care benefits. The focal areas for information are: program benefits to assist beneficiaries' understanding of the coverage and protections available to them; health promotion to influence the voluntary behavior of beneficiaries to improve their health and well-being; and choice of fee-for-service or managed care , and if managed care, among plans. The approach will include assessing needs through surveys (such as the Consumer Assessment of Health Plan Study-CAHPS); measuring quality through accepted performance measures beginning with the Health Plan Employer Data and Information Set (HEDIS), and providing beneficiaries with information to assist them in understanding their health care options and choice. There will be special emphasis on the requirements of populations with special communication needs.

The collection and distribution of HEDIS and CAHPS information on plan performance is intended to improve beneficiary satisfaction in two ways. First, it creates incentives for plans to improve the quality of service provided to beneficiaries. Second, beneficiaries considering managed care options often lack important information that could help guide their choice of plans, and that could help them make important decisions about their care. The data collected through HEDIS and CAHPS will be summarized by plan and made available to help beneficiaries make more informed choices among managed care plans. (These efforts are also noted under Goal 4's consumer information section.)

Using Surveillance, Research and Oversight to Improve Services. HCFA will employ improved surveillance tools to identify potential access problems and research to identify means of addressing those problems. Through its research programs, HCFA will investigate new health care delivery models that serve diverse populations (e.g. disabled, people with HIV/AIDS, non-English speaking persons, the chronically ill). An example is the demonstration on All-Inclusive Care for the Elderly, which is directed at integrating acute and long-term care. The recently passed Budget Bill makes PACE a permanent part of the Medicare program.

HCFA will also use information from the Medicare Quality of Care Surveillance System to look at utilization patterns and trends useful for targeting programs, tracking progress of improvements and raising questions requiring further investigation.

To protect beneficiaries from substandard care, HCFA will establish, publish, and apply minimum performance standards for plans and providers, collect data that objectively assesses providers' and plans' conformance with the expectations, and publish comparative aggregate data on performance. Substandard providers will be rapidly excluded from the programs. In addition, HCFA will assist providers, plans, states, and beneficiaries and their advocates by providing performance information, guidelines, benchmarks, and improvement strategies. The Office for Civil Rights will monitor the situation of protected populations as changes in Medicare and Medicaid unfold to assure that they are fairly treated.

Success Measures

Specific performance measures related to the Medicaid program are not included in the Strategic Plan because of the Administration's commitment to consult with states prior to their inclusion. Areas in which the Department expects to engage with states on performance include, among others, concerns relating to access and quality of care for Medicaid beneficiaries and the effect of children's initiatives on reducing the number of uninsured children.

- Medicare beneficiary rating of access in both fee-for-service and managed care.
- Percentage of Medicare beneficiaries who are satisfied with the health care services they receive in both fee-for-service and managed care.
- Percentage of Medicare beneficiaries who receive a screening mammogram within a 2 year period (clinical preventive service to improve beneficiary health).
- Percentage of Medicare beneficiaries who receive an influenza vaccination each year (clinical preventive service to improve beneficiary health).
- Number of managed care plans found to be in compliance with the requirement of civil rights statues and regulations.

Major New Resources

The Balanced Budget Act significantly increases the resource requirements for the provision of information to beneficiaries, and thus the resource needs. Levels will be specified in future Department budget requests.

New Legislation and Regulations

None.

Key External Factors

The Balanced Budget Act significantly increases the resource requirements for the provision of information to beneficiaries, and thus the resource needs.

Strategic Objective 3.5
Enhance the Fiscal Integrity of HCFA Programs

The Health Care Financing Administration is the world's largest health insurance entity, processing more than 800 million claims per year approximately $1.8 billion in plan payments each month to managed care organizations. Despite the enormous growth in size and complexity the program has experienced, the structure and operation of Medicare have remained substantially unchanged over the last thirty years. Over the next several years, the Health Care Financing Administration will undertake major changes to modernize the program. The objective of the modernization will be to prepare the program to meet the difficult challenges of the coming decade. The demographic changes already noted have enormous implications for Medicare and Medicaid. With a drop in the ratio of active workers to retirees, scheduled Medicare payroll tax revenues will not keep pace with program expenditure levels. The large expected growth in the number of very old—those over age 85—will significantly increase demands for long-term care under Medicaid. Medicare and Medicaid together account for nearly one-third of health spending in the United States.

Programs of this size and complexity require effective systems to prevent improper, abusive or fraudulent claims from straining the fiscal resources of the system. Certain program areas seem to be prone to fraud and abuse. For example, there have been many accounts of unnecessary home health services being provided to beneficiaries, excessive payments being made to suppliers for durable medical equipment, as well as providers fraudulently billing for services not rendered or exaggerating the level of services provided to obtain a higher level of reimbursement.
Prevention is the best remedy. This starts with paying appropriate claims correctly the first time. To do this we rely on the States and Medicare contractors' pre-payment and post-payment medical review, fraud and abuse detection, overpayment collections and

provider audit efforts.

Strategy for Achieving Objective

For Medicare, modernizing the management of the program, developing effective systems for purchasing quality care at competitive prices, and ensuring that HHS's management controls and data systems are adequate to secure the fiscal integrity of the programs are essential components of a long-term strategy to ensure that the program is fiscally sound in the next century.

The Medicaid program faces a different set of challenges. Each state has different rules and regulations, different management controls, and different data systems--in effect, 56 different Medicaid programs. Therefore, the Department must work through the state Medicaid agencies to implement proper program safeguards and develop more effective fraud control systems, including fraud control strategies that promote early detection of new types of fraud and abuse.

Implementing a New Management Structure. HCFA will implement a new management structure to better focus on beneficiaries, states, and providers. HCFA was created in 1977 to bring together the Medicare and Medicaid programs under single leadership. In subsequent years, this mission has expanded to include oversight of clinical laboratories and regulation of individual and small group insurance. In 1994, HCFA began a process of examining its mission and structure in view of its additional responsibilities, the changing health care marketplace, the shifting federal and state roles, and the need to have a more effective set of data and management systems to address concerns about the fiscal integrity of the programs. Out of this examination, HCFA has developed a new organizational structure that will be in place nationwide by August 1997. The new structure centers around the agency's three primary "audiences"-- beneficiaries, health plans and providers, and states. The new structure is central to HHS's strategy for successfully guiding the HCFA programs into the 21st century and will assist in the enhancement of the fiscal integrity of HCFA's programs. Under the new structure, a Chief financial Officer (CFO) will oversee all program and administrative expenditures. The creation of this position sends the clear message that HCFA is taking responsibility for and closely managing the fiscal integrity of the Medicare and Medicaid programs. Additionally, under this new structure, the CFO will have staff overseeing fraud and abuse detection and deterrence efforts with respect to the Medicaid program and the Medicare fee-for-service and

managed care programs.. It will provide a clearer organizational focus on provider issues and facilitate anti-fraud efforts.

Implementing Beneficiary-Centered Purchasing.. States are rapidly shifting their Medicaid programs into managed care as a means of both restraining costs and increasing access to services. The savings achieved through competitive purchasing have been critical to restraining costs and thus preserving the structure of the Medicaid program and the continued entitlement to coverage for low-income Americans. The long-term success of this model will depend on ensuring that Medicaid beneficiaries receive quality care in managed care systems (see Goal 4). The Department is working with Congress to establish safeguards for beneficiary choice. For example, the Balanced Budget Act requires states to offer beneficiaries a choice of at least two health plans, with some special provisions related to rural areas. HCFA will work with states to assure that beneficiary interests are safeguarded in Medicaid under new care arrangements.

The Recently enacted Budget Act directs HCFA to implement a range of new plan choices for Medicare beneficiaries. In implementing these provisions, HCFA is committed to becoming an active force in the health care market—in addition to its role as a payer of claims and regulator of the industry. HCFA will strive to use its market presence to obtain high value health care on behalf of Medicare and Medicaid beneficiaries. High value health care is both high in quality and reasonable in cost. Purchasing strategies may be modeled on best practices in private sector firms, states, and purchasing coalitions, or may be unique to HCFA programs.

Some aspects of beneficiary centered purchasing are already well underway at HCFA, most notably the consumer information initiatives, while others will require statutory change. Many purchasing strategies are being tested in demonstration projects such as the Centers of Excellence and Choices demonstrations. Using waivers of the Medicaid rules, some states are testing promising purchasing approaches that could have broader application in the future.

Enhancing Program safeguards. Medicare program safeguards will be enhanced in a number of ways. First, we will develop and implement a substantive claims testing program. We plan to increase the number of claims reviewed and conduct more look-behind reviews of medical documentation. Automated medical reviews of claims will be used wherever possible to increase the efficiency of the reviews. In the same respect, new computer software and data systems designed to detect

aberrant patterns and trends in billing will be brought on line by HCFA and its contractors.

Collaboration with state survey agencies begun under the successful Operation Restore Trust will be continued to enhance the resources and targeting of fraud activities. HHS will also educate its provider billing community on payment policy, documentation, and fraudulent practices to increase their participation and support for reducing fraud and billing errors. This will be enhanced by the new Medicare Integrity Program authorized under HIPAA which will provide for long-term, stable contracts to fight fraud.

Consolidation of Medicare payment systems into three standard systems for the processing of Part A, Part B and durable medical equipment claims will greatly improve the Department's ability to identify aberrant billing and utilization patterns. The development of a single integrated accounting system will enable HHS to track Medicare payments to the claim or transaction level, providing better payment accuracy.

As for Medicaid, HCFA will work with states to improve program safeguards. This will include: developing voluntary national models in key areas to promote consistency among states (i.e., provider enrollment); developing and distributing to state agencies a "model" anti-fraud and abuse legislative package that includes the most effective and efficient provisions from all state legislative proposals; assisting state agencies to identify and resolve cross cutting issues between the Medicare and Medicaid programs that could result in vulnerability to fraud (i.e., cross-over claims, duplicate payments by Medicaid and Medicare); developing a systematic method to keep state agencies informed of fraudulent activities that are currently occurring around the country; and initiating a Technical Advisory Group of representatives from HCFA and the state Medicaid agencies.

Finally, the Department will continue to support legislation requiring each health care provider applying for participation in Medicare or Medicaid to provide their Social Security number and employer identification number to allow HCFA to check on an applicant's history for fraudulent activity.

Implementing a Fraud and Abuse Control Program. The Office of the Inspector General will implement a Health Care Fraud and Abuse Control Program, in collaboration with HCFA, AoA, HRSA, the Department of Justice, and the states. The rising cost of health care has long been a national concern, but its impact on

federal and state budgets, as well as the financial strength and global competitiveness of American businesses, has become better understood over the last decade. Fraud and abuse contribute significantly to those rising costs. The HIPAA included provisions to intensify efforts to combat fraud and abuse against health care plans in the United States. HIPAA gives the Secretary (acting through the Inspector General) and the Attorney General joint responsibility for establishing a program to combat fraud and abuse committed against all public and private health plans. Implementation of this program was begun in 1997. The law provides for additional funding as the program proceeds toward complete operation over the six years covered by this strategic plan. During the initial years, the program will focus on the two largest public plans—Medicare and Medicaid. Its broad goals are: (1) to coordinate federal, state and local law enforcement programs to control fraud and abuse with respect to health plans; (2) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the U.S.; (3) to facilitate enforcement of the civil, criminal and administrative statutes applicable to health care; and (4) to establish a national data bank to receive and report final adverse actions against health care providers.

The effectiveness of the program will be jointly evaluated by the Department of Justice and the Department of Health and Human Services. Annual evaluations will include assessing whether the program's goals and objectives are appropriate, gauging the performance of the organizations which receive funds for the program, and providing help in identifying possible new areas in which to direct resources.

In addition, the recently enacted Balanced Budget Act of 19976 contains many anti-fraud and abuse provisions that will enhance the ability of HCFA and the Office of the Inspector General to fight fraud. The Department will implement and use these new authorities.

Success Measures

- Number of health plan choices available to Medicare beneficiaries.
- Information on payments Medicare has made or denied is routinely provided to Medicare beneficiaries.
- Percentage of improper payments under the Medicare fee-for-service program.

- More than half of program integrity savings are made by reducing inaccurate payments prior to payment.
- A "clean" opinion of HCFA CFO reports is achieved and maintained.

Major New Resources

Under the Medicare Integrity Program, which was enacted with HIPAA, HCFA is guaranteed a stable, increasing funding source for payment safeguard activities through fiscal year 2002.

New Legislation and Regulations

None.

Key External Factors

Achieving success in the Department's Medicaid objectives will require close and effective collaboration with states.

Strategic Objective 3.6
Improve the Health Status of American Indians and Alaska Natives

The Indian Health Service (IHS) executes the federal government's responsibility, established under law and through treaties, to provide health services for American Indian and Alaska Native (AI/AN) people in remote and inaccessible regions, as well as in more than thirty urban Indian communities. Tribal governments are active partners with the IHS in developing and managing programs to meet health needs; and, over the next five years, they are expected to assume an expanding role. The IHS and the Department are strongly committed to this new partnership and its potential outcome of improved health status for American Indians and Alaska Natives.

The Department and the tribal governments face formidable challenges in accomplishing this objective. American Indian and Alaska Native peoples have significantly greater health problems than the overall U.S. population. Yet IHS funding to provide health

services is roughly one-third of what the general U.S. population spends on health care annually. When other sources of funding for AI/AN people are taken into account (e.g., Medicare, Medicaid, private health insurance), per capita funding only reaches roughly two-thirds of the U.S. average and has actually declined 15 percent since 1991. As a result, although overall outpatient visits to IHS facilities have steadily increased with population growth (2.1 percent annually), decreases have occurred in important non-urgent primary services including: a 23 percent decrease in well child services since 1991, a 14 percent decrease in physical exams since 1994, an 18 percent decrease in access to dental services since 1994, and a 50 percent decrease in water fluoridation since 1991. These reductions reflect the fact that increasing demands for urgent care in the face of reduced per capita funding has diminished the capacity of the IHS and tribal governments to provide primary services which are critical to long-term health maintenance and improvement.

Strategy

Both the IHS and tribally-managed programs will emphasize prevention and treatment of those diseases that disproportionately affect American Indians and Alaska Natives. Diabetes, obesity, injuries, and alcohol and substance abuse alone and together are major contributors to the burden of disease in AI/AN communities. Diabetes in particular has reached epidemic proportions: one-third to one-half of adults have the disease, with high rates of complications including end-stage renal disease, amputations, and blindness. The effects on Indian people, families, and communities are devastating, and the cost of treating diabetes has a serious impact on IHS and tribal resources. The IHS and tribal governments will mount a comprehensive prevention and treatment strategy to address the major threats to health of their people and communities.

The major health problems identified as priorities for intervention by the IHS and their stakeholders include:

- diabetes and its complications
- obesity
- injuries
- alcohol and substance abuse
- cancer
- family abuse and violence
- mental disorders
- mental diseases
- diseases and conditions related to poor living environments

The key elements of the IHS strategy to reduce mortality and morbidity rates relating to these risk factors and diseases are:

Providing Quality Health Services. The IHS, in collaboration with tribal governments, will attempt to ensure that all eligible American Indian and Alaska Native people have access to high quality, comprehensive public health services (i.e. clinical, preventive, community-based, educational, etc.) provided by qualified, culturally-sensitive health professionals with adequate support infrastructure (i.e. facilities, staff, equipment, supplies, training). The deployment of resources to achieve this objective is specified in the IHS Performance Plan, and in the facilities and construction plans. Both the IHS and tribally-managed programs will emphasize prevention (clinic and community-based) and treatment of these priority risk factors and diseases. Some interventions will be targeted to women, children, and the elderly. Many will also focus on community awareness and empowerment to raise the local ownership of health problems and to expand local capacity to address them.

Quality assurance and accreditation will remain a focus, as will assessments of the relative cost of providing services and the consumers' satisfaction with them. IHS and tribal epidemiology centers will assist in defining health problems, monitoring health status, and evaluating program effectiveness.

Assuring Partnerships and Consultations. To ensure that IHS, tribal, and urban Indian programs and Area Offices and Headquarters achieve a mutually acceptable partnership in addressing health problems, priority will be given to providing adequate opportunities for stakeholder participation in critical functions such as policy development and budget formulation. In addition, IHS and its tribal partners will seek to expand collaborative partnerships with outside organizations which offer the opportunity of contributing to the realization of improved health and quality of life for American Indian and Alaska Native people.

Success Measures

- Specified indicators of mortality and morbidity for Indian and Alaska Native population (e.g. injury, death rates, prevalence of obesity, prevalence of diabetes related amputation or blindness).

- Assessments of proportions of the population receiving essential services, e.g., immunizations, cancer screening, diabetic maintenance, safe water, and waste

disposal.

- Assessments of consumer satisfaction with access and acceptability of health care (through periodic standardized surveys).

- Assessment of stakeholders satisfaction with consultation and opportunities for participation in important policy issues (monitored through surveys).

- Assessments of the number of collaborative agreements between the IHS and outside organizations, and their realized or potential health benefits for American Indian and Alaska Native populations.

Major New Resources

Meaningful progress in improving health status will depend on some restoration of prior per capita levels of appropriation to the IHS budget. At a lower level of funding, objectives will focus on preventing further deterioration in health status or risk factors.

Specific Legislation or Regulations

Reauthorization of the Indian Health Care Improvement Act and changes in regulations to simplify enrollment and allow higher levels of reimbursement to IHS and tribal governments for services provided to the Medicare/Medicaid eligible population will be necessary.

Key External Factors

Effectiveness of partnerships between the IHS and National Indian Health Board, Regional Indian Health Boards, the Tribal Self-governance Advisory Committee, and other federal and private agencies and the National Congress of American Indians are key external factors.

GOAL 4 IMPROVE THE QUALITY OF HEALTH CARE AND HUMAN SERVICES

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

Health Care Services. America is justifiably proud of the quality of care available from its health care system, which over the past 50 years has produced dramatic improvements in the prevention and effective treatment or cure of many diseases. These improvements have led to longer life spans and more productive lives. These advances were in large part supported by the fee-for-service financing of the health care system. However, a continuing escalation of health care costs in the fee-for-service system set the stage for the transformation that is now occurring in the financing and delivery of care. The demands of purchasers for better value in health care coverage has led to a variety of strategies and interventions now often described in the aggregate as "managed care". Interventions to assure greater value for the money spent on health care have brought utilization controls and competitive forces to bear on the industry. Such changes, along with payment reforms in Medicare, have contributed to a reduction in the rate of growth of health care expenditures.

At the same time, there are concerns that cost reductions might result in reductions in the quality of care. Studies have found that many patients do not receive the most appropriate treatment due to under-use or over-use of certain therapies. Assessments are difficult, however, since national baseline information on the quality of health care is in a developmental stage and consumers often erroneously equate restrictions on choice with diminished quality.

In addition, the role of patients in the health care system is changing. In contrast to prior practice, individuals are increasingly being asked to make choices about their health care plans, health providers, and even specific therapies. Many have responded to this change by demanding information about health plans, providers, delivery systems, and treatment options and products. Yet, most consumers have never seen information on quality of care, and when they have seen such information, they are not sure how to use it. In

addition, large disparities in access to quality health care services persist for certain groups, notably the economically disadvantaged and racial and ethnic minority groups. This contributes to important differences in health status and outcomes.

HHS plays many roles that significantly influence the quality of health care delivered in this country. Medical research sponsored by the NIH develops the knowledge base for clinical and population based health services. AHCPR-sponsored research has developed new measures of health outcomes and quality performance, and has studied the effectiveness of both medical services and ways to improve and assure quality of care. NIH, AHCPR, HCFA, HRSA, IHS, and SAMHSA develop and disseminate information on how that knowledge can be most effectively applied in various specialized settings. The Department is the largest purchaser of care in the U.S. through the Medicare and Medicaid programs and through its grant programs to states, tribal governments, and non-profit entities such as community health centers. HCFA develops standards of licensure and certification of providers, clinical laboratories, and health plans, and has been a leader in the development of performance standards and quality measures for health plans. These standards assure the basic quality of care for all Americans. Through the FDA's regulation of drugs, biologicals, and medical devices, and the quality of information disseminated about them, the Department ensures the safety and efficacy of these critical components of medical practice. Also, the Department directly provides health care to Native Americans through the Indian Health Service. Furthermore, HHS influences practitioners and consumers through the dissemination of health information to these audiences.

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

Breaking the cycle of dependency depends on both work with parents and early interventions on behalf of children. The Head Start program established in 1968 to provide comprehensive services to preschool children. In recent years, the program has been expanded to serve more low-income children. Program expansion has heightened the awareness of the importance of quality services even further. Recent research in related disciplines is helping to sharpen our understanding about early intervention and its

effects on early growth and development. The program has had a long history of monitoring and program improvement. But even more is needed to develop effective measures of quality and performance in Head Start, Early Head Start and child care programs. The Department will continue to work collaboratively with national organizations, researchers and local programs to develop measures. Rigorous study has commenced to measure Early Head Start outcomes; and child care research partnerships will be expanded to conduct field initiated studies to examine issues of quality, among other issues.

In related efforts, the NICHD has conducted a national study of the effects of child care on child development. The increasing child care services for welfare and low-income families have begun to be met with modest increases in funding for subsidized child care. However, little is known about how far the subsidy monies can be extended, the quality of child care which can be purchased with the amounts available, the supply and nature of child care available, utilization patterns, or the extent to which variations in subsidy and quality child care affect labor force attachment. ACF has initiated a number of activities to improve our understanding of the demands for child care, the child care market, and methods for assessing quality to help inform parents in their choices of care. The quality of license-exempt, unregulated family day care is of particular concern since this is frequently the choice of low-income families. Additional study is about to commence to examine the nature and effects of such care on children and on their parents' ability to enter and sustain employment.

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

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

Strategic Objective 4.1
Promote the Appropriate Use of Effective Health Services

Many health care services known to be effective are not used for all who could benefit. For example, only 21 percent of patients who have a heart attack receive medication (beta blockers) known since the early

1980s to reduce mortality. Patients with depression frequently are not diagnosed and treated effectively. Asthma guidelines published by the National Institutes of Health (NIH) in 1991 strongly recommend the use of inhaled steroids, but increases in the use of this medication have been quite modest--from 10-15 percent following dissemination of the guideline. A substantial portion of hospital admissions for children with gastroenteritis, the fifth leading cause of hospital admissions for children under age 5, could be avoided if oral rehydration therapy were prescribed in a timely fashion.

Significant improvements in health, as well as reductions in costs associated with unnecessary or remedial care, could be achieved by improving the extent to which physicians and other practitioners deliver the most appropriate treatments.

Strategy for Achieving Objective

First, enhanced knowledge about the most effective treatments and how to deliver them will be developed through clinical and health services research. Second, a focus on translation and dissemination will improve the acceptance of this information by physicians, other health professionals, and health systems, as well as patients and their families. The Department has many opportunities to influence practice by individual providers and health systems. It intends to more systematically exploit these opportunities by improving the quality and usefulness of practice information and by disseminating it to a wide range of providers in formats that are useful to specific practice settings.

For example, as the Medicare program has expanded to provide coverage of an increasing number of preventive services, it has also initiated actions to promote wellness through beneficiary education about health promotion and disease prevention. SAMHSA's knowledge development and application (KDA) programs similarly develop guidelines and models for treatment in mental health and substance abuse broadly, but with special reference to the treatment of particularly challenging patient populations such as homeless persons with dual diagnoses. For the general population, the Department will also develop tools to help individual practitioners and health systems to apply the most current information on preferred treatment. For example, *Putting Prevention Into Practice--Guidelines for Preventive Health Services* has been widely adopted by health systems such as the Department of Defense and managed care plans and has been used by individual practitioners and consumers.

Through standards set by the Medicare program, and Medicare's Peer Review Organization clinical quality improvement programs that incorporate specific beneficiary outcome priorities (e.g., for diabetes, flu vaccines, mammography), and through technical assistance and clinical practice guidance to its grantees, the Department will evaluate and disseminate knowledge about the relationship between health care services and health

outcomes and will develop mechanisms to measure and monitor the quality of these services. HHS will target several sentinel practice areas as a means of monitoring its success in this objective:

Success Measures

- Rates of age-appropriate mammography screening increase
- Rates of immunization for influenza among the elderly
- Hospitalization rates for pediatric asthma
- Percentage of HIV/AIDS patients treated in accordance with the most current clinical practice guidelines
- Rates of use of anticoagulation therapies for patients with atrial fibrillation increases
- Rates of use of oral rehydration therapies.
- Percentage of patients with a diagnosis of depression who receive appropriate treatment.
- States and providers find results of SAMHSA's KDA (knowledge development activities) relevant and useful in improving program performance (measured by customer surveys, focus groups consultations with state officials).

Major New Resources

Increasing the percentage of HIV/AIDS patients who receive treatment in accordance with HHS treatment guidelines assumes funding increases for the Ryan White Care Program. Levels will be specified in future Department budget requests.

New Legislation and Regulations

None.

Key External Factors

These strategies depend upon collaboration with key professional societies, the health care industry, organizations that develop and disseminate quality guidelines, and interactions with the Department's state and tribal partners and grantees. They also call

for increased partnership with organizations of providers, purchasers, plans, and professionals in evaluating the effectiveness of medical services and disseminating that information.

Strategic Objective 4.2
Reduce Disparities in the Receipt of Quality Health Care Services

Disparities in access to health care services and health outcomes across different groups exist for a variety of reasons--including financial, geographic, cultural, and structural factors, as well as outdated practice patterns and medical uncertainty. The task before HHS is to identify the causes of these disparities and the interventions most likely to be productive in reducing and eventually eliminating them.

Whatever their cause, disparities in access to and use of services frequently signal the presence of problems in the financing or delivery systems and often translate into poor health outcomes. For example: white patients are more likely than black patients to receive relatively costly interventions such as radical prostatectomy and cardiac procedures; mammography rates for women with less than 12 years of education are one-third lower than rates for other women; African American and economically disadvantaged patients are more likely to be discharged in unstable condition, less likely to be placed in intensive care, and more likely to receive less thorough interviews and physical examinations.

Strategies

As described in Goal 3, the Department will work with state governments to reduce the disparity in health insurance coverage through improved Medicaid outreach and enrollment and through the State Children's Health Insurance Plan. In addition, HHS will support research to identify key areas in which disparities are evident and actionable. Research will be designed to establish where disparities exist--types of organizations, providers, particular conditions--and to investigate the causal links that explain them. The Department will synthesize and make available research findings on care for specific conditions for which the evidence is strong and disseminate them widely. Since many variations in practice seem impervious to best practice information, HHS will increase its investment in research to understand how to influence practice behaviors. It will also evaluate whether these disparities also reflect differences in the epidemiology of disease in different groups or differences in these groups' preferences and values. In addition to reducing the disparities, it is important to understand why they occur and how they correlate with health outcomes.

The Department will work to reduce disparities in access to quality health services in a number of other ways. First, to focus national attention on the issue of disparities in health status and their impact on the health of individuals and the nation, the Department will target a number of areas in which risk factor reduction or access to better quality treatment could measurably improve the health status of racial and ethnic minorities. HHS will mount various interventions such as HCFA's Horizons program which is directed, in part, at reducing some of the known disparities in African American and Hispanic beneficiaries' use of preventive services such as flu vaccines and mammography. HHS will pursue a coordinated strategy to reduce disparities in access and outcomes by the year 2000 and to substantially eliminate them by the Year 2010 as part of its strategy for Healthy People 2010.

The Department's strategy also will involve enhanced research attention, dissemination of information about effective interventions, patient information, and demonstration projects. The intent is to show that concentrating attention on the factors that are known to produce disparities in health outcomes can yield meaningful results in a relatively short time frame. For example, the highly successful campaign to reduce infant deaths from SIDS, *Back to Sleep*, has shown significantly better results among white infants than racial and ethnic minorities. HHS will target improved information to parents, physicians, and other providers that is culturally and linguistically appropriate in order to reduce this disparity.

Success Measures

- Disparities in infant mortality rates with special attention to differential death rates from Sudden Infant Death (SIDS).
- Disparities in breast and cervical cancer screening and management.
- Disparities in detection and appropriate treatment of cardiovascular disease, including hypertension.
- Disparities in diabetes-related complications.
- Disparities in access to state-of-the-art HIV testing, counseling, health care, and support services.
- Disparities in age-appropriate immunization rates.
- Expanded science-based information on the causes of disparities in the quality of care provided to patients.

Major New Resources

None.

New Legislation and Regulations

None.

Key External Factors

Where system factors or financial barriers contribute to disparities, these factors will need to be addressed. Without regular reporting of health status and treatments by racial and ethnic classification, problem identification and monitoring of progress is impossible.

Strategic Objective 4.3
Increase Consumers' Understanding of Their Health Care Options

A recent poll found that 42 percent of Americans say that quality of care is their biggest concern in choosing a health plan. (AHCPR/Kaiser Family Foundation 1996 Survey) and that two out of five (39 percent) say they have seen quality comparisons within the last year. Although most respondents (over 80 percent) who have seen quality comparisons indicate it would be useful for someone trying to make a decision about health plans, doctors, and hospitals, far fewer (less than 35 percent) have actually ever used such information in their own decision making. A majority of respondents indicated that their doctor, family, and friends were their most common sources of information on quality, and that they would rely on these sources of information in choosing a health plan in preference to objective quality rankings. However, polls also show that consumers want to be better informed about quality and many believe they will use information that is accessible and timely.

In the area of health care decision making, HHS has a critical role to play in helping consumers get and use the information they need. Most Americans (88 percent) believe there is a role for the government in the quality of health care arena. A majority (52 percent) think the government should both monitor health providers to ensure a minimum standard of quality and make sure information about quality is available to the public (AHCPR/Kaiser Survey). By mobilizing and publicizing information resources, HHS can increase consumers' access to information and provide data to supplement the personal opinions of their friends and family members.

Strategies for Achieving Objective

HHS's strategy for this objective is to: empower consumers to make informed choices about health care and to evaluate the quality of care they are receiving.

Improve the Knowledge Base About Quality Measurement. Research and evaluations to improve the knowledge base about quality will include the development of improved measures of quality at the level of plan, health care delivery system or organization, and health professional. AHCPR will conduct research and evaluation to develop quality measures for the entire health system; HCFA will focus on measures that address concerns specific to the Medicare and Medicaid populations; and ASPE is conducting research to examine questions concerning the frail elderly and disabled populations. SAMHSA's KDA program expands the knowledge base on how to deliver quality behavioral health services to treat mental health, substance abuse, and other addictive disorders.

Develop and Disseminate Tools to Help Consumers Make Informed Decisions on Health Care. The fact that consumers do not rely upon quality data even when it is available indicates that new approaches are needed to assemble and present this information. These efforts will include the development of materials and tools which can be customized at the point of delivery and that utilize a wide range of formats (print, electronic, video, interactive disc) that will reach consumers where they seek health care information. Emphasis will be on grassroots dissemination, with a special emphasis on vulnerable populations. A number of significant initiatives are underway or planned. For example, AHCPR and HCFA will invest in the development and testing of better methods of presenting quality information to general and specialized audiences. SAMHSA has developed consumer-oriented report cards for patients and their families receiving mental health services, and is expanding that effort to include report cards with outcome scales for adults, adolescents, and children.

Success Measures

- Availability of valid, reliable, customer-friendly information and tools for decision making.
- The percentage of consumers who have seen information on quality and who use it in their own health care decision making and in advising friends and family on health care choices.

Major New Resources

None.

New Legislation and Regulations

None.

Key External Factors

Continuing public and private support of efforts to develop, use, and disseminate consumer-relevant measures of health care quality is critical.

Strategic Objective 4.4
Create and Expand Models for Value-Based Purchasing

HHS is the largest purchaser of health care in the United States, with HHS dollars accounting for more than one-third of all health care spending. In some communities, public funds support as much as 75 percent of spending on health care. The Department intends to focus its purchasing power to improve services for its own customers and will encourage other public and private employers to work in partnership with HHS to promote value-based purchasing.

There are a few pioneers of value-based purchasing in the private sector who are making important contributions to improving quality by collecting and analyzing data on the cost and quality of plans and providers and using their findings to purchase care or to drive improvement. Public-sector purchasers also are becoming more active in value-based purchasing. For example, HCFA has initiated demonstrations such as Centers of Excellence and Medicare Choices to test models of value-based purchasing, where decisions rely on both cost and quality factors. Public purchasers are collaborating with private purchasers and performance measurement developers such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Foundation for Accountability (FACCT), and others. HHS has also been a partner in these efforts.

Strategy for Achieving Objective

To achieve this goal, the Department will identify quality performance and accountability benchmarks that could be used in value-based purchasing in consultation with states and other purchasers. Efforts begun in 1997 are identifying measures already in use in HHS and describing the common elements for a coordinated model purchaser strategy. These measures are the building blocks for a quality purchasing strategy. As described in Goal

3, HCFA is funding several purchasing demonstrations that should yield important information to guide future Departmental actions in this area.

Identifying Key Elements of Value-Based Purchasing Strategies. The Department will employ an iterative approach for this strategy. Activities to identify needs and build consensus will include consultations with state officials, key private industry purchasers, purchasing groups, consumer groups, and others to learn from their experiences with value-based purchasing and to test ideas for the Department's efforts. The Department is supporting development and dissemination of tools to help purchasers select quality measures to meet their needs. With regard to HHS programs, an intra-departmental workgroup will identify key elements of purchasing strategies such as health care quality measures and benchmarks, reimbursement incentives, model contract language, and requirements for cultural competence of providers.

Testing Purchasing Strategies in HHS programs. The activities above will lead to the creation and testing of a set of quality performance measures for use in value-based purchasing agreements under HHS programs. For example, HCFA will test models of patient-centered purchasing for Medicaid and will collaborate with state and local governments to establish criteria and expectations for evaluating quality of services purchased on behalf of Medicaid beneficiaries.

Major New Resources Needed

None.

New Legislation or Regulations

None.

Key External Factors

Cooperation of states, grantees, and private-purchasers in adopting value-based purchasing practices is key.

Success Measures

- Availability of tools and resource materials.
- Number of public and private purchasers requiring providers to report quality performance data.

- Adoption of value-based purchasing practices by public and private purchasers of health care.

- Changes in provider behavior resulting from value-based purchasing programs.

Strategic Objective 4.5
Improve Consumer Protection

As the Department becomes more cost conscious, health plans can play an important role in helping it move from a "health care on demand" mind-set to a new approach where health care is given when medically necessary or to prevent illness. However, because such attention to the effectiveness of care is a relatively new phenomenon, there may be insufficient clinical knowledge to support evidence-based treatment protocols. The line between appropriate care management and inappropriate denial of access to necessary care is not always clear-cut. In light of this ambiguity, the imperative to reduce costs makes consumers wary of health plans' care management practices. In this uncertain environment, consumers should be protected from clearly inappropriate practices while, at the same time, health plans should remain free to develop new clinical and management protocols without undue interference. By the same token, services of questionable quality that are provided in a fee-for-service setting continue to be a matter of concern in terms of possible adverse outcomes and unnecessary costs to consumers, insurers, and public programs providing insurance coverage to consumers.

In addition, as new cost-management techniques are explored, health care delivery is becoming increasingly complex for consumers. As plans of all types look for ways to provide care more efficiently, consumers are now faced with a multitude of process requirements (e.g., prior authorizations) and choices about how to obtain their coverage (e.g., whether to use the local pharmacy or the plan's mail order pharmacy). These choices have potentially substantial financial implications. As health plans become more complex and more varied, information about how they operate is essential if consumers are to exercise their rights and make decisions that best meet their needs. Similarly, as different types of provider arrangements continue to proliferate, consumers need to become more aware of financial and contractual relationships that exist among providers outside of the health plan "umbrella.

These issues concern both publicly and privately funded health plans, programs, and grants. Indeed, sometimes there is no distinction (e.g., a health plan with both public sector and commercial enrollees). HHS has an obligation to ensure that all who obtain care under HHS auspices have the information they need to navigate the complex health care environment, that they are not subject to inappropriate extremes in health care and cost management, and that they are able to be heard when they have a complaint. HHS has a critical leadership role to play in evidence based analysis of issues and alternatives, the development of information that will empower beneficiaries, and the development of model approaches. However, as the agency that administers the Medicare HMO program and the federally-qualified HMO program, and that works with the states in administering Medicaid, HCFA has had a long history of dealing with the kinds of consumer protection issues that have received greater attention recently because of the "managed care revolution."

The standards set in HHS programs can have an important influence on privately purchased services and can demonstrate costs and cost effectiveness of these protections.

Providing Accurate Information. As a purchaser of health care, as a regulator of Federally-qualified HMOs, and in the management of its programs, the Department will ensure that beneficiaries, grantees, and others who receive care under HHS auspices have the information they need to navigate their health care delivery environment. The Department will accomplish this through information and outreach provided directly to the populations served, and through the evaluation of information provided by its contractors and grantees. The latter would include compliance with the requirement that Medicare and Medicaid health plan marketing materials be approved in advance by HCFA (or the state, under recently enacted legislation).

Protecting Against Harmful Practices. HHS will also work to protect people who obtain HHS-funded health care from harmful practices such as:

- withholding information on treatment options;
- conditioning coverage of emergency room care on pre-authorization or use of in-network providers even when there is a true emergency;
- denying coverage of ER care when the patient's belief that the emergency was real was a reasonable assessment of the situation for a layperson;

-- unnecessarily disrupting of the continuity of care for patients in the middle of a course of treatment when a plan changes its provider network;

-- use of gatekeepers and other case managers in ways that inappropriately impede access to needed care;

-- allowing unreasonable delay in determining whether a requested therapy is experimental (and therefore not covered).

These areas of concern are illustrative and will change over time. Many have been addressed through regulations, legislation, or policy positions, including the "prudent layperson" definition for Medicare and Medicaid health plans, prohibiting the withholding of information ("gag clauses"), forbidding health plans to require prior approval of emergency care, providing recourse for unreasonable delays in treatment decision (through Medicare [and newly enacted Medicaid] expedited appeals processes), as well as through general requirements for continuity of care. Whether Medicare and Medicaid plans meet these standards is determined through on-site reviews of the plans and by responding to member complaints.

Ensuring Effective Grievance and Complaint Procedures. The Department will provide protection and advocacy to consumers in HHS-funded programs, as well as to those in privately funded insurance or systems of care. The Center for Mental Health Services in SAMHSA administers the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program to protect the rights of individuals with mental illnesses and to investigate reports of abuse and neglect in facilities that care for or treat individuals with mental illness. The AoA ombudsman program serves a similar role for the aged and **(name of program)** in ACF's Administration on Developmental Disabilities concerns itself with providing protection and advocacy for persons with developmental disabilities.

Medicare and Medicaid beneficiaries have recourse to an expedited appeals process in addition to due process available through administrative and judicial review. Health plan compliance with requirements is determined through on-site reviews, and through the processing of complaints received directly by regulatory agencies. Medicare beneficiaries also have the right to complain directly to a Peer Review Organization about the quality of care received in a health plan.

Whether members are fully aware of the appeal rights available to them is a continuing concern. Plan marketing material is required to include detailed information about available grievance and appeals mechanisms. HCFA and the states also have direct mail

and outreach efforts (such as through the Information, Counseling, and Assistance Grants to the States) to provide beneficiaries with information about the appeals process.

In the management of all programs funded by the Department, HHS will ensure that beneficiaries, grantees, and others who receive HHS-funded health care have access to an appropriate grievance procedure as a way to have their complaints heard.

Ensuring Inter-agency Coordination. Through the Consumer Protection component of the Secretary's Quality Initiative, an inter-agency working group will be formed so that the protections described above can be implemented across HHS as uniformly as possible, given the differences among HHS programs. (For example, the information needed by a Medicare health plan enrollee may not be the same as that needed by a client of a Community Mental Health Clinic.) This working group will also be responsible for following the deliberations and recommendations of the President's Commission on Consumer Protections and Quality, and evaluating those ideas and recommendations for implementation in HHS programs and grants (see **External Factors** below).

Major New Resources

None.

New Legislation and Regulations

None identified at present.

Key External Factors

The President's Commission on Consumer Protection and Quality will address a range of issues and will provide recommendations regarding both policy and potential implementation mechanisms for many of the consumer protections listed here, as well as for additional consumer protections. The HHS inter-agency implementation group (see **Strategy** above) will follow the Commission's deliberations and assess the recommendations for implementation in HHS programs and grants. In large measure, the Department's strategy in consumer protection will be informed and modified by the deliberations of the Commission and its recommendations.

Success Measures

- procedural changes relating to HHS funded programs that are intended to protect consumers from management practices that compromise quality of care.

- availability and use of consumer informational materials as determined by the number of HHS programs and grants in which consumers know that information is available to them and find that information useful.

- how well the protections achieve the outcomes desired (e.g., do beneficiaries who need direct access to specialists actually get it?).

- health plan compliance with statutory and regulatory requirements as determined by evaluation studies and on-site reviews.

Strategic Objective 4.6
Promote Research That Improves Quality and Develops Knowledge of Effective Human Services Practice

Achieving the goal of improving the economic and social well being of communities, families, and individuals in the United States requires an understanding of the extent to which the services being delivered through HHS programs are effective, and how they might be improved.

With the legislative mandate to move more families from welfare to work, states are shifting their emphasis from providing ongoing cash assistance to families to providing assistance to help recipients enter the labor market. Job services, transportation and child care service needs are well recognized in enabling work. But, more is needed to improve the quality of those services. And, as the percentage of recipients who leave welfare for work or are actively engaged in work-related activities increases, those remaining are likely to have personal and family challenges that make it difficult for them gain or sustain employment. Their ability to succeed may depend on services to help overcome or cope with learning disabilities, substance abuse, depression and physical or mental disabilities, family responsibilities, such as caring for other family members with disabilities, histories of physical or sexual abuse and domestic violence, social isolation, or absent or non-supportive partners or community networks.

Head Start has been well recognized as a critical factor in promoting the sound health, growth, development and readiness for school of low-income 3-4 year olds. The program has had a long history of working to monitor and improve the quality of services for preschool children. Early Head Start, a demonstration program built on the Head Start experience, serve low-income children from 0-3 years and their parents. The

demonstration accompanied by a rigorous evaluation to measure outcomes is important to understanding how best to intervene early on behalf of low-income children.

Strategy for Achieving Objective

Human services delivery systems are currently undergoing enormous changes that place new demands on the Department's ability to provide quality services. HHS's role includes assisting states and other partners to develop their data and evaluation capacities and providing extensive technical assistance to help its partners in state and tribal governments and in communities to have access to current information on how to provide high quality and effective social services. The Department's strategy has four components: developing the research infrastructure, conducting research specifically related to welfare reform, conducting demonstrations and evaluations to develop and disseminate information on quality services and to provide technical assistance

Developing a Research Infrastructure. The Department will continue to maintain and improve the analytical infrastructure for evaluation and planning and to improve statistical modeling capacity, databases, and other resources necessary for improved evaluation. In addition, the Department funds two national centers focusing on poverty research which greatly enhance its understanding of the causes of poverty and the effectiveness of policies to reduce poverty. These centers focus on understanding the effectiveness of innovations in poverty policy at the state level, the well-being of low-income families and their children, changing labor market opportunities, and the particular issues associated with concentrated urban poverty.

Conducting Research to Support Welfare Reform. The Department's welfare reform research agenda has two main purposes: (1) to increase the success of that reform by providing timely, reliable data to inform policy and program design and decision making, especially at the state and local levels. (2) to inform the nation of the effects of policies on children, families, communities, and social well-being. To accomplish these purposes, the Department will maintain and strengthen a subset of projects begun as state waiver evaluations to provide early and continuing feedback on the implementation and impacts of different approaches to welfare reform; preserve and enhance the ability of university-based welfare researchers to continue to study and understand the effects of different policy and implementation choices, build on existing federal investments such as the national JOBS evaluation and Parents' Fair Share, and work with other public and private funders of research to obtain maximum leverage, creating a strong understanding of not only TANF, but other key areas such as child care, child support enforcement, and child welfare.

Conducting Demonstration and Evaluations to Improve Quality and Program Design. Through its own programs and those funded through grants to states and others, the Department will foster improvements in the quality of human services. For example, demonstration waivers are being used in several states to test alternative methods of financing and delivering child welfare services to improve outcomes for children and families. Through rigorous evaluations, HHS expects to learn a great deal about how federal financing of these services can be improved to better meet the needs of children and families. Carefully designed impact evaluations will inform policy and practice. For example, the impact of family preservation services affects permanency decisions for children; the impact of family support services will inform child abuse prevention; the impacts of Early Head Start program will inform issues affecting child development. Innovations will be tried and tested in adoption practice, kinship care, preventing and treating child abuse and neglect, and other areas affecting the well-being of children.

Technical Assistance and Information Dissemination. Throughout its technical assistance and dissemination activities, the Department intends to maximize the opportunity for policy and program design decisions to be based on reliable information. The law permits unprecedented local flexibility in the new TANF program. HHS's technical assistance efforts will focus on outcomes, best practices, and issues that localities have in common. Furthermore, the Department intends to strengthen efforts to implement joint planning, funding, and service partnerships among Head Start, child care, prekindergarten, and family literacy initiatives aimed at low income children and families.

Major New Resources

None.

New Legislation and Regulations

None.

Key External Factors

Research in this field will depend on the continuing commitment of HHS and its partners to understanding the effects of its programs and to persevere in those instances when results are different from those the Department had expected or hoped for.

Success Measures

- Research, evaluation, and demonstration programs address the key issues in their respective fields and research products provide significant new information to the field on important topics of policy and practice.

- Technical assistance efforts respond to the needs of State and local agencies to whom they are directed, as measured by the extent to which target audiences judge such assistance useful and the extent to which products and training are put to use by their target audiences.

GOAL 5 IMPROVE PUBLIC HEALTH SYSTEMS

Over the past fifty years, the American medical care system has made remarkable gains in saving lives and ameliorating suffering. Clinical medicine, however, is credited with only five of the thirty years that have been added to life expectancy since the turn of the century.[1] Public health interventions have had a far greater impact and, in concert with clinical medicine, will continue to play an important role in achieving the improvements the Department seeks in the future. The public health system has provided safe drinking water, reduced and even eliminated major infectious diseases such as smallpox and polio, and decreased contamination of the food supply.

State health agencies are working creatively to stretch their resources and support local partners. Yet today, the majority of local health agencies report that they lack sufficient information systems and trained staff to meet current needs. The technology gap is most evident among local health departments, in which many staff lack access to or training about computers and electronic information.

In addition, public health agencies are being affected by managed care as Medicaid beneficiaries previously served in public clinics are shifted into managed care networks. This shift deprives health departments of the Medicaid support for overhead costs that have helped to sustain basic public health services. Therefore, the shift to managed care heralds a changing role for health agencies, especially the opportunity to concentrate on providing a full range of essential public health services. This, however, will require staff training in population-based services as opposed to direct care. It also presents a challenge to health agencies to address the loss of resources that support basic public health services.

Challenges also exist in the area of food and drug safety. In the drug area, great progress has been made under the Prescription Drug User Fee Act (PDUFA) in making new drugs and biologics available more quickly to the American people. This has been done without compromising the scientific review process; however, more progress can be made, especially with the extension of PDUFA, which is required for continued progress.

Ensuring the safety of the food supply is one of the government's most enduring and important functions. While the United States has the world's safest food supply, major food safety issues also need to be addressed, including emerging pathogens, new and

novel food ingredients, hazardous dietary supplements, naturally-occurring food-borne toxins, and increasing importation of foods. Sources of contamination are more numerous and varied than the pathogens themselves, highlighting the importance of adequate research, surveillance, and prevention activities. Currently available diagnostic assays for detection of some pathogens have serious limitations, diminishing the Department's ability to ensure the safety of the food supply.

General Strategy for Achieving Goal

Preserving and improving the nation's public health systems are critical priorities for the Department. Investments in this area will maintain and improve the foundation for effective programs.[2] HHS must work with state and local governments to secure a work force that is appropriately trained, information systems that are adequate and effectively linked, and structures and resources that are sufficient to deliver the essential services of public health. The Department also must work with industry and consumers to implement new approaches in science-based regulation that will allow it to protect the food and drug supply while minimizing costs and intrusiveness.

These activities will be coordinated through the Office of Public Health and Science within the Office of the Secretary and involve the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the Substance Abuse and Mental Health Services Administration, the Food and Drug Administration, the Health Care Financing Administration, and the Administration for Children and Families.

Strategic Objective 5.1
Improve Public Health Systems' Capacity to Monitor the Health Status and Identify Threats to Health of the Nation's Population

Monitoring, surveillance, and assessment systems provide the basic information for public health and are fundamental to improvement in the quality of health care. Without timely and accurate data to identify changes and trends in key health indicators, it is impossible to mount effective interventions or to monitor their success. Researchers, policy makers, health professionals, and the public depend on the timely availability of national, state, and local health data. Using such data sources as vital statistics, notifiable disease reports, national health interview surveys, national health and nutrition examination surveys, and national health care surveys, HHS can learn about

causes of death, infant mortality, prenatal care, health status and disability, insurance coverage, access to care, health behaviors, diagnoses and treatments, utilization patterns, and many other important health issues. National summary information must be backed by state or region-specific information in order to allow the appropriate targeting of resources.

There is significant need to improve these systems. Data gaps identified by state and local health agencies, CDC staff, and the HHS Data Council (through the Secretary's *Research Initiative Regarding Transformations in Health and Human Services*) need to be closed. The lack of electronic capacity at the community level, where many of the most important results occur, is also an urgent concern, documented by national organizations and individual state public health systems. Therefore, investments in monitoring, surveillance, and assessment systems must be a clear priority.

Further, the types of health problems and threats to health have changed dramatically over the past 50 years, due in part to changes in human behaviors, increasing international commence and travel, environmental changes, and deteriorations in the public health infrastructure. Polio and smallpox are no longer major threats. Instead, they have been replaced by unintentional injuries, HIV/AIDS, environmentally caused diseases, newly emerging infectious diseases (including food-borne illnesses), and old diseases that are becoming resistant to available drugs. To meet these new challenges, the Department needs a work force that is trained to recognize and respond to these new and emerging public health problems and to use state-of-art technology and the most effective prevention strategies available.

Finally, state governments are reorganizing agencies and services to improve service delivery and contain costs; these strategies include rapid expansion of managed care plans serving low-income and medically frail populations. This expansion erodes the resource base for public health agencies that traditionally serve these clients by eliminating their reimbursement by Medicaid. It also raises concerns that public health prevention services for these populations will not be available in the managed care setting.

Of special concern to the Department are public health services for American Indians and Alaskan Natives. The Indian Health Service and other federal funds for the clinical care of Native Americans are being turned over to tribal governments in the process of self-governance, yet these funds are inadequate to maintain an adequate public health infrastructure. Federal action is needed to address this problem.

In order to ensure that the capacity of the public health system is adequate to meet threats to the public health, HHS needs to put in place or strengthen the critical elements of the infrastructure that are weak, i.e., resources, data systems, and professional competencies. Over the next five years, the Department will be an active partner with state and local public health agencies and tribal governments in actions designed to revitalize the public health system infrastructure.

Improving Use of Technology. The availability of state-of- the art computers and computer technology must be ensured in order to improve the ability of public health systems to compile, analyze, and transmit timely monitoring and surveillance information in all involved agencies. The Department's role will be to support computer acquisition and linkage. To do this, the Centers for Disease Control and Prevention, the IHS, and SAMHSA will provide funding to state and tribal governments for hardware and software purchases. These HHS agencies also will pursue the elimination of restrictions in current categorical grants to allow the purchase and shared-use of computers and information systems. If this can be accomplished under current authority, states will have additional flexibility to develop an adequate information infrastructure.

Investing in Data Infrastructure. The National Center for Health Statistics will coordinate a national effort to address identified gaps in public health information and to streamline the collection and analysis of the nation's health statistics so that the collection of information can be done more efficiently and disseminated more rapidly to the public health community. This will involve development of a long term plan for a balanced, unified program of surveys designed to meet current and future data needs. It will also involve continued automation of data collection, developing and applying new, improved data processing and analytic tools, and disseminating data more widely via the Internet. CDC, SAMHSA, IHS, HRSA, HCFA, and state and tribal governments will be partners in this process.

Because uniform definition of data elements and broad agreement on key measures of public health are essential to an effective system, the CDC, SAMHSA, IHS, and HRSA will work through their grant programs to define public health performance measures for improving public health systems in state and tribal governments and in communities. Creating performance partnerships is a core element in this strategy.

Investing in Training. HRSA, SAMHSA, IHS, and CDC, in partnership with academia, states, and local health agencies, will support improved training for the public health workforce at all levels. The training will focus on increasing the knowledge and capacity of the public health workforce to work with diverse populations, designing effective science-based prevention programs, and monitoring the cost and effectiveness of delivering essential services in priority areas. For example, CDC will include in its training activities an emphasis on training laboratory, surveillance, and evaluation scientists to increase the national capacity to improve food safety. Additionally, increasing the availability of computer technology will be complemented by providing technical assistance to the public health workforce to increase their capacity to use the new technology.

Resources. The Health Care Finance Administration, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention will cooperatively address the problem created by loss of Medicaid funds in public health agencies. On behalf of the Department, these agencies will continue working closely with the managed care industry and HHS's state and local partners to explore ways to improve health delivery systems through their purchasing power and to better link the health care and public health systems. HHS will continue to promote a greater public health and health promotion focus in performance measurement systems such as HEDIS (Health Plan Employers Data and Information Set).

CDC will provide states with technical assistance to enhance surveillance and response system capacity, including electronic laboratory-based reporting and molecular epidemiology. CDC also will implement domestic and global surveillance networks to monitor conditions including: antimicrobial resistance, threats from transfusions of blood and blood products, and infectious diseases among travelers, immunosuppressed and underserved populations.

The IHS will continue to support four existing tribal centers for epidemiologic research that require continued funds, training and technical support from the federal government. Additionally, at least two new centers will be needed to provide adequate coverage of all eligible American Indian and Alaska Native populations.

Success Measures

- Percentage of local health departments linked to and using the Internet for activities such as submitting reportable disease statistics electronically
- Percentage of local health departments that submit reportable disease statistics electronically
- The time lag between the year of data collection and publication of statistics for all national HHS health data sources
- Number of Epidemiologic Intelligence Service (EIS) officers trained by CDC
- Number of microbiology laboratory fellows trained by CDC and available for local, state, and federal laboratories
- Number of public health traineeships at HRSA

Major New Resources

IHS will need additional funds to support at least two more epidemiology centers. An increase in resources to support the training of public health staff will be needed to achieve this objective. Additional resources will be needed to implement the national effort to fill data gaps and automate data activities across departments, states, tribal governments and other partners. Specific amounts will be specified in future Department budget requests.

New Legislation and Regulations

The Department has asked Congress for authority to create additional flexibility in grants to states to facilitate developing the information infrastructure at the state level.

Key External Factors

Achievement of this objective will require collaborative efforts across public and private sectors.

As a result of the efforts of the Food and Drug Administration

Strategic Objective 5.2
Assure Food and Drug Safety by Increasing the Effectiveness of Science-based Regulation

(FDA), Americans have the world's safest food supply and are assured of the safety, reliability, and efficacy of drugs and medical products. FDA not only keeps unsafe or ineffective products off the market but ensures that valuable products are made available expeditiously. For foods and products already on the market, FDA's role is one of ensuring safety. Its ability to ensure the safety of the food supply is enhanced by surveillance and other programmatic activities conducted by the Centers for Disease Control and Prevention (see strategic objective 5.1).

Although the record of performance is impressive, continued attention is necessary. For example, although the U.S. food supply is the safest among developed nations, food-borne illnesses still threaten public health and contribute significantly to the escalating cost of health care. Among all the hazards associated with foods, microbes dominate; they account for 90 percent of the confirmed outbreaks, resulting in as many as 33 million illnesses, 9,000 deaths, and as much as $3 billion in health care costs every year.

A strong research capacity and the ability to identify and respond to new regulatory challenges have been, and will continue to be, critical factors in FDA's success. FDA's strategic challenge for the 21st century will be to maintain the effectiveness of FDA regulation in an environment of shrinking resources and increasing demands. By 2002, with expected resources at 70 percent of 1994 buying power, FDA will have a growing workload of complex and diverse new products to review along with an increasing level of domestic food production and imported food to monitor.

Strategy for Achieving Objective

FDA will need to address this resource and workload challenge in order to ensure the future safety of food, drugs, and medical products. It will meet the challenge in two ways. First, to address the increasing work load, FDA will improve the regulatory process by more efficiently utilizing the science base that underpins the effective and efficient regulation of food, drugs, and medical devices. Second, to address the shrinking resources, FDA will form partnerships with industry and stakeholders to help manage health hazards.

Utilizing the Science Base. To improve the efficient use of the science base underpinning FDA regulations, FDA will:

—expand its capacity to monitor and investigate post-market adverse events through the development of new laboratory testing methods and trained staff;

—in collaboration with the Centers for Disease Control and Prevention, expand its national "early-warning" system for detecting and responding to outbreaks of food-borne illness; and

—more efficiently use science-based improvements to the review process to shorten the time it takes to review and approve pre-market applications for drugs and other products, without compromising consumer safety.

Partnerships. Partnerships to make industry and consumer involvement in the regulation of foods and products more effective will be undertaken:

—industry quality assurance programs such as Hazard Analysis Critical Control Points and assurance programs under the Mammography Quality and Safety Act will be promoted;

—FDA, in collaboration with the U.S. Department of Agriculture, the U.S. Environmental Protection Agency, the Centers for Disease Control and Prevention, and state agencies, will expand support and technical assistance to state and local governments to develop the infrastructure necessary to ensure proper detection, evaluation, and coordination for responding to food-borne outbreaks;

—FDA, CDC, USDA, and the EPA will establish a program to improve outbreak coordination through the exchange of employees among federal, state, and local food safety programs;

—FDA will improve product labeling and conduct an outreach initiative to provide consumers with a better understanding about the science basis for regulatory action; and

—FDA and the pharmaceutical industry will work jointly to improve the supply of comprehensive information to patients by the year 2004 to guide patient use of prescription and over-the-counter drugs.

Success Measures

Food Safety

- Number of new laboratory testing methods for rapid detection of food hazards developed by JIFSAN (Joint Institute for Food Safety and Applied Nutrition)

- Percentage of all food safety problems identified by FDA that are corrected via immediate cooperative action

- Percentage of the seafood industry operating under Hazard Analysis Critical Control Points System

- Percentage of domestic food surveillance conducted through state contracting and partnerships

- Response time for food-borne disease outbreaks (time from initial case to first action by public health officials)

- Percentage of adults who use food labels to make nutritious food selections

Pre-market Review

- Percentage of complete priority biologics license applications and new drug applications reviewed within 6 months after submission date

- Percentage of complete standard biologics license applications and new drug applications reviewed within 12 months after submission date

- Percentage of complete medical device pre-market approval applications reviewed within 6 months after submission date

Major New Resources

Additional user fees from the extension of the Prescription Drug User Fee Act will be needed. Additional resources will also be needed in the area of food safety to support the food safety improvements. Specific amounts will be specified in future Department budget requests.

New Legislation and Regulations

Extension of the Prescription Drug User Fee Act is required to keep this objective on track. Some partnership activities, e.g., those involving user fees, may require legislation and supporting regulations.

FDA will depend on efforts of its partners in state and federal agencies, private organizations, and the industry for success.

GOAL 6

STRENGTHEN THE NATION'S HEALTH SCIENCES RESEARCH ENTERPRISE AND ENHANCE ITS PRODUCTIVITY

Improvements in health are grounded on knowledge acquired through research conducted and sponsored by the Department and other entities, both public and private. In the scope and quality of the science it sponsors, HHS sets the pace for the world in medical, epidemiological, behavioral, and health services research. It does so thanks to strong, sustained public support for research sponsored by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Policy Research (AHCPR), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Health Care Financing Administration (HCFA).

The NIH plays a vital role in the nation's medical research enterprise. NIH-sponsored research generates knowledge that leads to improvements in the health and quality of life of the American public. It also provides a continually expanding knowledge base for the development of commercial products by the pharmaceutical, medical device, and biotechnology industries and other key components of the national medical research infrastructure. Through its support of research training, the NIH provide the nation with highly trained scientists who rise to leadership positions in publicly funded research activities and in the biotechnology and related industries. To a very significant degree, future improvements in the health of the American people depend upon sustaining both the research infrastructure that has been developed through NIH support, and the basic principles that have enabled NIH research investments to be highly productive.

In addition to the research at NIH, CDC conducts a strong program of epidemiological and population-based research to protect the public health and prevent and control disease, injury, and disability.

Finally, the Department's health services research also plays a critical role by identifying what is most effective and cost-effective in day-to-day practice in community settings and by identifying the most efficient approaches for delivering and financing those services. Expansion in research investments across a broad front of scientific disciplines and operating divisions within the Department will do more than anything else to ensure improvements in health status and in the kinds and quality of services it sponsors.

The Department also plays an important role in enhancing the productivity of the nation's research enterprise through such means as international scientific cooperation and regulatory policies that encourage private sector investments in research.

General Strategy for Achieving Goal

Four principles are central to the Department's research investment strategy:

Basic Research. First is the high priority accorded to basic research in the life sciences and fundamental methodological work in health services research. In the area of life sciences, one need look no farther than the history of the biotechnology industry to see the wisdom of this approach. HHS investments in basic research undergird epidemiological, clinical, and health services research. In the case of the last, they have laid a foundation for better administration and reimbursement in both the public and the private sectors.

Investigator-initiated Research. The second is the high priority accorded to sponsorship of investigator-initiated research. The Department traditionally has eschewed top-down direction for science and instead has relied primarily on individual scientists to propose and carry out specific research projects within the context of broad program goals and policy priorities enunciated by its agencies. As a result, HHS has been uniquely effective in harnessing the creative energies of scientists throughout the nation toward improving human health and well-being.

Peer Review. Third is the reliance upon peer review to assess the quality of research proposals and outcomes. Determining the relative technical merits of competing research ideas is one of the most difficult tasks facing any research agency. The Department's success in directing investments to the most promising scientific opportunities and the most capable investigators year after year stems largely from its commitment to seeking and heeding the advice of leading experts drawn from the pertinent scientific communities.

Research Capacity/Infrastructure. Fourth is the Department's commitment to sponsoring research in a wide variety of institutional settings and to encouraging a healthy research enterprise in the for-profit sector. Universities, not-for-profit research organizations, hospitals and other practice settings, small and large businesses, and government laboratories —each in its own way has provided a hospitable environment for important scientific initiatives. Also, in view of the unique role played by academic institutions, the Department will continue its efforts to help research-intensive universities remain strong. In particular, it will

maintain its policy of paying a fair share of research costs and will collaborate with academic health centers to find ways to counter the destabilizing effects of managed care upon clinical research and the education of health professionals. The availability of up-to-date and safe research facilities and equipment is essential to assuring continued progress in medical research. The Department will continue its commitment to providing support for new and refurbished buildings and facilities for the conduct of medical research, as well as the maintenance, renovation, and construction of facilities for HHS intramural research. Finally, the Department will enhance the base of highly qualified scientific investigators.

The Department reaffirms these principles as the core of its strategy to guide new investments to increase the nation's health science knowledge base and maintain its quality. HHS intends to apply them even more broadly in the years immediately ahead. To guide action and measure progress in achieving its goal, the Department has established the following strategic objectives:

Strategic Objective 6.1
Improve the Understanding of Normal and Abnormal Biological Processes and Behaviors

Advancing the understanding of fundamental life processes is essential for continued progress in improving health and combating disease and disability. New knowledge of the biological and behavioral processes that occur throughout the lifespan provides the most powerful basis for understanding the course of disease and how it can be delayed, treated, cured or ultimately prevented.

> "Basic science studies matter at all levels of aggregation, from the materials we experience everyday down to their most fundamental constituents. This progress leads to new scientific and technical knowledge and, years later, to innovative products and lucrative commercial markers. These advances have generated millions of high-skilled, high-wage jobs and significantly improved the quality of life for Americans." (1996 Biennial Report to Congress of Science and Technology Policy, *Science and Technology Shaping the Twenty-First Century.*)

The link between medical research and improving health is well illustrated by the vast new knowledge that is accumulating almost daily on the characteristics of various human genes. This research is providing many new concepts and tools for understanding the

molecular mechanisms of various kinds of cancer and other chronic diseases; it is also opening the way for new avenues of prevention and therapy.

Strategy for Achieving Objective

HHS will advance its knowledge of biological and behavioral processes by:

- sustaining its priority of investment in medical research;
- adhering to the investigator initiated, peer review model for selecting the highest quality research proposals;
- implementing decision making mechanisms and policies that ensure medical research is responsive to emerging health needs, scientific opportunities, and new technologies. Examples include the designation of research emphasis areas which show the most promise of addressing public health needs and yielding medical advances that will lead to improvements in human health. Mechanisms for accomplishing this include convening workshops and forums in cross-cutting areas of research, regular conduct of internal and external reviews, and review of the effectiveness of a variety of support mechanisms (such as those focused on support of new investigators).
- promoting technology transfer through partnerships with industry that enhance the federal medical research capacity and facilitate the flow of new technology. This will be accomplished through the development and implementation of policies, procedures, and guidelines that facilitate patenting, licensing, and cooperative research.

Success Measure

- Evidence of increases to the body of knowledge that have resulted in an improvement to the understanding of *normal/abnormal* biological processes and behavior.

Major New Resources

Achieving this objective assumes an annual increase in the NIH research budget over the next six years. Specific level will be presented in future Department budget requests.

New Legislation and Regulations

None.

Key External Factors

Progress in achieving this objective will be influenced by increasingly constrained resources for the scientific endeavor and the largely unpredictable nature of scientific discovery and advancement.

Strategic Objective 6.2
Improve the Prevention, Diagnosis, and Treatment of Disease and Disability

Medical research is yielding knowledge that can be translated into new and improved methods for detecting, diagnosing, and treating disease. New insights into normal disease processes will also provide the knowledge base for developing preventive measures, which are the ultimate manifestation of improvements in health.

The importance of this research is summed up by a 1996 National Science and Technology Council report, *Technology in the National Interest*. The report recognizes the contributions of medical research when it states, "[m]edical research supported by the National Institutes of Health has led to many discoveries that have improved both the health and quality of life of the American people. This is the NIH's foremost goal, but medical research also yields technological and economic benefits."

In addition, research at CDC is contributing to the understanding of pathogens and immunology and the basis for the prevention of the transmission of diseases.

Strategy for Achieving Objective

The strategy for achieving this objective parallels that for Objective 6.1.

Major New Resources

The resource requirements for this objective parallel those for Objective 6.1

Success Measures

Success in achieving this objective will be measured by:

- Improvements in the *prevention or delay of the onset* of disease and disability.
- Improvements in the diagnosis of disease and disability.
- Improvement in the treatments for disease and disability.
- Evidence of the development of new or improved medical technologies and medical products (e.g. vaccines, diagnostics, therapeutics, etc.).

New Legislation and Regulations

None.

Key External Factors

The rate at which scientific findings are adopted by the private sector and translated into commercial products and processes affects the transfer of research findings into practice. Moreover, the nature of scientific discovery and advancement is inherently unpredictable.

Strategic Objective 6.3
Improve Public Health Prevention Efforts through Population-Based Research

Research addressed to controlling the spread of communicable diseases, eliminating the environmental causes of illnesses, and promoting health behaviors that cause illness and premature death also are essential to HHS's efforts to improve the health and quality of life of the nation's citizens. Within the Department, the Centers for Disease Control and Prevention (CDC) is the focal point for conducting population-based, public health prevention research. This research is used by the Department and public health agencies throughout the nation to solve public health problems and improve the effectiveness of public health prevention programs. For example, research on the prevention of sexually transmitted diseases, translated into public health practice, has lead to significant advances in the control of those diseases.

Strategy for Achieving Objective

The Department believes that continued investment in prevention research is essential to ensure continued improvements in public health. Therefore, HHS will:

- sustain its priority of investment in population-based, public health prevention research;
- implement mechanisms that ensure prevention research is responsive to emerging public health needs; and
- promote the collaboration between public health departments and academic institutions in the conduct of prevention research.

Success Measure

- Evidence of new, innovative prevention strategies that are adopted into public health programs.
- Prevention objectives of Healthy People 2000 and 2010 are met.

Major New Resources

Achieving this objective will require additional resources above current levels to sustain a level of research adequate to improve prevention practice. Future Department budget requests will contain specific amounts.

New Legislation and Regulations

None.

Key External Factors

A number of external factors will strongly influence the accomplishment of this objective. They include such variables as changing public health needs including the impact of new and re-emerging infectious diseases, changing demographics, including increasing numbers of elderly persons and the incidence of chronic diseases. Increasingly the

prevention and treatment of a range of diseases centers on behavioral changes, yet effecting permanent behavioral changes (such as reducing high risk behaviors that can lead to disease) and the adoption of health-enhancing behaviors remains enormously difficult. Developing successful research networks with the participation of state and local health agencies, health providers, and academic institutions is necessary to carry out population-based research.

Strategic Objective 6.4
Increase the Understanding of and Response to the Major Issues Related to the Quality, Financing, Cost, and Cost-effectiveness of Health Care Services

The Nation's health care system is undergoing a dramatic transformation as a result of rapid mergers and acquisitions among hospital systems, pharmaceutical firms, health plans, and managed care firms. Health care delivery systems are larger and more complex; cost pressures are forcing innovation in how and where care is provided; and the population is getting older.

Health services research, which examines health care as it operates in everyday practice, is needed to assess the effect of current change and innovation on the cost, quality, and effectiveness of health care services. Important questions that need to be answered include: have the changes made a difference in who is getting care, how much care is being provided, or on the types of services offered; what is the cost and quality of the care being provided; which services are most cost-effective; and how can research findings on effective treatments be moved more quickly into the everyday practice of providers? Development of new methods and products for assessing quality, patient satisfaction, efficiency, and outcomes is also needed. Health services research is important in providing the analytical foundations for making payment reforms, especially in federal programs such as Medicare.

Strategy for Achieving Objective

Therefore, HHS will increase its understanding and response to the major issues in health services by:

- investing in health services research.

- relying increasingly on the model of investigator initiated, peer reviewed research to identify key research questions and select the highest quality research proposals. Processes for accomplishing this include convening workshops and forums in cross-cutting areas of research, regular conduct of internal and external reviews, and review of the effectiveness of support mechanisms.

- creating research partnerships with states and private sector organizations.

Success Measures

- Availability of new tools and performance measures useful for assessing the quality of care provided in a range of health care settings, including measures of effectiveness of clinical care that recognize the role of patients in decisions affecting their treatment.

- Availability of new, useful knowledge about the impact of changes in the organization and financing of health care.

- Availability of new, useful knowledge about the cost and cost effectiveness of alternative treatments for common, high-cost conditions, especially conditions affecting the Medicare population.

- Evidence that research results are relevant and are being used by the public, practitioners, and the health policy community.

Major New Resources

The pace and the scale of changes in the health sector will require a substantial research investment if HHS is to acquire the knowledge needed to guide its programs and produce the information needed by the private sector. Outside of NIH, the health services research efforts in the Department have been significantly scaled back in recent years as a result of budget reductions in AHCPR , SAMHSA, HCFA, and the Office of the Secretary. Significant increases in research are needed outside of that supported by NIH. Without this investment, critical information on how to effectively balance quality, cost containment, and access concerns will not be available. Specific levels will be specified in future Department budget requests.

New Legislation and Regulations

None.

Key External Factors

Collaboration with other federal agencies, as well as with states and the private sector is essential to ensure that health services research is responsive to current and future challenges in the health care marketplace.

Strategic Objective 6.5
Accelerate Private-sector Development of New Drugs, Biologic Therapies, and Medical Technology

One of the critical missions of the Department is to protect the public health. The Department performs this role in a number of ways, including the review and approval of new drugs and medical products developed by private-sector research. The review and approval process, managed by the Food and Drug Administration, ensures the effectiveness and safety of the products being brought to the market place.

Recent public debate has questioned the amount of time it takes for new health products to be developed and made available to the American public. Recognizing that there is always a balance between an adequate process to protect health from dangerous or ineffective products and the benefits to health from expeditiously moving health products through the research process to the market place, the Department believes it is important to enhance the benefits to the public health by assisting the medical industry to accelerate the research and development process.

Strategy for Achieving Objective

The Department, through the Food and Drug Administration, envisions a multi-part strategy to assist the private sector in reducing the time required to bring new drugs and medical products to market. Specifically, FDA will:

- concentrate on, and give priority to, those products that have the greatest potential for health benefits and that address serious or life-threatening illnesses. This will assure the widest public health benefit from expedited reviews.

- increase the speed of all reviews by transforming the regulatory review process for new drugs and biologic therapies into an electronic, paperless system.

  This will reduce the amount of time and effort drug and therapy sponsors and FDA staff spend in preparing and handling large volumes of paper. For example, the average new drug application has about 250 volumes of information and occupies about 46 linear feet of shelf space. Electronic handling will reduce time and costs associated with paper based applications. Further, electronic files will enhance reviewer productivity by increasing the speed and convenience of analysis, including risk assessment supporting review decisions and the review process itself.

  In the risk assessment phase, automation will contribute to a more complete understanding of how a new drug or biological product works, its benefits and potential role in health care. In the review stage, electronic data handling will eliminate pounds of paper and facilitate a reviewer's ability to access information within the agency, as well as communications with the sponsor. The Department expects a direct correlation between the degree of automation achieved and the time saved in the review process--and by extension, the industry's development time.

- improve and have more frequent communication with sponsors.

  This will assist in speeding up sponsors' responses to FDA questions or concerns. By meeting with sponsors during the development period for new products and the preparation of applications for review, FDA also expects that sponsors will be able to present applications that are complete and informative, thus reducing the 'down time' now experienced while FDA reviews a completed application and prepares requests for clarification or additional information.

- harmonize U.S. regulatory standards with those of other industrialized nations.

  Product sponsors will be spared the time and expense of preparing applications in different formats and with varied data and analytic requirements. Mutual recognition agreements will be used to promote a "level playing field."

Success Measure

- Average time savings in overall product development processes.

Major New Resources

Additional user fees from the extension of the Prescription Drug User Fee Act will be needed.

New Legislation and Regulations

Extension of the Prescription Drug User Fee Act Legislation is required to keep this objective on track. Many new regulatory standards will result from the harmonization process and will be integrated directly into the U.S. Regulatory framework. Others will require new regulations.

Key External Factors

Outside factors that could affect the successful achievement of this objective include the health of the economy and its impact on the rate of industry's investment in the development of new medical therapies. The rate at which new medical technologies emerge will also affect the speed of the development process. The degree of complexity associated with these breakthroughs will also impact the development rate. The nature, scope, and severity of emerging health risks will influence the rate at which medical therapies will be developed to address these risks. Harmonizing regulatory standards will be limited by the rate at which the international community comes to agreement of key issues.

Economic conditions, and the pace and direction of information and communication technology development could each have a bearing on FDA's ability to automate the review process and could also influence the ultimate configuration of the automation process. Economic conditions, particularly in the private sector, could affect the pace with which industry systems could be successfully articulated with the Agency's systems. The direction taken by both information and communication technology over the next few years will influence the speed of automation and the configuration of automation.

Strategic Objective 6.6
Improve the Quality and Efficiency of HHS-funded Medical and Health Sciences Research Through Excellence in Program Management

The path of scientific discovery is difficult, if not impossible, to chart in advance. History, however, has consistently demonstrated that investing in high quality research ensures a positive return in the form of knowledge that leads to enhanced quality of life. Additionally, experience has taught HHS that the way it manages its research program directly affects the ultimate quality of that research and its ability to meet changing public health needs and to capitalize upon scientific opportunities. The way HHS manages also determines how efficiently it invests its research resources and maximizes the use of those dollars to support high quality research.

Over the last five years, the Department's research components have carefully reviewed and revised their processes for oversight and management of research to ensure that every step of the process is efficient and effective for both the agency and the grantee community. For example, NIH has made extensive investment in enhancing its procedures for providing grant information to applicants, accepting and reviewing grant applications, managing study sections, and minimizing the application burdens on both investigators and reviewers. All of these reinvention efforts, and those planned for the next several years, have as their objective ensuring that funds appropriated for research fund **research** -- not unnecessary Departmental administrative processes.

Strategy for Achieving the Objective

Maintaining excellence in the way HHS manages its health science research programs is a critical factor in enhancing quality and efficiency. To maintain excellence, the Department will:

- ensure that its medical, public health, and health science research components implement policies and procedures that have been demonstrated to improve quality and maximize the use of resources.

  Processes to accomplish this objective will include regular assessments of research portfolios by internal and external reviewers to ensure that portfolios are responsive to emerging health needs and scientific opportunities. HHS will also regularly assess peer review systems to evaluate and improve quality and efficiency.

- identify and reduce or eliminate non-fiscal barriers such as unnecessary administrative processes that siphon funds away from research.

  Over the last several years, new applications of technology to streamline administrative processes have paid major dividends and additional gains are possible in this area.

- conduct forums and other activities around cross-cutting areas of research to coordinate and develop collaborative research partnerships in order to maximize resources.

Success Measures

- Evidence of the responsiveness of research funding to emerging health needs and scientific opportunities.

- Evidence of a continuing process of seeking advice in setting priorities from the medical and scientific communities, patient advocacy groups, Congress and the Administration, and others.

- Evidence of collaboration within HHS and with other federal organizations and the private research sector.

- Evidence of the general effectiveness of the strategies used to manage the scientific research program, forthcoming from reviews of management and administrative practices.

Major New Resources

The cost of program management is a function of a growing research portfolio. As research investments increase, additional increases in funds for program management will be necessary. However, increased management efficiencies will offset this growth to some extent, so that the rate of increase will be slower than for research. Future program management increases will be detailed in Department budget requests.

New Legislation and Regulations

None.

Key External Factors

Enhancing and streamlining program management activities requires a significant level of coordination within NIH and with other federal agencies, as well as a partnership with the grantee community, primarily the university community. This partnership includes initiation of pilot projects between NIH and a subset of universities which are essential steps prior to full scale implementation of major changes. In addition, there is joint sponsorship of a variety of forums to share information and experiences and seek feedback from HHS customers -- all of which are used in planning and implementing reinvention and other enhancements to research administration activities.

Strategic Objective 6.7
Improve the Quality of Medical and Health Science Research by Enhancing the Base of Highly Qualified Scientific Investigators

The presence of a cadre of talented individuals in medical sciences and health services research is essential to improving the health of the Nation. A robust and diverse research workforce -- in laboratory, patient-oriented, population-based, and systems research -- is central to carrying out the Department's mission and also to the vitality of the present and future medical research enterprise and its associated industries.

Strategy for Achieving Objective

The maintenance, enhancement, and renewal of the scientific talent base requires strong research training and career development programs, a commitment to the recruitment and retention of underrepresented groups into science, and the ability to provide a nurturing and stable research environment. This will be accomplished by measures such as:

- investing in research training programs at institutions and fellowships for individuals through the National Research Service Award (NRSA) program;
- supporting mentored research experiences for clinical, laboratory and health services research scientists through research career development fellowships; and
- recruitment of racial/ethnic minorities into medical research training and career development programs, starting with minority youth.

Success Measure

- Increased numbers of highly qualified persons, including minorities, pursuing medical and health science research, parallel to the estimates of need by the National Research Council for medical research.

Major New Resources

To accomplish research training and career development objectives, support is needed for the level of trainees recommended by the most recent National Academy of Sciences Report on Research Training Needs. Support at this level will provide for a pipeline of highly trained investigators in areas of national need. Resources are also needed to provide a cost of living increase for stipends each year as well as an adequate level of tuition support, and to provide for program management.

New Legislation and Regulations

None.

Key External Factors

A number of external factors are important in influencing the success of research training efforts. Demographic factors that shape the pool from which future scientists can be recruited are very important. In addition, it is difficult to attract talented young people into science if they perceive that the job market in research is unstable or significantly less financially rewarding that other fields of comparable interest. Thus, the increasingly constrained resources for research limit opportunities for training and career advancement, and discourage new entrants into basic science careers. Finally, the universities that provide the training opportunities are undergoing enormous changes that will influence their ability to support and nurture young researchers.

Strategic Objective 6.8
Ensure That Research Results Are Effectively Communicated to the Public, Practitioners, and the Scientific Community

The expeditious communication of research results is a vital step in translating new knowledge into changes in medical practice and into technologies that improve human health and well being. Effective

communication of research findings drives scientific innovation, fosters new discoveries, and ensures that public investment in research yields new methods of prevention, diagnosis, and treatment.

Strategy for Achieving Objective

Adopting and using effective communication practices will be the core of the strategy to achieve the objective. This will include:

- routine preparation and dissemination of information materials on scientific advances and technologies to individuals and medical, scientific, industrial, media, and patient groups;

- wide dissemination of the results of supported research through various information channels, including scientific publications workshops and symposia, scientific meetings, consensus development conferences, press releases, special physician and public education programs, clinical alerts concerning immediate health and safety issues, and electronic databases.

- prompt responses to inquiries from the public, health professionals, Congress, and the media through information offices, clearinghouses, electronic databases, Internet-based information services, publications and press releases, as well as direct responses by letter and telephone.

Major improvements have already been accomplished through recent initiatives such as providing free public access to Medline -- the world's most extensive collection of published medical information -- over the World Wide Web. All Americans can now access timely and accurate medical information at the web address: http//www.nlm.gov. More consumer-focused information advances include *Healthfinder*, launched by the Department in April, 1997. *Healthfinder* provides easy access to high quality consumer health information from federal and private sources at : http//www.Healthfinder.gov. The Cancer Information Service (CIS) is an award winning program that provides the latest, most accurate cancer information for patients, their families, the general public, and health professionals. CIS responds to calls in English and Spanish. These are illustrative of the ways HHS intends to take advantage of the opportunities of Internet and other communication technology to bring the results of research into easy access for the practitioner community and the public.

Success Measures

- Improvements in communication on information about research discoveries, new therapies, and actions individuals can take to protect and improve their health.

- Improvements in dissemination of research findings and emergency or critical information learned from medical and health services research.

Major New Resources

The cost of communicating the results of research is a function of a growing portfolio. As research investments increase, additional increases in funds will be necessary. However, increased managerial efficiencies will offset this growth to some extent so that the rate of increase will be slower than for research.

New Legislation and Regulations

None.

Key External Factors

The pace of advancement in information technology is a key factor in future advances. The capacity of national Web resources will limit public access to and use of HHS-sponsored resources. The success of efforts to connect schools, libraries, and other public facilities to the Web will also set the pace for public access to these information sources.

IMPROVING PERFORMANCE

In conjunction with implementation of the Government Performance and Results Act, HHS is taking steps to change the way it works day-to-day in order to improve its performance. These steps include restructuring to focus on critical elements of the HHS mission, instituting Department-wide systems to embed performance management in HHS operations, and adopting new ways of responding to the transformations that challenge the Department to better integrate its planning and programs.

Restructuring

With its numerous and specialized responsibilities, the Department of Health and Human Services is one of the largest and most complex federal departments. To carry out those responsibilities, the Department works through ten major operating divisions (described in the introduction to this document), shaped by separate statutes, funding over 300 programs, and, moreover, overseen by many authorizing and oversight committees.

In 1995, as part of a comprehensive management assessment of the Department (known as REGO-2), its entire operations were streamlined and decentralized. Two divisions that coordinated policy and management functions on behalf of the Secretary were eliminated (the Office of the Assistant Secretary for Health and the Office of the Assistant Secretary for Personnel Administration). The component operating divisions were given enhanced authority and the headquarters management staff was substantially downsized. These changes have increased the autonomy of the operating divisions, in line with streamlining approaches used in the private sector. The experience of the last two years under the new structure has fulfilled the Department's expectations regarding improvements in customer focus, innovations in program management, and enhanced efficiency of operations. (The HHS organizational structure is portrayed in the chart on the inside back cover.)

However, the Department recognizes that both its new management structure and the segmented interests of Congress and its constituencies exert strong centrifugal forces on its programs. At the same time, the challenges that the Department must address--whether in delivering effective health care, enabling families to move from welfare to work, or assuring food safety--require the coordinated efforts of programs across the Department and integration with the other levels of government with which we work.

Internal/External Coordination

Better internal and external coordination of its wide-ranging activities is a pressing priority for the Department. Internally, success of the strategic planning process and the accomplishment of goals and objectives will depend on how well we are able to create a new way of doing business that relies on teamwork among its operating divisions and programs. Similarly, teamwork between the Department and its federal, state, local and tribal service delivery partners, contractors, public interest organizations and customers is also critical if we are to achieve what we have set out to do.

To achieve this end, the Department is experimenting with a range of approaches to collaboration both internally across its operating divisions and externally. The following summarizes the new approaches.

Using Secretarial Initiatives

Both to advance important areas of policy interest, and to begin managing through teamwork, the Secretary designated six special initiatives to be managed by two or more operating divisions. These relate closely to the Department's strategic goals. In the past, this type of initiative would have been coordinated from the Office of the Secretary. The six are:

- Preventing youth substance abuse
- Improving health care quality
- Operation Restore Trust
- Children's Health Care Initiative
- Welfare to work
- Reduce tobacco use among teens and pre-teens

Using Coordinating Councils

In addition, the Department has established coordinating councils that integrate planning and policy development across the Department in key activities. The most important of these are:

- *THE CHIEF FINANCIAL OFFICERS COUNCIL* ensures that HHS's financial management policy and reporting supports program missions by providing accurate, timely and useful information for decision making. The council is also responsible for reporting financial information to Congress, OMB, GAO, Treasury, and the public.

- *THE INFORMATION RESOURCES MANAGEMENT ADVISORY COUNCIL* includes membership from each of the Operating Divisions. The council advises the CIO on the promotion of Department-wide IRM goals, strategic policies and initiatives, and enhances communications among the OpDivs. Members of the IRM Advisory Council also serve as members of the HHS Information Technology Investment Review Board.

- *THE GPRA ROUNDTABLE AND THE GPRA RESEARCH ROUNDTABLE* provide forums for HHS and other Departments to focus on issues and concerns, exchange lessons learned, and disseminate information and guidance on GPRA implementation.

Using Reinvention Results

The Department has taken steps in concert with the Administration-wide drive to reinvent government. These efforts have reshaped many of its new management practices, permitting the Department to change the way it does business. Some important changes are taking place:

CUSTOMER STANDARDS ensure that the Department remains responsive to those it serves. HHS has established standards for all direct service programs, and has requested its partners to develop standards for the services they deliver through HHS grants. Performance measures and targets for customer service are benchmarked against the "best in business." Surveys and focus groups have yielded suggestions for improving programs, grants management, and service delivery to meet these standards.

REINVENTION LABORATORIES have tested new approaches to managing the Department's business and improving service to its customers. The lessons learned through these innovations have been incorporated into the Department's planning and management strategies for the next decade. Here are examples of these applications:

The Internet Laboratory was convened by the Office of the Secretary to provide timely information to HHS customers, partners, and employees over the World Wide Web. Collaboration among the Department's "web pioneers" resulted in a major expansion of

HHS Internet-based information sources and led to the development of important new resources, including *Healthfinder.gov*, the country's most comprehensive source of consumer health information from federal and reliable private sources.

Indian Health Service Labs were established as reinvention laboratories at the Alaska Native Medical Center and the Phoenix Indian Medical Center. The IHS was able to develop and test innovative management, purchasing, and patient monitoring practices that are now being applied agency-wide. Improved administrative processes for health care delivery bolstered staff morale and resulted in higher patient satisfaction ratings.

National Institutes of Health Grants and Information Systems Labs streamlined the grants review and awards process, modernized the National Library of Medicine Information System, and developed a model for one-stop access to the products and services of the National Cancer Information Center. Successful new ways of managing NIH grants and information systems design and dissemination are being emulated throughout HHS.

The Food and Drug Administration Electronic Entry Processing System, developed in close coordination with the U.S. Customs Service, has automated procedures for regulating imports. Application of these procedures at eighteen locations has greatly reduced delays and backlogs at the country's busiest ports. This is an example of HHS's use of technology to streamline management and administrative processes.

Improving External Coordination

Besides being responsible for directly delivering services under several programs, the Department principally relies on a large network of state, local, and tribal government organizations, contractors, and private entities, with varying degrees of autonomy, to help develop and carry out the goals, objectives and programs of the Department. Services delivered by these organizations range from financing and providing health services to a large number of nation's citizens to services that help families, communities, and individuals improve their well-being. Furthermore, we know from experience and research that services work best when provided through networks that understand the needs of individuals are often not limited to a single service but often encompass the need for a range of services that cut across programs, service providers and locations. The challenge for the Department in this is to promote , across the many services and providers on which the Department relies, the integration and coordination of the planning and delivery of health and human services--not a small undertaking at best.

Steps to promote external coordination that have already begun and will continue to be expanded upon include:

- support for infrastructure development activities that assist states and communities develop comprehensive approaches to service planning and delivery;

- use of interagency and intergovernmental councils and work groups to promote planning and coordination of program activities, such as the Vice President's Community Empowerment Board, the Interagency Council on the Homeless, the Welfare-to-Work Partnership, and the Joint Institute for Food Safety and Nutrition;

- increased day to day staff contact with other Federal agencies to coordinate planning and program implementation activities; for example, cooperation with the Department of Education on substance abuse prevention activities in schools, work with the Department of Transportation to develop ways to help welfare recipients obtain affordable transportation to workplace, or partnerships with the Department of Justice and Labor to implement the Health Insurance Portability and Accountability Act.

- promotion of community based, performance partnerships;

- ongoing assessment and reinvention of program operations to promote coordination, including the consolidation of program activities;

- commitment to frequent consultation with stakeholders in the development and implementation of Department goals and programs; and

- support for the reduction of legislative, regulatory and other barriers that prevent the coordination and integration of services.

Management Responsibilities

The central purpose of the Government Performance and Results Act is to improve the management and accountability of federal programs. The Department's strategic goals and objectives establish its framework for the management and measurement of specific areas of Department responsibility. This section summarizes areas of management responsibility that cut across operating divisions, where HHS is taking action on a Department-wide basis to enhance the performance and accountability of its programs

Financial Management. An unqualified, or "clean" audit opinion on an agency's financial statements is one of the most important indicators of excellence in financial management. This is a fundamental and critical objective and challenge for HHS. Among many specified in the ***HHS Financial Management Status Report and Plan,*** this single objective encompasses many objectives for improvement of financial management. Its attainment has wide-ranging implications. In and of itself, it represents proper accounting for the flow of funds that in turn facilitates financial analysis. It reflects the maintenance of strong internal checks and balances in financial information systems to ensure that errors and fraudulent activities are prevented or detected. It signifies the proper management of cash, and the confirmation that vendors are paid promptly, minimizing interest payments and late fees. It reflects the proper management of receivables, ensuring that monies owed to HHS are tracked and collected in a timely manner. HHS will work toward clean opinions for its operating components and HHS-wide financial statements.

Information Technology. More than ever before, electronic data processing and telecommunications offer opportunities for efficiency and cost savings. HHS has already realized such improvements by using electronic means in conducting its day-to-day business. Funds are now being transferred electronically for 90 percent of salary payments and 99 percent of grant payments (over $170 billion in FY 1996). HHS must continue to take advantage of technological advances and innovations, and employ prudent management practices to make the best use of its technology assets. Toward this end, the Department will institute sound capital planning and investment review of major system developments and modifications, measure performance, and confirm that automated systems contribute to mission accomplishment. HHS will also ensure the establishment of information architectures to facilitate communication, data exchange, and electronic commerce.

HHS will ensure that its systems are compliant with Year 2000 goals, either through repair, replacement, or, in some cases, elimination. HHS intends to complete routine testing and implementation activities by late FY 1998. Another key HHS objective is to guarantee that Year 2000 repairs and replacements are made correctly and, wherever possible, within budget, while minimizing the financial impact on other system improvements activities that are critical to its mission. HHS will accomplish these aims through judicious use of new system development where the existing system is outdated and where timely completion is possible, and through the establishment of system priorities through the capital planning/investment analysis.

Acquisition Management. HHS is one of the largest federal purchasers of goods and services. In FY 1996, approximately 900 HHS procurement personnel awarded and

administered over 700,000 procurement actions, worth more than $3.7 billion. HHS obligated an additional $1.5 billion from the Medicare Trust Fund for contracts with Medicare intermediaries and carriers. Recognizing its impact on federal procurement, HHS has, in consultation with the National Performance Review and the Office of Management and Budget, embarked on an intensive program of procurement management and reform rooted firmly in a commitment to performance measurement. HHS has thus developed the ***HHS Acquisition Scorecard***, a customer-oriented and results-driven system intended to measure how HHS procurement systems meet their objectives to provide quality products and services, at a fair price, when program offices need them.

The scorecard system requires a fundamental linkage of acquisition planning with the mission, strategic direction, and core values of HHS and its component agencies. It embodies important improvements in long-term acquisition management in areas such as workforce quality, information technology, acquisition excellence and efficiency, project officer performance, and executive leadership. Finally, the scorecard accommodates the monitoring and management of project costs and schedules.

Performance management via the scorecard dovetails with the Department's commitment to strengthen management of capital asset projects through its cross-functional implementation of OMB Circular A-11, Part 3: "Planning, Budgeting and Acquisition of Capital Assets." In capital planning, HHS focuses on acquisitions that enhance mission performance, and on closely monitoring the progress of its projects against cost, schedule, and performance goals. Such monitoring will enable the Department to swiftly remedy problems while they are still manageable. In addition, HHS is pursuing the application of principles of capital planning beyond OMB's specific requirements to cover a broader range of capital asset projects.

Improving the Quality of Work Life. In response to concerns about employee commitment and morale during a period of unprecedented change and uncertainty, and cognizant of the need for a dedicated, high-performing work force to meet the challenges of the future, the Secretary has developed a comprehensive initiative to improve the quality of work life for employees. ***The Secretary's Quality of Work Life Initiative*** has three objectives: to improve employee satisfaction, to strengthen workplace learning, and to better manage change and transition. The desired outcome is improved individual and organizational performance. A variety of actions are being taken to achieve these aims: communications are being improved, with special emphasis on communication between front line supervisors and employees; Internet access is being provided to all employees; a model work life center has been established to provide leadership for strengthening family-friendly policies and programs across the Department; diversity management is

being strengthened; a greater investment is being made in workplace learning, with special emphasis on development of the knowledge and skills that employees need to achieve strategic objectives, and on improvement in the effectiveness of supervisors; and training, consulting, and desktop guides are being provided to executives and managers to help them manage change and transition. The HHS Union-Management Partnership Council, which is chaired by the Deputy Secretary, provides ongoing leadership for the quality of work initiative, and reports annually to the Secretary on improvements in the quality of work life of HHS employees.

HHS Performance Management

Implementation of the Government Performance and Results Act helped the Department shift its management focus from process to results. Other elements are also critical, including employee and manager participation and the use of the Department's evaluation program. The Department has implemented a number of processes, that, taken together, comprise its approach to performance management.

Strategic Goals and Objectives

Strategic goals and objectives are key elements of the HHS performance management system. They set measurable outcomes that the Department will be held accountable for achieving over the six-year period covered by the strategic plan. To achieve them, a variety of HHS program activities are marshaled and deployed. These activities and their role in achieving the goals and objectives are identified in the strategy statements that accompany each strategic goal and objective.

Annual Performance Goals

As required by the Government Performance and Results Act, the Department develops annual performance plans covering each program activity. The goals in the plans represent the annual steps these programs are committed to take longer-term, strategic goals and objectives.

Performance Measurement

Measuring whether the Department is accomplishing its strategic and annual performance goals and objectives is a third critical element underpinning the HHS performance management system. This process begins with choosing realistic performance measures or indicators to assess progress; they will be part of the annual performance plan

submitted with the President's budget request each year. Subsequently, they will be used in both the accountability report and the performance plans to assess how well the Department met its goals for the previous year.

In addition to that assessment of annual goals, the Department will assess progress toward the goals and objectives in the strategic plan annually. Measures for this assessment (success measures) are set forth in the strategic plan and are largely combinations of those that gauge success in achieving the annual performance goals. Other measures may be drawn from existing cross-cutting activities like Healthy People and Presidential and Secretarial initiatives. The success measures set forth in the strategic plan will be continuously refined and improved over time.

Performance Partnerships

The Department remains committed to the development of Performance Partnerships as a better way of managing its grant relationships with state governments. The purposes of these PPGs are to afford state governments more flexibility in program management and to give them and the Department a better accounting of the programs' results. The last Congress did not act on the Administration's requests to convert a number of Centers for Disease Control and Prevention (CDC) categorical programs and the Substance Abuse and Mental Health Services Administration (SAMHSA) block grants into Performance Partnerships. SAMHSA's proposed reauthorization contains "performance partnership block grants" in which state flexibility and capacity to collect performance data are expanded. The Department will continue its efforts to convince the Congress that a PPG model will enable it and the states to get better results from program investments.

In the absence of new legislation, the Department is working with state governments to develop features of the PPG model that can be adopted under current statutes. SAMHSA has already been working with states to develop outcome indicators for substance abuse and mental health. Within the current structure of categorical grants, CDC is working with states to develop health status indicators, uniform data sets, and public health surveillance systems. CDC is also streamlining and improving the accountability mechanisms for its grants. Through these means, CDC can work with states to focus on making grants more flexible while moving toward a system for measuring program performance.

Meanwhile, the Maternal and Child Health Block Grant program (HRSA) has collaborated with its state grantees to develop a set of core performance measures that FY 1998 will become the basis for awarding and monitoring grants under the program,

effectively transforming it into a Performance Partnership.

Additional work is being undertaken with the National Academy of Sciences/National Research Council to identify the improvements needed in federal and state data systems to measure the performance objectives that both the Department and the states believe are critical to monitoring program performance. All of this work has contributed materially to the development of performance objectives and measures for these programs as required under the Government Performance and Results Act.

Managerial Accountability

It is the Department managers who are primarily responsible for aligning program activities and program performance plans to support strategic plan objectives. Manager accountability for achieving strategic and annual performance goals and objectives is being reinforced through the Department's performance appraisal system.

Evaluation Studies

Information gained from evaluation studies, policy research, analysis of databases, and other sources of information on health and human services played a large role in the development of the HHS strategic plan. It was used to identify critical health and human service issues and to develop the best available strategies for addressing them in the HHS strategic plan.

The capabilities and resources at HHS to conduct evaluations also will play an important role in the Department's performance management system and in the continuing implementation of the Government Performance and Results Act. The Office of the Secretary has the chief responsibility for coordinating projects that focus on one or more aspects of strategic planning and performance management. Evaluation projects will be used in support of performance management and the Government Performance and Results Act in the following ways:

Developing Performance Measures. Since the passage of the Government Performance and Results Act in 1993, HHS evaluation resources have been used to examine ways to measure the performance of program activities. For example, the Department recently completed a substantial effort to develop public health performance measures for activities within the Substance Abuse and Mental Health Services Administration and the Centers for Disease Control and Prevention. Work in this area will continue.

Also, although we select performance measures to assess program outcomes, we need to continually assess the measures and the data they use to ensure their validity and accuracy. Evaluation resources at HHS will contribute to these types of assessments.

Building Data Capacity. Evaluation resources will also be used to install new data systems to support performance measurement. Moreover, as HHS developed its strategic plan, it became clear that some existing systems needed modification or expansion. For example, the Department's performance measurement system for the Healthy People 2000 Goals and Objectives is under development and expansion. At the 1995 mid-course review, HHS reported that 29 percent of the 300 objectives of that program lacked adequate data for measuring progress. Since 1995 the Department has continued to invest evaluation resources in measuring those objectives so that today adequate data are lacking for only 18 percent of the now 319 health outcome objectives.

In addition, the HHS Data Council is working to prepare a Survey Integration Plan to bring all major health surveys within HHS into a coordinated strategy and integrated framework. The plan includes redesign and automation of the National Health Interview Survey (NHIS) to serve as the sampling "nucleus" for many HHS population surveys. Already implemented in the plan is the longitudinal panel survey on insurance and expenditures -- the Medical Expenditures Panel Survey (MEPS) — which uses the 1995 National Health Interview Survey as a sampling frame. The council has also initiated a consolidation of HHS's surveys of employers, like the National Employer Health Insurance Survey and the insurance follow-up component to the medical expenditure survey. The council's plan will include strategies for obtaining state-level data, such as the possibility of developing modular designs for the Department's national surveys. The new designs will facilitate state-level estimates and afford states a way to participate in national survey efforts to meet their own needs, as well as serving the Department's needs, for better performance measurement.

These examples illustrate the type of investment of evaluation resources that will continue across the Department. A fuller discussion of the challenge data pose in performance management is provided in the introduction to the plan.

Assessing Program Impact on Performance Outcomes. In the last category of activity, HHS will use evaluation resources to explore the relationships among performance data, program activities, and the outcomes of services to HHS target populations or service customers. Although such outcome data can indicate the direction and magnitude of change over time, it is difficult to determine the precise contribution of HHS program activities to the achievement of a strategic objective, especially since it is often made in

partnership with state and local programs. Evaluation resources will be used to determine this cause-effect relationship.

Schedule of Future Evaluation

Information about recently completed HHS evaluations and a discussion of evaluations to be completed in future years is reported in the Department's annual report on evaluations, *Performance Improvement 1997: Evaluation Activities of the U.S. Department of Health and Human Services*. The report is available through HHS's World Wide Web server (http://www.os.dhhs.gov). Abstracts of all evaluation projects in progress and their expected dates of completion are also accessible on the HHS Home Page in a searchable database maintained by the Office of the Assistant Secretary for Planning and Evaluation. Projects that are focused on performance measurement and implementation of the Government Performance and Results Act are listed in the report index.

SPECIAL

Total Pages: ____

LRM ID: CJB94

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

Wednesday, August 20, 1997

LEGISLATIVE REFERRAL MEMORANDUM

TO:	Legislative Liaison Officer - See Distribution below
FROM:	Janet R. Forsgren (for) Assistant Director for Legislative Reference
OMB CONTACT:	William L. Dorotinsky PHONE: (202)395-7790 FAX: (202)395-3910
SUBJECT:	**HHS 1997 Strategic Plan (GPRA)**
DEADLINE:	**Tuesday, September 2, 1997**

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. **Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.**

COMMENTS: HHS has distributed copies of this plan directly to all cabinet departments. It has also been sent to the heads of all OMB divisions.

Agencies: Please provide copies of the report to your agency's GPRA strategic plan coordinator (see attached list of contacts.)

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LRM ID: CJB94 **SUBJECT:** HHS 1997 Strategic Plan (GPRA)

RESPONSE TO
LEGISLATIVE REFERRAL
MEMORANDUM

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet. If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:

(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or

(2) sending us a memo or letter

Please include the LRM number shown above, and the subject shown below.

TO: William L. Dorotinsky Phone: 395-7790 Fax: 395-3910
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FROM: _____ (Date)

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_____ (Agency)

_____ (Telephone)

The following is the reponse of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this reponse sheet

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