U.S. Department of Health and Human Services
FY 2023 Annual Performance Plan

Message from the Acting Performance Improvement Officer of the U.S. Department of Health and Human Services

The U.S. Department of Health and Human Services (HHS) supports and implements programs that enhance the health, safety, and well-being of the American people. In accordance with the Government Performance and Results Act (GPRA) of 1993, as amended in the GPRA Modernization Act (GPRAMA) of 2010, I am pleased to present the Fiscal Year 2023 Annual Performance Plan, documenting the Department's performance plans for the upcoming year. HHS provides further information detailing HHS performance at Performance.gov.

HHS is monitoring more than 900 performance measures to manage and improve the efficiency and effectiveness of departmental programs and activities. This report includes a representative set of performance measures which will be used to illustrate progress toward achieving the Department's strategic goals under HHS' new Strategic Plan for FY 2022-2026. The representative set of measures and discussion in this report spans the Department's 11 operating divisions and 14 staff divisions and includes work done across the country and throughout the world.

Each HHS division has reviewed its submission and as required by law I confirm, based on certifications from the divisions, that the data are reliable and complete. When targets or results are not available because of delays in data collection, the report notes the date when the results will be available. Where known, impacts of the COVID-19 pandemic on HHS performance results are also identified in this report. As additional data becomes available, HHS will continue to update the information on those impacts in future reports. The targets presented here demonstrate that HHS has set strong goals across a wide range of activities.

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U.S. Department of Health and Human Services

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Overview

The U.S. Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services. HHS is tackling major challenges facing our country today, including the COVID-19 pandemic, increasing numbers of Unaccompanied Migrant Children, climate change, the opioid and substance use crisis, health inequality between this country's diverse populations, and more.

HHS works closely with other federal departments and international partners to coordinate efforts and ensure the maximum benefit for the public throughout its work. HHS also works with state, local, and U.S. territorial governments to achieve its mission. The Federal Government has a unique legal and political government-to-government relationship with tribal governments and provides health services for American Indians and Alaska Natives consistent with this special relationship. HHS works with tribal governments, urban Indian organizations, and other tribal organizations to facilitate greater consultation and coordination between state and tribal governments on health and human services.

HHS also has strong partnerships with the private sector and nongovernmental organizations. The Department works with industries, academic institutions, trade organizations, and advocacy groups to leverage resources from organizations and individuals with shared interests. By collaborating with these partners, HHS accomplishes its mission in ways that are the least burdensome and most beneficial to the American public. Private sector grantees, such as academic institutions and faith-based and neighborhood partnerships, often provide HHS-funded services at the local level.

The Annual Performance Plan provides information on the Department's planned measures of progress towards achieving the goals and objectives described in the newly developed HHS Strategic Plan for FY 2022-2026. This document first provides the HHS Mission Statement and the HHS Organizational Structure. The Annual Performance Plan provides an overview of Cross-Agency Priority Goals, Strategic Goals, Agency Priority Goals, Performance Management, and Strategic Reviews. The plan then provides historical results and upcoming targets for the performance measures under each Strategic Objective, as well as an explanation for how the program will accomplish each target for FY 2023. Finally, the Plan details evidence building efforts at HHS, cross-government collaborations, and major management priorities for HHS.

Mission Statement

The mission of the U.S. Department of Health and Human Services is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

HHS Organizational Structure

The Department includes 11 OpDivs that administer HHS programs:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

In addition, 14 StaffDivs and the Immediate Office of the Secretary (IOS) coordinate Department operations and provide guidance to the operating divisions:

- Assistant Secretary for Administration (ASA)
- Assistant Secretary for Financial Resources (ASFR)
- Assistant Secretary for Health (OASH)
- Assistant Secretary for Legislation (ASL)
- Assistant Secretary for Planning and Evaluation (ASPE)
- Assistant Secretary for Preparedness and Response (ASPR)
- Assistant Secretary for Public Affairs (ASPA)
- Departmental Appeals Board (DAB)
- Office for Civil Rights (OCR)
- Office of Global Affairs (OGA)
- Office of Inspector General (OIG)
- Office of Medicare Hearings and Appeals (OMHA)
- Office of the General Counsel (OGC)
- Office of the National Coordinator for Health Information Technology (ONC)

The HHS organizational chart is available at http://www.hhs.gov/about/orgchart/.

Cross-Agency Priority Goals

Per the GPRAMA requirement to address Cross-Agency Priority (CAP) Goals in the agency strategic plan, the annual performance plan, and the annual performance report, please refer to www.Performance.gov for the agency's contributions to those goals and progress, where applicable.

Strategic Goals Overview

HHS recently developed the HHS Strategic Plan FY 2022-2026. The strategic goals and strategic objectives will be included in the FY 2023 Annual Performance Plan and posted here: https://www.hhs.gov/about/strategic-plan/index.html.

The five strategic goals are:

Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.
Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes.
Goal 3: Strengthen Social Well-being, Equity and Economic Resilience.
Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All.
Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability.

Agency Priority Goals

HHS recently developed the FY 2022-2023 Agency Priority goals. The five goals include:

- **Behavioral Health:** Increase equitable access to and utilization of prevention, treatment, and recovery services to improve health outcomes for those affected by behavioral health conditions.
    - By September 30, 2023, increase by 15% over a baseline of 1,015,386 the number of unique patients dispensed prescriptions for buprenorphine from retail pharmacies in the U.S. and 15% over a baseline of 324,126 the number of prescriptions dispensed for naloxone in U.S. outpatient retail and mail-order pharmacies.
    - By September 30, 2023, increase by 20% the number of individuals referred for behavioral health services by SAMHSA grantees engaged in screening and assessment.
- **Child Well-Being:** By September 30, 2023, HHS will improve child well-being, especially in underserved or marginalized populations and communities.
- **Emergency Preparedness:** While promoting equitable access, strengthen the systems for domestic and global health, human services, and public health to protect the nation's well-being before, during, and after disasters and public health emergencies. By September 30, 2023, HHS will complete 4 projects, establish a new ASPR office, and increase by at least 10% key deliverables to increase resources that develop and improve the national capacity of public health, human services, and global health disaster management entities to respond equitably to emerging threats and emergency incidents above FY 2020.
- **Equity:** Advance progress towards equity in health and human services by optimizing opportunities and access for underserved and marginalized populations and addressing drivers of inequities throughout the life course in order to remove barriers, reduce disparities, and

improve outcomes. By September 30, 2023, initiate at least 10 equity assessments on HHS policies and activities and identify potential actions for improvement.

- **Maternal Health:** Improve maternal health and advance health equity across the life course by assuring the equitable provision of evidence-based high-quality care and addressing racism, discrimination, and other biases. By September 30, 2023, HHS will:
    - increase by 10% the number of hospitals participating in Perinatal Quality Collaboratives engaged in data-informed quality improvement efforts to address the drivers of maternal mortality and achieve equity;
    - increase by 10% the number of birthing facilities that are participating in the Alliance for Innovation on Maternal Health; and
    - increase by 20% the number of pregnant and postpartum people, their support networks, and providers reached by HHS messages about urgent maternal warning signs.

Performance Management

Performance goals and measures are powerful tools to advance an effective, efficient, and productive government, while being accountable for achieving program outcomes. HHS regularly collects and analyzes performance data to inform decisions, to gauge meaningful progress towards objectives, and to identify more cost-efficient ways to achieve results. Responding to opportunities afforded by GPRAMA, HHS continues to institute significant improvements in performance management, including:

- Developing, analyzing, reporting, and managing agency priority goals and conducting performance reviews between HHS component staff and HHS leadership to monitor progress towards achieving key performance objectives.
- Conducting the Strategic Reviews process to support decision-making and performance improvement across the Department.
- Coordinating performance measurement, budgeting, strategic planning, and enterprise risk management activities within the Department.
- Fostering a network of component Performance Officers who support, coordinate, and implement performance management efforts across HHS.
- Sharing best practices in performance management at HHS through webinars and other media.

Strategic Review

GPRAMA aligned agency strategic planning cycles to presidential election cycles and administrative transitions. As a result, the administration established HHS's FY 2022–2026 Strategic Plan with a set of strategic priorities that began in FY 2022. Strategic review summaries and categorizations of progress

accompanying HHS's strategic objective descriptions will be reported in future HHS Annual Performance Reports.

Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare

HHS works to protect and strengthen equitable access to high quality and affordable healthcare. Increasing choice, affordability and enrollment in high-quality healthcare coverage is a focus of the Department's efforts in addition to reducing costs, improving quality of healthcare services, and ensuring access to safe medical devices and drugs. HHS also works to expand equitable access to comprehensive, community-based, innovative, and culturally- and linguistically-appropriate healthcare services while addressing social determinants of health. The Department is driving the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families. HHS also bolsters the health workforce to ensure delivery of quality services and care.

Objective 1.1: Increase choice, affordability, and enrollment in high-quality healthcare coverage

HHS supports strategies to increase choice, affordability, and enrollment in high-quality healthcare coverage. HHS promotes available and affordable healthcare coverage to improve health outcomes in our communities and empowers consumers with high quality healthcare coverage choices. The Department also leverages knowledge and partnerships to increase enrollment in health insurance coverage.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, AHRQ, ASPE, CMS, HRSA and OASH. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 1.1 Table of Related Performance Measures

Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid (Lead Agency - CMS; Measure ID - CHIP 3.3)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	45.3 million children[1]	46.1 million children[2]	46.4 million children[3]	46.6 million children[4]	46.7 million children[5]	46.7 million children[6]	46.2 million children[7]	44.5 million children[8]

[1]Medicaid 36,217,330/ CHIP 9,054,332
[2]Medicaid 36,850,065/CHIP 9,212,516
[3]Medicaid 37,152,321/CHIP 9,288,080
[4]Medicaid 37,245,202/CHIP 9,311,300
[5]Medicaid 37,338,314/CHIP 9,334,579
[6]Medicaid 37,338,314/CHIP 9,334,579
[7] Medicaid 35,720,173/CHIP 8,930,043
[8] Medicaid 35,391,786/CHIP 9,147,083

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Result	46.0 million [9]	46.3 million children[10]	46.0 million children[11]	44.7 million children[12]	44.1 million children[13]	Mar 31, 2022	Mar 31, 2023	Mar 31, 2024
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Pending	Pending	Pending

The purpose of this measure is to increase enrollment in CHIP and Medicaid from 43,542,385 children in FY 2011 to 44,538,869 children by the end of FY 2023. The agency's enrollment target for FY 2023 takes into consideration that the prior FY enrollment targets have not been met since FY 2017, and that the majority of eligible children are enrolled in Medicaid and CHIP. The remaining uninsured children are the hardest to reach. Under the CHIP and Medicaid programs, States submit quarterly and annual statistical forms, which report the number of children who are enrolled in Medicaid, separate CHIP programs, and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year, and are not reflective of point-in-time enrollment.

The FY 2020 enrollment result as of June 23, 2021 is 44,259,975 children enrolled in Medicaid and CHIP, which does not meet the FY 2020 enrollment target of 46,672,893 children enrolled in Medicaid and CHIP. The program specific enrollment targets of 37,338,314 children enrolled in Medicaid and 9,334,579 children enrolled in CHIP were also not met by the enrollment results, which indicate that 35,197,225 children were enrolled in Medicaid, and 9,062,750 children were enrolled in CHIP during FY 2020.

The FY 2020 enrollment results should be considered in the context of a recent Urban Institute Analysis highlighting 2019 data that show that nationally, 91.9 percent of children eligible for Medicaid and CHIP are enrolled in these programs, with participation rates at or above 90 percent in 36 states.

CMS has seen continuous enrollment declines through calendar year 2019 and into early calendar year 2020. This was largely due to factors such as a strong economy, state systems and operational issues, and reducing backlog of delayed redeterminations. It is important to note that many states' enrollment totals were impacted by changes to policies and state operations as a result of the COVID-19 public health emergency (PHE). For example, the Families First Coronavirus Response Act (FFCRA) makes available to states a temporary 6.2 percent Federal Medical Assistance Percentage (FMAP) bump that includes a requirement to maintain Medicaid enrollment (for continuous coverage requirement) starting in March 2020. This requirement increased retention in Medicaid and potentially reduced churn in and out of the Medicaid program throughout the second half of FY 2020. CMS anticipates an increase in the Medicaid and CHIP enrollment total for FY 2021, as data submitted by states for this timeframe should reflect the growth in enrollment due to policy changes in response to the COVID-19 PHE mentioned above. CMS issued guidance on resuming normal operations related to processing renewals following

[9]Medicaid 37,080,521/CHIP 8,900,074
[10]Medicaid 36,862,057/CHIP 9,460,160
[11]Medicaid 36,287,063/CHIP 9,632,367
[12] Medicaid 35,090,387/CHIP 9,654,742
[13] Medicaid 35,055,383/CHIP 9,043,038

the end of the PHE on March 3, 2022, and is providing intensive technical assistance to states on this process.

With 91.9 percent of eligible children enrolled in Medicaid and CHIP in 2019, effective and targeted strategies are needed to enroll the remaining 8.1 percent of eligible uninsured children. Continuous coverage in Medicaid as required by the FFCRA is expected to increase enrollment and retention of children in Medicaid throughout FY 2021 and moving forward for the duration of the COVID-19 PHE.

Increase the number of tables per year added to the MEPS table series (Lead Agency - AHRQ; Measure ID - 1.3.19)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	8,162 total tables in MEPS table series	8,609 total tables in MEPS table series	9,199 total tables in MEPS table series	9,627 total tables in MEPS table series	10,136 total tables in MEPS table series	10,707 total tables in MEPS table series	11,431 total tables in MEPS table series	11,681 total tables in MEPS table series
Result	8,359 total tables in MEPS table series	8,949 total tables in MEPS table series	9,377 total tables in MEPS table series	9,886 total tables in MEPS table series	10,457 total tables in MEPS table series	11,181 total tables in MEPS table series	Sep 30, 2022	Sep 30, 2023
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The Medical Expenditure Panel Survey – Household Component (MEPS HC) Tables Compendia has recently been updated moving to a more user friendly and versatile format (https://meps.ahrq.gov/mepstrends/home/index.html). Interactive tables are provided for the following: use, expenditures, and population; health insurance, accessibility, and quality of care; medical conditions and prescribed drugs. The new format greatly expands the number of tables generated dependent on the parameters entered by the user.

The MEPS Tables Compendia is scheduled to be expanded a minimum of 250 tables per year. For the Insurance Component there are a total of 3,410 national level tables and 6,475 state and metro area tables. Additionally, there are 1,296 tables available for the MEPS Household Component. The total number of tables available to the user population is currently 11,181.

The MEPS Tables Compendia is a source of important data that is easily accessed by users. Expanding the content and coverage of these tables furthers the utility of the data for conducting research and informing policy. Currently data are available in tabular format for the years 1996 – 2019. This represents over twenty years of data for both the Household and Insurance Components, enabling the user to follow trends on a variety of topics.

Number of patients served by health centers (Lead Agency - HRSA; Measure ID - 1010.01)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	25.5 million	25.7 million	26 million	27.2 million	28.6 million	29.8 million	29.8 million	30.0 million
Result	25.9 million	27.2 million	28.4 million	29.8 million	28.6 million	Aug 1, 2022	Aug 1, 2023	Aug 1, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	Pending	Pending

For more than 50 years, HRSA funded health centers have delivered affordable, accessible, quality, and cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become an essential primary care provider for millions of people across the country. Health centers advance a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, behavioral health, and patient support/enabling services. Today, approximately 1,400 health centers operate over 13,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Historically, success in increasing the number of patients served by health centers has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics.

In 2020, health centers served 28.6 million patients, a reduction of approximately 1.2 million patients, or 4 percent, due to the impact of the COVID-19 pandemic on the operations of health centers nationwide. To ensure our nation's underserved communities and those disproportionately affected by COVID-19 are equitably vaccinated against COVID-19, HRSA in partnership with the Centers for Disease Control and Prevention (CDC) developed the Health Center COVID-19 Vaccine Program to directly allocate COVID-19 vaccines to HRSA-supported health centers. Through this program, millions of people living in the nation's medically underserved communities and those disproportionately affected by COVID-19 have received vaccines. As the impacts of COVID-19 are resolved through national mitigation and resolution strategies, health centers are projected to return to pre-pandemic patient levels.

Percentage of Health Center patients who are at or below 200 percent of poverty (Lead Agency - HRSA; Measure ID - 1010.10)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	91%	91%	91%	91%	91%	91%	91%	91%
Result	92%	91%	91%	91%	91%	Aug 1, 2022	Aug 1, 2023	Aug 1, 2024
Status	Target Exceeded	Target Met	Target Met	Target Met	Target Met	Pending	Pending	Pending

HRSA funded health centers deliver affordable, accessible, quality, and cost-effective primary health care to patients regardless of their ability to pay. Health centers emphasize coordinated primary and preventive services that promote reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved populations. In FY 2020, approximately 91 percent of health center patients were individuals or families living at or below 200 percent of the Federal Poverty Guidelines, as compared to approximately 26 percent of the U.S. population as a whole. The FY 23 target is set based on historical program trends of the composition of health center patients.

Objective 1.2: Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs

HHS supports strategies to reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs for everyone. HHS develops and implements payment models in partnership with healthcare providers and establishes other incentives to improve quality care while reducing healthcare spending. HHS implements and assesses approaches to improve healthcare quality, and address disparities in healthcare quality, treatment, and outcomes. The Department also improves patient safety, strengthens access to safe and effective medical products and devices, and expands approaches to safely exchange information among patients, providers, and payers.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, ASPE, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, ONC, and SAMHSA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 1.2 Table of Related Performance Measures

Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-Low Income Subsidy (LIS) Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap (Lead Agency - CMS; Measure ID - MCR23)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	48 %	43 %	37 %	28 %	25 %	25 %	25 %	25 %
Result	48 %	42 %	36.7 %	27 %	Apr 30, 2022	Apr 30, 2023	Apr 30, 2024	Apr 30, 2025
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

The Medicare Prescription Drug Improvement and Modernization Act of 2003 amends Title XVIII of the Social Security Act by adding a Voluntary Prescription Drug Benefit Program (Medicare Part D). Since its inception, Medicare Part D has significantly increased the number of beneficiaries with comprehensive drug coverage and enhanced access to medicines.

While Medicare Part D offers substantial insurance coverage for prescription drugs, beneficiaries pay a deductible and cost-sharing amounts that vary depending on the benefit coverage phase. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit did Medicare coverage recommence. This is known as the coverage gap (or "donut hole"). The Affordable Care Act began closing the coverage gap phase through a combination of manufacturer discounts and gradually increasing federal subsidies until it closed in 2020. The discount applies at the point of sale, and both the beneficiary cost sharing and the manufacturer discounts count toward the annual out-of-pocket threshold (known as True Out-of-Pocket Costs). This performance measure reflects CMS's effort to reduce the average out-of-pocket costs paid by non-Low Income Subsidy Medicare beneficiaries while in the coverage gap, reached once the combined amount a beneficiary and their drug plan pay for prescription drugs reaches a certain level. Starting in 2020, non-LIS beneficiaries, who reach this phase of Medicare Part D coverage pay no more than 25 percent of costs for all covered Part D drugs. CMS's tracking of this measure has shown that that in most years non-LIS out-of-pocket costs have decreased beyond the targets required by statute (2019 exceeded the target goal).

Increase the percentage of Medicare healthcare dollars tied to Alternate Payment Models (APMs) incorporating downside risk (Lead Agency - CMS; Measure ID - MCR36)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	Set Baseline	30 %	40 %	TBD[14]	TBD[15]
Result	N/A	N/A	N/A	20.21 %	24.2%1	Dec 15, 2022	TBD	TBD
Status	Not Collected	Not Collected	Not Collected	Baseline	Pending	Target Not Met	Pending	Pending

CMS identifies, tests, evaluates, and expands, as appropriate, innovative payment and service delivery models that can reduce Medicare, Medicaid, and the Children's Health Insurance Program expenditures while improving or preserving beneficiary health and quality of care. Under this authority, CMS is testing a variety of alternative payment models (APMs) that create new incentives for clinicians to deliver better care at a lower cost and reward quality and efficiency of care.

Medicare is leading the way by publicly announcing, tracking, and reporting payments tied to APMs that are taking on a downside risk, while working through the Health Care Payment Learning and Action Network (HCP-LAN or LAN) to ensure that its large group of payers, providers, purchasers, patients, product manufacturers, and policymakers across the United States also adopt aligned goals to move towards downside risk APMs.

The final CY 2019 baseline for this new downside risk APM goal is 20.21 percent. The FY 2020 target was not met due to the unprecedented impact of the COVID-19 pandemic, more limited opportunities

[14] "Result" date and "Target" have been updated to reflect (TBD) due to the unknown impacts of the Coronavirus (COVID-19) pandemic. CMS cannot fully commit to specific future result dates at this time.

[15]. Due to a strategic refresh, CMS will reevaluate future targets for this goal during the fall of 2021.

for enrollment in new CMMI models, and a plateauing of participation in the Medicare Shared Savings Program. On October 20, 2021, CMS published a white paper detailing CMS's vision for the next 10 years (Innovation Strategy Refresh). As part of this strategic refresh, CMMI is reevaluating the methodology for this measure and future targets to ensure alignment with the new 10-year Medicare goal and target to have all beneficiaries in a care relationship with accountability for quality and total cost of care by 2030.

Review and act on 90 percent of standard original Abbreviated New Drug Application (ANDA) submissions within 10 months of receipt. (Lead Agency - FDA; Measure ID - 223215)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	75% within 15 months	90% within 10 months	90%	90%	90%	90%	90%	90%
Result	98%	96%	96%	97%	95%	Feb 28, 2023	Feb 29, 2024	Feb 28, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

The goal of Generic Drug User Fee Amendments (GDUFA) II is to enhance the efficiency of the generic drug review process, promote transparency between FDA and generic drug sponsors, and enhance access to high-quality, lower cost generic drugs. Through the reauthorization of the GDUFA program in 2017 (GDUFA II), FDA acquired additional performance goals and higher expectations for program enhancements and approvals. The value of this investment in the Generic Drug Review program is reflected by FDA's performance on its review goals under GDUFA and FDA's commitment to meet shorter review goals (8 months) for priority submissions under GDUFA II. Despite the unforeseen challenges due to the COVID-19 pandemic, having to transition to a remote work environment with an increased workload due to the expedited development and review of generic drug products to help address the public health emergency, FDA rose to the challenge and maintained its high level of performance in meeting GDUFA's goals and initiatives. HHS is confident that the new processes introduced through GDUFA II and activities taken under FDA's Drug Competition Action Plan will continue to help reduce review cycles, to improve approval times, and to boost competition, helping to ensure that safe, effective, high-quality generic drug products are available to the American public.

Increase the cumulative number of evidence-based resources and tools available to improve the quality of healthcare and reduce the risk of patient harm. (Lead Agency - AHRQ; Measure ID - 1.3.41)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	162 tools	177 tools	187 tools	200 tools	225 tools	250 tools	275 tools	300 tools
Result	167 tools	180 tools	191 tools	204 tools	225 tools	250 tools	Sep 30, 2022	Sep 30, 2023
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Target Met	Pending	Pending

A major output of the Patient Safety Portfolio is the availability of evidence-based resources and tools that can be utilized by healthcare organizations to improve the care they deliver, and, specifically, patient safety. An expanding set of evidence-based tools is available as a result of ongoing investments to generate knowledge through research and synthesize and disseminate this new knowledge in the optimal format to facilitate its application.

The Agency continues provide many and a large variety of resources and tools to improve patient safety. Examples include:

- AHRQ Patient Safety Network (AHRQ PSNet) & Web M&M (Morbidity and Mortality Rounds);
- AHRQ Question Builder App;
- AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention;
- Common Formats (standardized specifications for reporting patient safety events);
- Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families;
- Healthcare Simulation Dictionary, Second Edition;
- Making Healthcare Safer III Report; Primary Care-Based Efforts To Reduce Potentially Preventable Readmissions;
- *Reducing Diagnostic Errors in Primary Care Pediatrics* (Project RedDE!);
- Re-Engineered Discharge (RED) Toolkit;
- Toolkit To Improve Antibiotic Use in Acute Care Hospitals;
- Understanding Omissions of Care in Nursing Homes.

The Patient Safety Portfolio is projecting that the number of evidence-based resources and tools will continue to increase with a projected cumulative number of 275 in FY 2022 and 300 in FY 2023.

Percentage of health centers with at least one site recognized as a patient centered medical home (Lead Agency - HRSA; Measure ID - 1010.11)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	65%	65%	65%	65%	70%	75%	75%	76%
Result	66%	67%	75%	76%	76%	77%	Dec 15, 2022	Dec 15, 2023
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

HRSA funded health centers improve health outcomes by emphasizing the care management of patients with multiple health care needs and the use of key quality improvement practices, including health information technology. HRSA's Health Center Program Patient Centered Medical Home (PCMH) Initiative supports health centers to achieve national PCMH recognition, an advanced model of primary care using a team-based approach to improve quality through coordination of care and patient engagement. Seventy-seven percent of health centers are currently recognized by national accrediting organizations as Patient Centered Medical Homes.

PCMH recognition assesses a health center's approach to patient-centered care and evaluates health centers against national standards for primary care that emphasize care coordination and on-going quality improvement. PCMH recognition increases health outcomes, improves health equity, and lowers

costs for patients and health centers, and has become a standard of care for HRSA funded health centers. This target was set based on recent data and trends, and on budget projections of no increased targeted funding to support additional PCMH expansion.

Increase the number of communities that have access to tele-behavioral health services where access did not exist in the community prior to Telehealth Network Grant Program grant (Lead Agency - HRSA; Measure ID - 6070.01)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	No Target	No Target	No Target	No Target	TBD
Result	N/A	N/A	N/A	176	74	Dec 31, 2022	Dec 31, 2023	Dec 31, 2024
Status	Not Collected	Not Collected	Not Collected	Historical Actual	Historical Actual	Pending	Pending	Pending

HRSA's Office for the Advancement of Telehealth (OAT) has several programs that allow grantees to focus entirely, or in part, on expanding access to telebehavioral services in rural and underserved communities. This is a developmental measure that reflects programs with different focus areas and cohorts. For example, for FY 2019, these results include the School-based Telehealth Network Grant Program and Substance Abuse Treatment Telehealth Network Grant Program, which were discontinued after FY 2019. For FY 2020, these results include the Emergency Medical Services Telehealth Network Grant Program and the Evidence-based Tele-behavioral Network Program. Measure results will vary from year-to-year due to expected turnover in grantee cohorts and focus areas, and targets will need to be evaluated on an ongoing basis. OAT plans to identify result trends to establish future targets in FY 2023 based on a three-year average.

For the Title X program, # of unduplicated clients receiving high-quality services through the program. (Lead Agency – OASH; Measure ID – 8000.07)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	4,672,000	4,259,000	4,000,000	3,991,000	4,018,000	3,300,000	3,500,000	4,250,000
Result	4,007,552	4,004,246	3,939,749	3,095,666	1,536,743	Sep 30, 2022	Sep 30, 2023	Sep 30, 2024
Status	Not Met	Not Met	Not Met	Not Met	Not Met	--	--	--

The Title X Family Planning program is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. Enacted in 1970 as part of the Public Health Service Act, the Title X program is designed to provide access to contraceptive services, supplies, and information to all who want and need them. By law, priority is given to persons from low-income families.

The program's performance measures focus on increasing access to high-quality care and serving individuals and families from underserved, vulnerable and low-income populations, gauging the extent to which Title X expands the availability of quality healthcare to the public. Performance measurement

guides program strategies; establishes directions for technical assistance, and directs revisions to program policies. This enables Title X to better address program performance and facilitates methods to increase efficiency in the delivery of preventive healthcare services.

Of particular importance, Title X service grantees provide high-quality contraceptive counseling and care, recommended chlamydia screening, screening for undiagnosed cervical tissue abnormalities, preconception care and counseling, basic infertility services, pregnancy testing and counseling, adolescent services and related education and counseling. These services, along with community-based education and outreach, assist individuals and families with pregnancy leading to healthy birth outcomes and prevention of unintended pregnancy. The target and data collection efforts around unduplicated clients served through the Title X program helps track core performance aligned with Title X's mission.

The marked decrease in Title X performance between 2020 and 2019 is attributable to two main factors: the 2019 Final Rule and the COVID-19 pandemic. On March 3, 2019, HHS issued a Final Rule that revised Title X regulations governing several aspects of how Title X-funded projects deliver family planning

care. The implementation of the 2019 Title X Final Rule led to 19 grantees (and their networks) immediately withdrawing from the program; 18 other grantees reported losses to their service networks. These departures significantly reduced the Title X service network. While supplemental awards were made to compensate for these departures; the program experienced a net decrease of more than 1,000 service sites. Additionally, the emergence of the novel coronavirus in 2020 created a public health emergency that affected all aspects of healthcare delivery, which varied in both scope and duration, severely disrupting Title X clinical operations.

In October 2021, the Department amended the Title X Family Planning regulations to restore access to equitable, affordable, client-centered, quality family planning services for more Americans. Aligned with the new program policies, performance targets have been established to restore the breadth of client access that is central to Title X's mission.

Objective 1.3: Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services, while addressing social determinants of health

HHS invests in strategies to expand equitable access to comprehensive, community-based, innovative, and culturally- and linguistically-appropriate healthcare services while addressing social determinants of health. HHS supports community-based healthcare services to meet the diverse healthcare needs of underserved populations while removing barriers to access to advance health equity and reduce disparities. The Department also works to understand how to best address social determinants of health in its programs.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, AHRQ, ASPE, CDC, CMS, HRSA, IHS, NIH,

SAMHSA, OASH, and OCR. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 1.3 Table of Related Performance Measures

Public Health Nursing (PHN): Total number of IHS public health activities captured by the PHN data system; emphasis on primary, secondary, and tertiary prevention activities to individuals, families, and community groups. (Lead Agency - IHS; Measure ID - 23)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	390,556	381,314	381,314	381,314	381,314	330,000	411,325	TBD
Result	370,556	362,358	329,980	324,391	391,738	428,476	Jan 31, 2023	Jan 31, 2024
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending

The Indian Health Service (IHS) Public Health Nursing (PHN) Program provides critical support for health care services in the tribal communities served. PHNs are licensed, professional nursing staff that support population-focused services to promote healthier communities through community based direct nursing services, community development, and health promotion and disease prevention activities. The PHN Program expands access to comprehensive, community-based, innovative, and culturally-competent healthcare services. One way the PHN Program measures this intervention is through monitoring the total number of individual public health encounters documented in the electronic health record and reported by the PHN data mart system with an emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups. The FY 2021 target for the PHN Program measure was 330,000 encounters. The final FY 2021 result of 428,476 patient encounters exceeded the target by 98,476 encounters, a 30 percent increase. During the IHS COVID-19 pandemic response, PHNs reported critical patient encounters for communicable disease, surveillance, contact tracing, testing, patient monitoring, and vaccination activities. These efforts resulted in an overall increase in the number of PHN activities reported for community nursing services to address the COVID-19 crisis. Prior to FY 2020, the PHN program did not meet the established targets due to anticipated Tribal programs migrating away from reporting to the IHS Resource and Patient Management System. The PHN Program shares data, such as provider productivity and the number of health care delivery services provided, to inform I/T/U decision-making and promote data reporting. Efforts are underway to improve PHN data reports.

The PHN program uses key evidence-based strategies in delivering services. PHNs improve care transitions by providing patients with tools and support that promote self-management of their condition as they transition from the hospital/clinical setting to home. The PHN expertise in communicable disease assessment, outreach, investigation, and surveillance, aids in the management and prevention of the spread of communicable diseases. PHNs contribute to several primary prevention efforts such as providing community immunization clinics, administering immunizations to homebound AI/AN individuals, and through public health education, encouraging AI/AN people to engage in healthy lifestyles and ultimately live longer lives. PHNs provide nurse home visiting services via referral for such activities as follows: maternal and pediatric populations, including childhood obesity prevention through breastfeeding promotion, screening for early identification of developmental problems, and parenting education; elder care services including safety assessment and health maintenance care; chronic disease care management; and communicable disease investigation and follow up. The PHN program works to

improve the overall wellness of AI/AN people by using a variety of methods to educate the AI/AN population such as, individual and group patient education sessions, screening activities and referring high-risk patients, and immunizing individuals to prevent illnesses. PHNs provide valuable preventative health care service to the AI/AN population by promoting healthy lifestyles and providing early treatment for illnesses.

Percentage of underserved population accessing mental health and substance use services. (Lead Agency – SAMHSA; Measure ID –3.4.15)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	66%	66%	54%	65%	64%	64%	64%	64%
Result	54%	55%	65%	64%	64%	April 30, 2022	April 30, 2023	April 30, 2024
Status	Target Not Met	Target Not Met	Target Exceeded	Target Not Met	Target Met	Pending	Pending	Pending

The PATH program serves individuals with serious mental illness (SMI), or with SMI and a co-occurring substance use disorder, who are homeless or at risk of homelessness. The PATH program offers an array of essential services and supports, including community mental health services. A significant aspect of the PATH program that may not be supported by traditional mental health programs or funding is extensive outreach activity to build relationships with hard to reach homeless populations and link them to needed services. PATH providers ensure that the PATH-eligible clients receive treatment and recovery services either through the PATH program, Medicaid or other funding sources. SAMHSA encourages PATH providers at the local level to work with HUD continuums of care to ensure PATH eligible clients will be prioritized for HUD housing vouchers. SAMHSA will encourage grantees (states) to provide supportive services for those who are at risk of housing instability. The combination of linkage to essential services, such as community mental health, and housing supportive services is important for the attainment and maintenance of housing stability for the people served by this program

Targets were set for FY 2023 based on the FY 2020 target. The number of people experiencing homelessness has remained steady over the years.

Increase the likelihood that the most vulnerable people receiving Older Americans Act Home and Community-based and Caregiver Support Services will continue to live in their homes and communities. (Lead Agency - ACL; Measure ID - 2.10)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	63 weighted average	63.25 weighted average	63.25 weighted average	63.6 weighted average	64 weighted average	64.7 weighted average	64.3 weighted average	64.3 weighted average
Result	63.6 weighted average	63.7 weighted average	66.7 weighted average	66.64 weighted average	Dec 31, 2021	Dec 31, 2022	Dec 31, 2023	Dec 31, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

Since FY 2012, ACL has been successful in exceeding this goal. The FY 2020 result for ACL Measure ID - 2.10 is calculated using data from the 2020 National Survey of Older Americans Act Participants. The survey was not conducted in 2021 due to the COVID-19 Pandemic. ACL anticipated receiving a result of 65.68 which is a 3 year weighted average[16]. ACL's Administration on Aging believes this composite index of nursing home predictors will experience modest increases or be maintained over the next few years. ACL collaborates with the Aging Network to target services to those at high risk of losing their independence. ACL has consistently strived to exceed this goal by ensuring the most vulnerable participants receive home- and community-based services and caregiver support by collaborating with the Aging Network, promoting community living, and providing person centered services. These successes are a reflection of ACL's collaboration with the Aging Network and efforts to target services to those at high risk of losing their independence and thereby promote and enhance community living.

Percentage of pregnant health center patients beginning prenatal care in the first trimester (Lead Agency - HRSA; Measure ID - 1010.09)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	67%	70%	70 %	73 %	73 %	73 %	73 %	73 %
Result	74%	74%	74 %	74 %	73 %	Aug 1, 2022	Aug 1, 2023	Aug 1, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	Pending	Pending

Timely entry into prenatal care is an indicator of both access to and quality of care. Identifying maternal disease and risks for complications of pregnancy or birth during the first trimester can also help improve birth outcomes. At HRSA funded health centers, results over the past few years demonstrate improved performance as the percentage of pregnant health center patients that began prenatal care in the first trimester grew from 57.8 percent in 2011 to 73.0 percent in 2020, meeting the program target. The FY 2023 target was set based on data trends, including a slight reduction in 2020 data.

In collaboration with FEMA and DHS, OCR (Agencies) will conduct compliance reviews of select state COVID-19 vaccine provider programs to determine whether their services are being provided free of discrimination on the basis of race or national origin (including limited English proficient (LEP) persons and communities). (Lead Agency - OCR; Measure ID - TBD)

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	Collaborate with DHS Office of	Analyze data received from

[16] This is a composite measure that utilizes data from multiple sources. One source is the State Program Report. Another source is the National Survey. The State Program Report data is submitted annually by grantees (states and territories). The web-based submissions include multiple data checks for consistency. The National Survey draws a sample of Area Agencies on Aging to obtain a random sample of clients receiving selected Older Americans Act (OAA) services. Since the National Survey draws a sample of Area Agencies on Aging to obtain a random sample of clients it is not possible to measure the actual number of vulnerable people who continue to live in their homes after receiving these services.

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
					Civil Rights and Civil Liberties and FEMA to review COVID testing, treatment and vaccination related practices and policies of 19 states to determine whether COVID related programs are conducted in compliance with Title VI of the Civil Rights Act of 1964	states regarding policies and procedures of their respective vaccine provider programs, share findings with all 19 states, identify corrective actions, and offer technical assistance to ensure vaccine provider programs are accessible to persons with LEP.
Result	Issued guidance: HHS OCR Guidance on Ensuring Language Access and Effective Communication During Response and Recovery - A Checklist for Emergency Responders; Collaborated to develop: HHS ASPR Blog - Four Ways to Enhance Language Access during Disaster Response and Recovery	Issued guidance and checklist: HHS OCR Ensuring Effective Emergency Preparedness, Response and Recovery for Individuals with Access and Functional Needs – A Checklist for Emergency Managers; Collaborated to develop: HHS ACL Webpage: Helping Community-Based Organizations Be Prepared for Emergencies; and HHS ACL Webpage - New	Issued bulletins: HHS OCR Bulletin on Civil Rights Protections Prohibiting Race, Color and National Origin Discrimination During COVID-19, Application of Title VI of the Civil Rights Act of 1964; HHS OCR Bulletin on Civil Rights, HIPAA, and the Coronavirus Disease (COVID-19); HHS OCR Bulletin on Civil Rights, HIPAA, and the Coronavirus Disease (COVID-19); HHS OCR Bulletin on Ensuring the Rights of Persons with Limited English	Issued bulletins: HHS and DOJ Issue Guidance on "Long COVID" and Disability Rights Under the ADA, Section 504, and Section 1557; OCR Issues Guidance on HIPAA, COVID-19 Vaccinations, and the Workplace; and New Guidance to Boost Accessibility and Equity in COVID-19 Vaccine Programs Collaborated to develop: HHS CDC's Guidance Access and Functional Needs Toolkit for Integrating a		

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
		Resource Available: Emergency Planning Toolkit for the Aging and Disability Networks	Proficiency in Health Care During COVID-19; and HHS OCR Bulletin on HIPAA Privacy and Novel Coronavirus; Collaborated to develop: HHS SAMHSA Webpage - Disaster Preparedness, Response, and Recovery	Community Partner Network to Inform Risk Communication Strategies		
Status	Historic Result	Historic Result	Historic Result	Historic Result		

The purpose of this initiative is to analyze data received from select states regarding policies and procedures of vaccine provider programs to ensure that these services are being provided free of discrimination on the basis of race or national origin, including discrimination against limited English proficient (LEP) persons and underserved racial and ethnic minority communities. By conducting compliance reviews in select states, OCR will identify corrective actions, where needed, and provide technical assistance to ensure vaccine provider programs are administered in compliance with Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. These compliance reviews will provide initial and historical results to be used in strengthening this measure going forward.

Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families

HHS supports strategies to drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families across all settings. HHS is enhancing the ability to serve those in need of behavioral health services by exchanging data, information, and resources while expanding evidence-based integrated systems of behavioral and physical healthcare to improve equitable access to quality care. HHS is also engaging and educating healthcare providers, healthcare professionals, paraprofessionals, other health workforce professionals, and students in these professions to build their practice competence and capacity to address the behavioral and physical health needs of individuals, families, caregivers, and communities.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, ASPE, AHRQ, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, OCR, OGA, and SAMHSA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 1.4 Table of Related Performance Measures

Number of people train for the support of the recovery community organizations and peer support networks (Lead Agency – SAMHSA; Measure ID – 1.1.0)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	Set Baseline	1083	2,250	2,000
Result	N/A	N/A	N/A	N/A	4,766	4,766	Aug 30, 2022	Aug 30, 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Baseline	Target Exceeded	Pending	Pending

The number of people trained for the support of the recovery community organizations and peer support networks was above the initial target for this program. Because of the COVID-19 pandemic the Peer Recovery Center of Excellence adjusted their activities to mainly virtual training and technical assistance which provided the environment for many additional participants to attend their trainings and activities. Over 4,700 participants attended events during this period however only 541 responded to the post event data collection form. This program was funded on August 2020 and the training and events center around focus areas: Clinical Integration of Peers into Non-Traditional Settings, Recovery Community Organization Capacity Building, Peer Workforce Development, and Evidence-Based Practice and Practice-Based Evidence Dissemination. Early 2021 this program stared accepting Technical Assistance (TA) requests from anyone in need of support related to substance use disorder peer support services. As the pandemic emergency continues, the majority or training and technical assistance will be delivered virtually. The Peer Recovery Center of Excellence target for FY 2022 increased slightly to

account for supplemental funds that were awarded to provide technical assistance to support infrastructure development, training, and other supports to SAMHSA's Minority AIDS Initiative grantees, including the Prevention Navigators, and other grantees and recipients who are interested in integrating peer recovery strategies into their prevention approaches.

Increase the cumulative amount of publicly available data on 1) Opioid-Related Hospital Use, 2) Neonatal Abstinence Syndrome (NAS), and 3) outpatient use of opioids. (Lead Agency – AHRQ; Measure ID – 2.3.9)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	1) Opioid-Related Hospital Use – create interactive maps with 2018 data 2) NAS – create interactive map with 2018 data 3) outpatient use of opioids – post a Brief on outpatient opioid use for non-elderly and elderly adults.	1) Opioid-Related Hospital Use – update interactive maps using 2019 data 2) NAS – update interactive maps using 2019 data 3) outpatient use of opioids – update Brief and/or do new analysis addressing trends or other measures.
Result	N/A	N/A	N/A	N/A	N/A	N/A	Sep 30, 2022	Sep 30, 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

This measure supports AHRQ's ongoing work to create accurate data for monitoring and responding to the opioid crisis. AHRQ maintains two large databases capable of monitoring data relevant to the opioid overdose epidemic – the Healthcare Cost and Utilization Project (HCUP) and the Medical Expenditure Panel Survey-Household Component (MEPS-HC).

HCUP includes the largest collection of longitudinal hospital care data in the United States and HCUP Fast Stats displays that information in an interactive format that provides easy access to the latest HCUP-based statistics for healthcare information topics. More information on HCUP can be found on the HCUP website at https://hcup-us.ahrq.gov/. HCUP is able to produce national estimates on Opioid-Related Hospital Use based on data from the HCUP National Inpatient Sample (NIS) and the HCUP Nationwide Emergency Department Sample (NEDS). HCUP is able to produce State-level estimates on Opioid-Related Hospital Use based on data from the HCUP State Inpatient Databases (SID) and HCUP State Emergency Department Databases (SEDD). HCUP is also able to produce data on the rate of births diagnosed with NAS (newborns exhibiting withdrawal symptoms due to prenatal exposure to op

ioids) by State. State-level statistics on newborn NAS hospitalizations are from the HCUP State Inpatient Databases (SID). National statistics on newborn hospitalizations are from the HCUP National (Nationwide) Inpatient Sample (NIS).

The MEPS-HC collects nationally representative data on health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian noninstitutionalized population. The MEPS-HC is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS). More information about the MEPS-HC can be found on the MEPS Web site at http://www.meps.ahrq.gov/. MEPS-HC data can be used to produce Statistical Briefs that examine a wide range of measures of opioid use and expenditures including the percentages of adults with any use and frequent use of outpatient opioids during the year.

Currently, the AHRQ website hosts interactive maps that provide trends in opioid-related inpatient stays and emergency department visits at the national and State levels through 2017 and a Neonatal Abstinence Syndrome (NAS) Among Newborn Hospitalizations interactive heat map that visualizes the rate of births diagnosed with NAS by State, also through 2017. For FY 22, this data will be updated with 2018 data.

For the outpatient use of opioid measure, in FY 22, MEPS will produce a Brief on outpatient opioid use for non-elderly and elderly adults overall and by socioeconomic characteristics including sex, race-ethnicity, income, insurance status, perceived health status, Census region and Metropolitan Statistical Area (MSA) status. In FY 23, that Brief will be updated and, if relevant, new analyses of trends or using additional data sources may be added.

Number of providers who have provided Medication-Assisted Treatment (Lead Agency - HRSA; Measure ID - 6090.03)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	No Target	No Target	No Target	No Target	No Target	2,750	2,000	2,100

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Result	N/A	N/A	N/A	N/A	2,676	Nov 30, 2022	Nov 30, 2023	Nov 30, 2024
Status	Not Collected	Not Collected	Not Collected	Not Collected	Historical Actual	Pending	Pending	Pending

The Rural Communities Opioid Response Program (RCORP) is a multi-year initiative administered by HRSA that funds community-based grants and technical assistance to reduce the morbidity and mortality of substance use disorder (SUD), including opioid use disorder (OUD), in rural communities. Since its inception in FY 2018, RCORP has served over 1,500 counties in 47 states and two territories. Given the initiative's initial focus on OUD, and the limited availability of DATA 2000-waivered providers in rural communities, increasing the number of providers willing and able to provide Medication-Assisted Treatment (MAT) was a key focus area and objective of RCORP's inaugural grant programs. In FY 2020, 2,676 providers provided MAT in areas served by RCORP grant recipients. HRSA has since expanded the scope of the RCORP initiative to include other substances of concern (e.g., methamphetamine) as well as broader behavioral health challenges in rural communities. Consequently, HRSA expects that the number of RCORP grant recipients focused solely on MAT provision will decrease and has set targets that reflect that anticipated downward trend.

Number of outreach events to provide training and technical assistance to healthcare providers, healthcare professionals, and paraprofessionals on providing healthcare services free of disability discrimination against persons receiving medication assisted treatment (MAT) for substance abuse disorder and on protecting the confidentiality and care coordination of behavioral health through HIPAA. (Lead Agency - OCR; Measure ID - TBD)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	No Target	No Target	N/A	N/A	N/A	N/A	1	1
Result	N/A	N/A	1	4	1+	3	TBD	TBD
Status	Not Collected	Not Collected	Historic Result	Historic Result	Historic Result	Historic Result	Pending	Pending

Outreach events have proven to be an effective approach to addressing civil rights and HIPAA compliance in provider communities. The intent of these events is to provide necessary training and technical assistance to healthcare providers, healthcare professionals, and paraprofessionals to increase awareness of civil rights protections for individuals in recovery from substance use disorder including individuals receiving Medications for Opioid Use Disorders (MOUD) and providing those. The outreach events will also train and provide technical assistance on protecting the confidentiality and care coordination of behavioral health through HIPAA. Information provided during these events will help to eliminate discriminatory barriers and expand access to mental health and substance use disorder treatment and recovery services for individuals and families. These outreach events will provide initial and historical data/results to be used by OCR to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families in the future.

Objective 1.5: Bolster the health workforce to ensure delivery of quality services and care

HHS supports strategies to bolster the health workforce to ensure delivery of quality services and care. HHS is committed to facilitating coordinated efforts to address long-standing barriers to strengthening the health workforce. HHS efforts focus on developing professional development opportunities to learn and use new skills to improve the delivery of quality services and care. HHS is also strengthening the integration of culturally- and linguistically-appropriate and effective care into the services delivered by the health workforce.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, ASPE, CDC, CMS, FDA, HRSA, IHS, OASH, OGA, and SAMHSA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 1.5 Table of Related Performance Measures

Percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program. (Lead Agency – HRSA; Measure ID – 2000.04)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	19%	19%	24%	45%	50%	50%	55%	65%
Result	30%[17]	59%[18]	64%	71%	50%	Dec 31, 2022	Dec 31, 2023	Dec 31, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	Pending	Pending

HRSA's health professions programs strengthen the health workforce by developing, expanding, and enhancing training for health care professionals, particularly primary care providers, through grants awarded to health professions schools and training programs. These programs prepare trainees to deliver quality, team-based patient care by offering interprofessional training experiences at clinical sites across the U.S. This measure calculates the percent of active clinical training sites at which individuals from more than one profession or discipline train together.

According to annual grantee performance report data, the number of sites providing interprofessional training experiences has increased by 41 percent from FY 2016 to FY 2020. The rapid increase in this outcome is primarily due to efforts to increase interprofessional training across more than 40 health professions training programs. The FY 2023 target was increased to 65 percent to reflect this upward trend, but was not increased further due to the uncertainty of the long-term impact of the COVID-19

[17]Most recent results are for Academic Year 2016-2017 and funded in FY 2016.
[18]Most recent results are for Academic Year 2017-2018 and funded in FY 2017.

pandemic. The pandemic may have prevented sites from creating new interprofessional training partnerships or maintaining existing ones which may not be reflected in the data right away.

In 2021, HRSA implemented a new grantee scorecard. The scorecard allows program staff and grantees to determine whether individual grant programs and awardees are meeting the interprofessional training target. Having increased access to the results of this measure is one strategy HRSA developed to ensure it can continue to meet its targets.

Percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas[19] (Lead Agency - HRSA; Measure ID - 2000.03)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	34%	40%	40 %	40 %	40 %	40 %	40 %	40 %
Result	46%[20]	43%[21]	47 %	43 %[22]	40%	Dec 31, 2022	Dec 31, 2023	Dec 31, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	Pending	Pending

HRSA's health professions programs strengthen the health workforce by developing, expanding, and enhancing training for health care professionals, particularly primary care providers, through grants awarded to health professions schools and training programs. These programs improve access to health care in our Nation's communities by training individuals who go on to work in medically underserved areas after completing their HRSA primary care training program. This measure indicates the percent of individuals who report being employed in an underserved area one-year after they complete a HRSA Bureau of Health Workforce training program. According to annual grantee performance reports, the number of individuals who completed a HRSA primary care training program and then found employment in medically underserved areas has remained relatively stable from FY 2016 to FY 2020, fluctuating by three to four percentage points each year. Given the lack of a clear trend and the potential impact of COVID-19 on program completers' employment decisions, HRSA is maintaining the FY 2022 target for FY 2023.

[19] Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Results are from Academic Year 2019-2020 based on graduates from Academic Year 2018-2019

[20]Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Results are from Academic Year 2016-2017 based on graduates from Academic Year 2015-2016.

[21]Most recent results are for Academic Year 2017-2018 and funded in FY 2017.
Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Results are from Academic Year 2017-2018 based on graduates from Academic Year 2016-2017.

22 Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Most recent results are for Academic Year 2019-2020 (funded in FY 2019) based on graduates from Academic Year 2018-2019.

In 2021, HRSA implemented a new grantee scorecard. The scorecard allows program staff and grantees to identify individual grant programs or awardees that may have best practices to share or may need additional assistance to increase program completers' employment in medically underserved areas. Having increased access to the results of this measure is one strategy HRSA developed to ensure it can continue to meet its targets.

Percent growth of USPHS Ready Reserve Officers Year-over-Year (or total officers). (Lead Agency – OASH; Measure ID –6.1.8

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	200	200	250
Result	N/A	N/A	N/A	N/A	N/A	15	Sep 30, 2022	Sep 30, 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Target Not Met	Pending	Pending

On March 27, 2020, the President signed H.R. 748, the Coronavirus Aid, Relief, and Economic Security (CARES) Act into law. This historic legislation provided the necessary legislative changes to reinstate/implement the Ready Reserve Corps as well provided the initial funding to build the infrastructure for the program and begin the recruitment and training of the initial cohort.

All USPHS Ready Reserve officers are part-time officers; paid when on Active Duty (such as training or deployment). Reservists are required to train (drill') for a minimum of 2 weekends/month (on average) and 14 days/year for annual training. Reservists are called to active duty for deployment or for training. Based on critical specialized skill sets, reservists can also be placed on Active Duty (temporary/part-time) to support personnel shortages in HHS/or non-HHS agencies (e.g. the Indian Health Service or other hard to fill positions). The Ready Reserve ensures the USPHS has trained, ready and equipped surge capacity to respond to any public health emergency. Recruitment is focused for high-demand, already-trained clinical professionals. When not activated, Reservists work in their respective civilian jobs in their communities.

Commissioned Corp Headquarters' s (CCHQ) Division of Commissioned Corps Services and Ready Reserve Affairs are leading the development and implementation of a comprehensive recruitment strategy and accompanying operations plan to reach the recruitment goals for the Ready Reserve Program. The framework for this new strategy consists of three key areas of focus: Communication and Stakeholder Engagement, CCHQ Infrastructure, and Performance Management. Each focus area contains a series of activities with high impact on the overall strategy as well as a detailed plan of operation. In addition, the strategy includes a performance management plan that consists of important milestones, key performance indicators, and a risk management plan.

As a new program, upon release of the CARES Act money in July of 2020, many policies and infrastructure related needs had to be created. While some efforts for this are ongoing, HHS is pleased that OASH has been able to complete many of these endeavors which have provided the structural foundation that has allowed HHS to onboard a quickly growing number of Ready Reserve Officers. However, in FY 2021, a discrepancy did exist between targets and results. As described above, the

infrastructural needs of a new program limited the agency's ability to onboard officers to meet initial target goals. HHS looks forward to meeting the FY 2022 target with the new strategy described above.

Strategic Goal 2: Safeguard and Improve National and Global Health Outcomes

HHS is dedicated to safeguarding and improving health conditions and health outcomes for everyone. The Department improves capabilities to predict, prevent, prepare for, respond to, and recover from disasters, public health and medical emergencies, and threats, domestically and abroad. The Department protects individuals, families, and communities from infectious disease and prevent non-communicable disease through the development and equitable delivery of effective, innovative, readily available, treatments, therapeutics, medical devices, and vaccines. HHS enhances the promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death. The Department also mitigates the impacts of environmental factors, including climate change, on health outcomes.

Objective 2.1: Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe

HHS invests in strategies to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats. HHS leverages opportunities to improve collaboration and coordination, to build capacity and foster readiness for effective emergency and disaster response. HHS advances comprehensive planning for mitigation and response. HHS also applies knowledge gained from the effective and efficient use and application of technology, data, and research to improve preparedness and health and human services outcomes during emergencies and disasters.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, ASPE, ASPR, ATSDR, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, OCR, OGA, and ONC. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 2.1 Table of Related Performance Measures

Increase the number of new licensed medical countermeasures across BARDA programs (Lead Agency - ASPR; Measure ID - 2.4.13a)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	3 medical countermeasures	3 medical countermeasures	3 medical countermeasures	3 medical countermeasures	3 medical countermeasures	3 medical countermeasures	3 medical countermeasures	3 medical countermeasures
Result	3 medical countermeasures	5 medical countermeasures	9 medical countermeasures	7 medical countermeasures	3 medical countermeasures	6 medical countermeasures	Dec 31, 2022	Dec 31, 2023
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Target Exceeded	Pending	Pending

Within ASPR, the Biomedical Advanced Research and Development Authority (BARDA) program invests in the innovation, advanced research and development, acquisition, and manufacturing of medical countermeasures (MCMs) – including the vaccines, drugs, therapeutics, diagnostic tools, and non-pharmaceutical products needed to combat health security threats. The data informs the public about BARDA's capacity to provide an integrated, systematic approach to developing MCMs for public health medical emergencies such as chemical, biological, radiological, and nuclear (CBRN) accidents, incidents and attacks, pandemic influenza, and emerging infectious diseases. The targets for this measure were met or exceeded each year. The data sources are stable with no gaps or delays in reporting. The data reported reflect ASPR's efforts to save lives and protect Americans from 21st century health security threats. Together with industry partners, BARDA's support spans early development into advanced development and FDA approval. As of December 2021, BARDA-supported products have achieved 61 FDA approvals, licensures, or clearances. ASPR also oversees the procurement of MCMs for storage in the Strategic National Stockpile to ensure their availability during a public health emergency.

Number of cumulative Field Epidemiology Training Program (FETP) - Frontline graduates (Lead Agency - CDC; Measure ID - 10.F.1c)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	11,015	12,315	12,435	12,555	12,675
Result	5,182	8,021	10,906	12,197	12,534	Jun 30, 2022	Jun 30, 2023	Jun 30, 2024
Status	Historical Actual	Historical Actual	Historical Actual	Target Exceeded	Target Exceeded	Pending	Pending	Pending

International Field Epidemiology Training Programs (FETP) are recognized worldwide[23] as an effective means to strengthen countries' capacity in surveillance, epidemiology, and outbreak response. These graduates strengthen public health capacity so individual countries are able to transition from U.S.-led global health investments to more long-term host country ownership. Frontline is a three-month program that aims to increase the number of capable public health workers in a community setting. This program is part of three tiers in the FETP program which all help countries meet International Health Regulation guidelines. In FY 2020, there were 12,534 Frontline program graduates, an increase over FY 2019 and exceeding the FY 2020 target. By tracking the number of people who graduate from FETP – including the Frontline program every year, CDC can better gauge its impact on developing other countries' abilities to prevent, detect, and respond to disease outbreaks.

[23] Traicoff D et al. 2015. Strong and flexible: Developing a three-tiered curriculum for the Regional Central America Field Epidemiology Training Program. Pedagogy in Health Promotion 1(2): 74–82. http://php.sagepub.com/content/1/2/74.full.pdf+html.

By 2026, establish a formalized funding pathway for the development, validation, and regulatory review of diagnostic technologies to enhance surveillance and pandemic preparedness. (Lead Agency – NIH; Measure ID – SRO-5.19)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	Receive FDA authorization for marketability for 3 home, point-of-care, or lab-based diagnostics.	Receive FDA authorization for marketability for 2 home, point-of-care, or lab-based diagnostics.
Result	N/A	N/A	N/A	N/A	N/A	N/A	Dec. 2022	Dec. 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	In progress	In progress

NIH is aiming to accelerate the innovation of new technologies using a design, build, test and deploy approach to improve future pandemic preparedness and surveillance. In response to the COVID-19 pandemic, NIH launched the Rapid Acceleration of Diagnostics (RADx®) initiative to speed up innovation in the development and deployment of COVID-19 testing approaches and strategies. RADx Tech, a component of RADx, focuses on speeding up the development, validation, and commercialization of innovative diagnostic tests, including home, point-of-care, and laboratory-based tests. NIH is building on the research mechanisms used and lessons learned through the RADx® Tech program to help guide and inform approaches and specific capabilities needed for surveillance and preparedness over the next five years and to move innovative and needed technologies to market. RADx Tech's success was achieved by facilitating partnerships across the federal government, industry, and academia and drawing on expertise from technology innovators, clinical testing, regulatory affairs, entrepreneurs, and business leaders. This approach resulted in many new home-based and point-of-care tests available for purchase under FDA's Emergency Use Authorization within eight months, an unprecedented speed. In FY 2022, NIH is working to receive FDA authorization for marketability for three home, point-of-care, or laboratory-based diagnostics. In FY 2023, NIH aims to receive this FDA authorization for two diagnostics.

By 2026, advance the preclinical or clinical development of 10 antivirals for current or future infectious disease threats. (Lead Agency – NIH; Measure ID – SRO-5.20)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	Advance preclinical or clinical development of 1 antiviral therapeutic	Advance preclinical or clinical development of 2 antiviral therapeutics
Result	N/A	N/A	N/A	N/A	N/A	N/A	Dec. 2022	Dec. 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	In progress	In progress

The development of antiviral drugs to combat harmful viruses can take a long time. When SARS-CoV-2,

the coronavirus that causes COVID-19, first emerged, there were no approved treatments or vaccines for treating any coronavirus infection. However, NIH was able to build on existing research on other coronaviruses that had caused earlier outbreaks or pandemics and actively contribute to the Federal response to COVID-19. To prepare for future threats posed by known and unknown viruses, NIH is taking a proactive approach by drawing on existing research and investing in antiviral drug discovery and development. The goal is to generate a pool of new antiviral drugs and increase the availability of antiviral drug candidates that might be used to address future outbreaks or pandemics. In FY 2022, NIH is working to advance the preclinical or clinical development of one antiviral therapeutic. In FY 2023, NIH will aim to advance the preclinical or clinical development of two antiviral therapeutics.

Objective 2.2: Protect individuals, families, and communities from infectious disease and non-communicable disease through development and equitable delivery of effective, innovative, readily available, diagnostics, treatments, therapeutics, medical devices, and vaccines

HHS is working on strategies to protect the public from known and emerging infectious diseases and prevent non-communicable diseases, including cardiovascular diseases, cancer, diabetes, and other chronic conditions. HHS advances the development and delivery of safe and effective, and innovative diagnostics, treatments, therapeutics, medical devices, and vaccines. HHS invests in innovative technology and development to ensure the supply and availability of diagnostics, treatments, therapeutics, medical devices, and vaccines while leveraging resources and collaborations to support and apply research, evaluation, and data insights about non-communicable and infectious disease.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, ASPR, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, and OGA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 2.2 Table of Related Performance Measures

Increase the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza (Lead Agency - CDC; Measure ID - 1.3.3a)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	56 %	59 %	62 %	66 %	70 %	70 %	70 %	70 %
Result	43 %	38 %	45 %	48 %	50%	Sep 30, 2022	Sep 30, 2023	Sep 30, 2024
Status	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

In the United States, on average 5 to 20 percent of the population contracts the flu, more than 200,000 people are hospitalized from seasonal flu-related complications, and approximately 36,000 people die from seasonal flu-related causes. This measure reflects the universal influenza vaccination recommendation and aligns with the Advisory Committee on Immunization Practices' updated

recommendation (as of 2010) for the seasonal influenza vaccine. Seasonal influenza vaccination rates for adults aged 18 and older increased slightly from 48 percent in FY 2019 to 50 percent in FY 2020. Targets for this measure have remained level for several years as CDC works to achieve the current level of seasonal flu vaccination. Interpretation of these results should take into account limitations of the survey, which include reliance on self-reporting of vaccination status and a decrease in response rates.

While the most recent data shows a slight improvement, flu vaccination coverage among adults remains at about 5 in 10 adults reporting receipt of a flu vaccination.

CDC's continuing efforts to improve adult vaccination coverage rates include:

- Increasing patient and provider education to improve demand and implement system changes in practitioner office settings to reduce missed opportunities for vaccinations.
- Funding state and local health departments to implement the Standards for Adult Immunization Practice in large health care systems, community health centers, pharmacies, and other settings.
- Partnering with professional organizations (e.g., F1.3 American Pharmacists Association, American College of Physicians, American Academy of Family Physicians, American College of Obstetricians and Gynecologists) and other organizations (e.g., National Association of Chain Drug Stores, National Association of Community Health Centers, American Immunization Registry Association) to develop and implement strategies to improve adult immunization at provider, practice, and systems levels.
- Enhancing evidence-based communication campaigns to increase public awareness about adult vaccines and recommendations. CDC routinely conducts literature reviews and surveys of the general public and healthcare providers to provide a deeper understanding of the target audiences for development of adult immunization communication messages and campaigns.
- Partnering with the National Adult and Influenza Immunization Summit, a national coalition of partners and stakeholders represented by clinicians, public health, industry, government, and other entities with the common goal to promote immunization for adults.
- Expanding the reach of vaccination programs including new venues such as pharmacies and other retail clinics. CDC has existing partnerships to implement adult immunization practice standards, HPV vaccination, and pandemic vaccine program planning efforts to expand access to pandemic vaccine. As of 2016-2017 influenza season, nearly one in four adults who got an influenza vaccine were vaccinated in a pharmacy or retail setting.
- Designing and funding investigations into the factors associated with disparities in adult vaccination among racial and ethnic minority populations and projects designed to expand the evidence base for interventions to increase vaccination among adults with chronic medical conditions and underserved populations.

Collaborating with numerous existing and new partners to expand flu vaccine coverage, with specific efforts to address racial and ethnic disparities for the 2021-2022 influenza season. For example, CDC is working with the National Association for Community Health Centers to implement evidence-based strategies to increase adult vaccination coverage among underserved priority populations. CDC has developed a large portfolio of new partnerships to promote COVID-19 and flu vaccination in high-risk populations, including communities of color, those living in rural settings, adults with chronic medical conditions (cardiovascular, diabetes, chronic lung conditions, etc.) and those in congregate settings (i.e., long-term care facilities, homeless shelters, and prisons).

Percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test who are virally suppressed. (Lead Agency – HRSA; Measure ID –4000.03)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	No Target	No Target	83%	83%	83%	83%	83%	84%
Result	85%	86%	87.1%	88%	89.4%	Dec 31, 2022	Dec 31, 2023	Dec 31, 2024
Status	Target not in place	Target not in place	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

HRSA's Ryan White HIV/AIDS Program (RWHAP) works to improve health outcomes by preventing disease transmission or slowing disease progression for disproportionately impacted communities. One way RWHAP accomplishes its mission is through the provision of medications that help patients reach HIV viral suppression. People living with HIV who use medications designed to virally suppress the disease are less infectious, which reduces the risk of their transmitting HIV to others. The target has not been adjusted because it is unknown what impact EHE activities will have on overall viral suppression rates.

Continue advanced research and development initiatives for more effective influenza vaccines and the development of safe and broad-spectrum therapeutics for use in seriously ill and/or hospitalized patients, including pediatric patients (Lead Agency - ASPR; Measure ID - 2.4.15b)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	Set Baseline	2 programs	2 programs	2 programs	2 programs	2 programs	3 programs
Result	N/A	2 programs	7 programs	6 programs	2 programs	2 programs	Dec 31, 2022	Dec 31, 2023
Status	Not Collected	Baseline	Target Exceeded	Target Exceeded	Target Met	Target Met	Pending	Pending

Within ASPR, the Biomedical Advanced Research and Development Authority (BARDA) uses an end-to-end strategy to prepare for the next influenza pandemic by supporting development, licensure, and manufacturing of better products to detect, treat, and prevent seasonal and pandemic influenza. This strategy relies on the development of superior influenza diagnostics, treatments, and vaccines that can be rapidly manufactured. BARDA continues to focus on developing capabilities to recognize potential pandemic influenza viruses in point-of-care settings, speeding influenza diagnosis to prompt early antiviral use and will also continue to support advanced development of new nucleotide sequencing technologies and prodromal or pre-symptomatic biomarkers for influenza. The targets for this measure have been met or exceeded each year. There are no missing or delayed data. The data source is stable and quality assurance procedures are conducted. The measure reflects that ASPR uses a comprehensive portfolio approach to develop and acquire a broad array of medical countermeasures for pandemic influenza and emerging infectious diseases. The ASPR investments reflected through this data highlight support for advanced research and development, stockpiling, procurement, and capacity expansion.

Important context is that previous and ongoing investments in addressing the pandemic influenza threat proved invaluable to accelerate the COVID-19 response by jump-starting therapeutic and vaccine development using platform technologies for more rapid production and increased fill/finish capability. By continuing to widen availability of enhanced influenza diagnostic tools, BARDA promotes effective, timely management and treatment of seasonal and pandemic influenza, and reduces its impact on health, communities, the Nation, and internationally. Targets are set based on ongoing active projects in BARDA's Influenza Therapeutics branch specifically as it relates to complex advanced research and development projects that are on the product development pathway to FDA licensure. The products reported for this measure include those from ongoing clinical trials and manufacturing campaigns only related to Pandemic Influenza.

Influenza vaccination rates among adult American Indian and Alaska Native patients 18 years and older (Lead Agency - IHS; Measure ID - 68)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	18.8 %	18.8 %	25.4 %	24.4 %	28 %	TBD[24]
Result	N/A	N/A	23.3 %	23.6 %	24.3 %	18.1%	Jan 31, 2023	Jan 31, 2024
Status	Not Collected	Not Collected	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

Influenza is a serious disease that causes significant morbidity and mortality, especially in the American Indian /Alaska Native (AI/AN) population. Influenza and resulting sequelae such as pneumonia are among the top 10 leading causes of death for AI/ANs, and influenza-related mortality is significantly higher among AI/AN populations compared with non-Hispanic Whites. Influenza vaccination remains the best strategy for reducing influenza-related illness. The IHS offers influenza vaccinations to eligible AI/ANs to support public health strategies for preventing influenza illnesses while also reducing influenza-related hospitalizations and deaths.

Monitoring influenza vaccination uptake is critical to ensure that the AI/AN population is sufficiently protected from primary influenza infections as well as severe health outcomes such as pneumonia and influenza-related death. The influenza vaccination rate measures the proportion of individuals receiving seasonal influenza vaccine among AI/AN adult patients.

Beginning in fiscal year (FY) 2018, the IHS transitioned measure reporting from the Clinical Reporting System to the Integrated Data Collection System Data Mart and measure targets, including the influenza vaccination rate, were reset. From FY 2018 through FY 2020, the IHS seasonal influenza vaccination rate for AI/AN adults 18 years of age and older has improved. The IHS FY targets are set based on prior year performance and projected funding. During FY 2021, the influenza vaccination rate was 18.1% and lower than the 24.4% target. IHS results are impacted by immunization data exchange issues and the reliance on patients' self-reporting of vaccinations completed outside IHS health care facilities.

[24] At the time of publication, an FY 2023 target for this measure was unavailable. An FY 2023 target for this measure is reported in the Indian Health Service FY 2023 Congressional Justification.

IHS reviews evidence-based recommendations to inform strategies to increase influenza vaccination coverage among AI/AN populations. Each fiscal year the Influenza Vaccination Action Plan is updated with current recommendations and issued as the framework to increase vaccination coverage across the health care system. The IHS continues to apply evidence-based approaches, including co-administration of COVID-19 and influenza vaccines and combining with other targeted vaccination efforts to maximize opportunities for influenza vaccination. The IHS regularly incorporates strategies that improve influenza vaccination rates, such as use of standing orders that promote vaccine administration, proper documentation of vaccines given to aid tracking, and automated point-of-care reminders generated through electronic health record alerts to prompt vaccination when a patient is due. Additionally, the IHS has also implemented data-driven interventions targeted to specific, highly susceptible patient populations to improve their specific influenza vaccination rates and related health outcomes.

Objective 2.3: Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death

HHS supports strategies to promote healthy behaviors to reduce the occurrence of and disparities in preventable injury, illness, and death. The Department develops, communicates, and disseminates information to improve health literacy about the benefits of healthy behaviors. HHS leverages resources, partnerships, and collaborations to support healthy behaviors that improve health conditions and reduce disparities in health outcomes. HHS also advances and applies research and data insights to inform evidence-based prevention, intervention, and policy approaches to address disparities in preventable injury, illness, and death.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, ACF, ACL, ASFR, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, and SAMHSA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 2.3 Table of Related Performance Measures

Reduce the annual adult per-capita combustible tobacco consumption in the United States. (Lead Agency - CDC; Measure ID - 4.6.2a)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023[25]
Target	1,145	1,128	967	903	838	817	755	693
Result	1,164	1,114	1,061	1,004	1,004	Jul 31, 2022	Jul 31, 2023	Jul 31, 2024

[25] This measure uses the CDC's National Center for Health Statistics (NCHS)-provided trend setting tool for the Healthy People 2030 targets. It uses a linear trend to calculate at least 5 options. Specifically, ordinary least-squares was fit. The targets were selected from Option 3, there is a 50% chance that the target value will meet or exceed. 2018 was selected as the baseline year since that is the year with the most recent data available.

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023[25]
Status	Target Not Met but Improved	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Pending	Pending	Pending

Although cigarette smoking remains the leading cause of preventable disease and death in the United States, the tobacco[26] product use landscape continues to diversify to include multiple combustible tobacco products, including cigars, cigarillos and little cigars, pipe tobacco, roll-your-own tobacco, and hookah. Per capita combustible tobacco product consumption remained unchanged from 1,004 cigarette equivalents in FY 2019 to 1,004 cigarette equivalents in FY 2020. CDC will continue to work to decrease combustible tobacco consumption in the U.S.

CDC recommendations to help reduce tobacco consumption include: raising the price of tobacco products, providing access to cessation services, protecting everyone's right to breathe clean air, and mass-reach media campaigns warning about the dangers of tobacco use. CDC strategies to promote these interventions include providing funding to 50 states, Washington, DC, 8 U.S territories and 26 tribes/tribal organizations through the National Tobacco Control Program and supporting grantees to implement Best Practices for Comprehensive Tobacco Control Programs. CDC also funds the Tips From Former Smokers Campaign,® a national campaign profiling real people who live with serious health effects due to smoking and secondhand smoke exposure.

Increase the proportion of adults (age 18 and older) that engage in leisure-time physical activity. (Lead Agency - CDC; Measure ID - 4.11.9)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	73.2 %	73.5 %	73.8 %	N/A	74.4 %	N/A	75 %	N/A
Result	73.1 %	74.1 %	74.6 %	N/A	73.9%	N/A	Dec 31, 2023	N/A
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Not Collected	Target Not Met	Not Collected	Pending	Not Collected

The proportion of adults who engage in leisure-time physical activity increased from 63.8% in FY 2008 to 73.9% in FY 2020. CDC's Active People, Healthy Nation℠ is a national initiative to help 27 million Americans become more physically active by 2027. CDC used percent improvement target setting methodology to set a goal of a 0.3% increase per year for the proportion of adults (age 18 and older) that engage in leisure-time physical activity. This translates to a 0.6% increase every two years and is consistent with administration of the National Health Interview Survey (NHIS), the survey used to collect this data, which is administered every two years instead of annually.

CDC funds states, communities, and organizations with national reach to design communities that are safe and easy for people of all ages and abilities to be physically active. In addition, CDC trains states

[26] References to tobacco refer to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian communities.

and communities to implement strategies to improve the walkability of communities. For example, the CDC funded Walkability Action Institute has trained 51 teams that potentially reach over 40 million people. CDC will continue to promote the critical need for safe and easy places for physical activity to take place and help implement high impact strategies for walking and walkable communities like Complete Streets and Safe Routes to Schools. As of December 2021, over 1,600 Complete Streets policies, including those adopted by 35 state governments plus the Commonwealth of Puerto Rico, and Washington D.C., have been reported to the National Complete Streets Coalition.

Percentage of adult health center patients with diagnosed hypertension whose blood pressure is under adequate control (less than 140/90) (Lead Agency - HRSA; Measure ID - 1010.07)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	63%	63%	63%	63%	63%	63%	63%	64%
Result	62%	63%	63%	65%	58%	Aug 1, 2022	Aug 1, 2023	Aug 1, 2024
Status	Target Not Met	Target Met	Target Met	Target Exceeded	Target Not Met	Pending	Pending	Pending

Percentage of adult health center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) (Lead Agency - HRSA; Measure ID - 1010.08)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	69%	69%	69%	69%	67%	67%	67%	67%
Result	68%	67%	67%	68%	64%	Aug 1, 2022	Aug 1, 2023	Aug 1, 2024
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met but Improved	Target Not Met	Pending	Pending	Pending

Health centers continue to be a critical element of the health system, largely because they can provide an accessible and dependable source of high quality, affordable, and cost-effective primary health care services in underserved communities. In particular, health centers emphasize coordinated primary and preventive services that promote reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved populations. Health centers emphasize coordinated and comprehensive care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices. Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities.

The FY 23 target was set based on historical data trends. Recovery efforts from COVID-19, including significant use of telemedicine, are expected to bring performance back to previous levels.

Objective 2.4: Mitigate the impacts of environmental factors, including climate change, on health outcomes

HHS invests in strategies to mitigate the impacts of environmental factors, including climate change, on health outcomes. HHS detects, investigates, forecasts, monitors, responds to, prevents, and aids in recovery from environmental and hazardous public health threats and their health effects. HHS promotes cross-disciplinary and multi-stakeholder coordination to improve the outcomes of climate change and environmental exposures on workers, communities, and domestic and international systems. Additionally, HHS expands awareness and increases knowledge of environmental hazards and actions that individuals and communities can take to reduce negative health outcomes.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ASPR, ATSDR, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, OCR, and OGA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 2.4 Table of Related Performance Measures

Number of public health actions undertaken (using Environmental Health Tracking data) that prevent or control potential adverse health effects from environmental exposures (Lead Agency - CDC; Measure ID - 6.C)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	30.0	21.0	21.0	40.0	40.0	45.0	45.0	60.0
Result	74.0	57.0	97.0	87.0	66.0	80.0	Oct 31, 2022	Oct 31, 2023
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The Environmental and Health Outcome Tracking Network covers over 185 million people, which made up about 57% of the population in the U.S. in 2021. The Tracking Network serves as a source of information on environmental hazards and exposures, population data, and health outcomes. CDC exceeded expectations for the number of data-driven actions to improve public health using the Tracking Network which is in keeping with previous years. CDC is refining how public health actions are captured and anticipates that the total number of actions may be reduced or remain flat. Performance for this measure is dependent on Environmental Health Tracking recipients reporting on the actions they undertake which may vary from year to year. FY 2023 targets are increased slightly over previous year targets as a result. From FY 2005 to FY 2021, state and local public health officials have used the Tracking Network to implement over 820 data-driven public health actions to save lives and prevent adverse health effects that are due to environmental exposures.

For example, in 2021 over 80 public health actions were reported, with COVID, heat stress illness, climate change, and air quality as the most common environmental health topics addressed. Policies included requiring city agencies to use organic pest control measures in parks and requiring a licensure program for radon professionals to ensure they consistently and correctly measure home radon levels. Programs or interventions described by Tracking recipients included hosting free COVID testing events in areas identified as high-risk based on sewer shed surveillance data and ensuring that K-12 public school

locations with the highest lead exposure risk for receive prioritized testing of lead in drinking water. The Tracking Network also serves as a source of information for health professionals, elected officials, researchers, parents, and the public on environmental hazards and exposures, population data, and health outcomes.

Increase training and resources to address the access and functional needs of electricity and healthcare service-dependent at-risk individuals who live independently and are impacted by incidents, emergencies, and disasters (Lead Agency - ASPR; Measure ID - 1.3)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	Set Baseline	81,720 trained	88,826 trained	110,322 trained	118,494 trained
Result	N/A	N/A	N/A	71,061 trained	234,802 trained	130,610 trained	Dec 31, 2022	Dec 31, 2023
Status	Not Collected	Not Collected	Not Collected	Baseline	Target Exceeded	Target Exceeded	Pending	Pending

ASPR measure 1.3 is part of ASPR's National Disaster Medical System (NDMS) work to support communities nationwide. When disaster strikes, NDMS is important because States, Localities, Territories, and Tribes (SLTT) may have medical infrastructure that becomes overwhelmed and requires assistance with their critical services. At that point, they can request NDMS help for their communities as they respond and recover. NDMS capabilities and tools deliver essential medical and emergency management services and subject matter expertise when requested by an SLTT agency. As a tool within NDMS, the HHS empower Program's federal health data are used to advance SLTT and community partner capabilities to anticipate and plan for healthcare system surge, including pre-emptively taking action to protect health and save the lives of at-risk populations that may be rapidly and adversely impacted during an emergency or disaster. emPOWER provides public health agencies and their partners with Medicare datasets, mapping, rest service and artificial intelligence tools, training, technical assistance and best practices to protect the health of individuals who live independently and rely on life-maintaining electricity-dependent equipment (including ventilators) and healthcare services (such as dialysis and oxygen). Baseline data was collected in 2019 and the target exceeded in 2020 and 2021. The data source is stable with no delays or lags. Quality checks are in place to assure the validity and reliability of the data. For the FY 2022 HHS budget, the measure definition was slightly refined for clarity based on additional data sources, which are designed to improve the data collection processes and the accuracy of the data. In May 2020, the methodology used to define targets was also slightly refined from baseline+ to the projected quantitative numbers (calculated in the same way). This helped those who use the data to understand it more easily. Such efforts strengthened the analysis, trending, and application of emPOWER data in ways that promote decision support and drive improvements. The nationwide use of emPOWER data represents the rapid scientific advancement of data-driven mitigation strategies that help during a broad array of disasters, including the Covid-19 pandemic and events associated with climate change.

By FY 2026, OCR will conduct a Title VI Environmental Justice/Public Health compliance review and undertake any needed steps for resolution. (Lead Agency - OCR; Measure ID - TBD)

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	Draft Title VI Environmental Justice/Public Health notice and data request letter; send notice and data request letter to the covered entity; review data responses; request supplemental data as needed; interview witnesses.	Request additional data as needed; conduct outreach to community leaders and advocates; conduct onsite investigation; coordinate comprehensive public health response by federal partners, including CDC and HRSA; analyze the data and share results with the covered entity; provide technical assistance to the covered entity based on analysis of collected data.
Result	N/A	N/A	N/A	Background investigation completed; joint meetings held with other partner federal agencies, including USDA, DOJ, and Office of Climate Change and Health Equity; follow-up interviews conducted with Complainants; compliance review opened September 2021.		
Status	Not Collected	Not Collected	Not Collected	Baseline		

The purpose of this initiative is to analyze data received from at least one Title VI/Section 1557 environmental justice/public health compliance review. OCR will conduct an on-site investigation, identify corrective actions, if needed, and provide technical assistance to ensure that federally assisted health programs and activities are accessible to underserved racial and ethnic minority communities. OCR will coordinate with HHS partner agencies to develop and implement a comprehensive public health response to improve community health outcomes. These on-site investigations will provide initial and historical results to be used in strengthening this measure going forward.

Strategic Goal 3: Strengthen Social Well-being, Equity, and Economic Resilience

HHS works to strengthen the economic and social well-being of Americans across the lifespan. HHS provides effective and innovative pathways leading to equitable economic success for all individuals and families. The Department strengthens early childhood development and expands opportunities to help children and youth thrive equitably within their families and communities. HHS expands access to high-quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life. HHS also increases safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence.

Objective 3.1: Provide effective and innovative pathways leading to equitable economic success for all individuals and families

HHS invests in strategies to provide effective and innovative pathways that lead to equitable economic success for all individuals and families. HHS facilitates system enhancements and partnerships across the federal government to coordinate resources and technical assistance to individuals and families hoping to achieve and sustain economic independence.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, ASPE, CDC, CMS, HRSA, IHS, OASH, and OCR. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 3.1 Table of Related Performance Measures

Reduce energy burden among the most energy burdened households (Lead Agency - ACF; Measure ID - 1D (new))

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	Maintain Prior Result (90)	Maintain Prior Result (86)	Maintain Prior Result	Maintain Prior Result
Result	97[27]	83[28]	87	90	86	Nov 30, 2022	Nov 30, 2023	Nov 30, 2024
Status	Historical Actual	Historical Actual	Historical Actual	Baseline	Target Not Met	TBD	TBD	TBD

[27]The FY 2016 data is the first set of information collected from the states, including the District of Columbia, for the developmental measures 1C through 1F.
[28]The preliminary result for FY 2017 is based on result for 46 states that submitted usable data.

By design, LIHEAP targets energy assistance to low-income households with the highest energy needs. It does so as part of Congress' statutory mandate, as expressed in 42 U.S.C. 8624(b)(5). ACF measures the extent to which LIHEAP meets this mandate through targeting indices, which show the extent to which the program reaches selected households over others, specifically households with (a) elderly members, (b) young children, and (c) high energy burdens. ACF also measures the extent to which LIHEAP reduces energy-burdens among high-energy burden households. A household's energy burden is the household's energy costs as a share of its income. Reducing a household's energy burden prevents the household from suffering adverse outcomes—including hypothermia, heat stroke, etc.—due to extreme indoor temperatures. It also prevents the household from forgoing essential items; like food, medication, etc.; in order to pay for energy. The index score that measures the targeting of energy burden reduction shows the extent to which high energy burden recipients receive more benefits than other recipients. ACF computes this score by dividing the percent reduction, attributable to LIHEAP, in the median individual energy burden for *high energy burden recipients* by the equivalent type of reduction for *all recipients* and multiplying the result by 100.

In FY 2016, 40 states initially submitted usable data and the result was 97, indicating that LIHEAP paid about 3 percent less of the energy bill for households with the highest energy burden compared to average recipient households. For FY 2018 reporting, state capacity to report the new performance measures data improved with 49 states reporting results with Burden Reduction Targeting Index score of 87, indicating that LIHEAP paid about 13 percent less of the energy bill for households with the highest energy burden compared to average recipient households.

For FY 2020 reporting, state capacity to report this new performance measure data improved further, with only 13 percent of states lacking data or having low data reliability. The Burden Reduction Targeting Index score for FY 2020 based on all states with usable data was 86, indicating that LIHEAP paid about 14 percent less of the energy bill for households with the highest energy burden compared to average recipient households. This result was just below the target of 90 for FY 2020. Under funding provided by the Consolidated Appropriations act of 2012, which increased training and technical assistance funds to $3 million, ACF has invested in increased grantee training and technical assistance to improve performance management and monitoring activities by states. A virtual conference for LIHEAP grantees was held in March 2021 and included performance management training to improve reporting on the new performance measures, including the Burden Reduction Targeting Index. ACF plans to continue its support for the LIHEAP Performance Management Workgroup (PMIWG), which is comprised of selected state directors; make each year's Report to Congress available for publication, continue to make LIHEAP household and performance management preliminary data available for public consumption through the LIHEAP Performance Management website; and develop evidence-based more precise T&TA tools to support LIHEAP grantees. They include an energy price increase dashboard, grantee performance management profiles, and other fact sheets.

Increase the percent of cash assistance terminations due to earned income from employment for those clients receiving cash assistance at employment entry. (outcome) (Lead Agency - ACF; Measure ID - 15.1LT and 15A)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	54.25%	54.5%	55%	55.5%	56%	56.5%	56.75%	56.75%

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Result	60.22%	56.2%	50.99%	43.47%	42.45%	Dec 1, 2022	Dec 1, 2023	Dec 1, 2024
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Pending	Pending	Pending

The Transitional and Medical Services (TAMS) program provides refugees and other eligible populations with time-limited assistance to purchase food and clothing, pay rent, use public transportation, and secure medical care. Additionally, this program provides a path to economic self-sufficiency by supplying resources for employment training and placement, case management services, and English language training in order to facilitate economic self-sufficiency and effective resettlement as quickly as possible. A cash assistance termination is defined as the closing of a cash assistance case due to earned income in an amount that is predicted to exceed the state's payment standard for the case based on family size, rendering the case ineligible for cash assistance. The FY 2020 actual result of 42.45 percent was below the target of 56.00 percent by 13.55 percent. Many refugees are placed into full-time jobs with reduced work hours, thus not always producing termination. A few large programs had lower termination rates, which negatively affected the overall, national termination rate. The COVID-19 pandemic also contributed to delays in employment and extended benefit periods due to COVID-19 eligibility extensions. ACF plans to continue to work with states to increase the ratio of full-time job placements and to increase terminations to 56.75 percent in FY 2023.

Increase the percentage of refugees who are self-sufficient (not dependent on any cash assistance) within the first six months (180 days) of the service period. (Lead Agency - ACF; Measure ID - 16.1LT and 16C)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	83.02 %	85.24 %	84.84 %	82.88 %	81.76 %	76.05 %	78.8%	Prior Result +1%
Result	84.4 %	84 %	82.06 %	80.95 %	75.3 %	77.8%	Nov 30, 2022	Nov 30, 2023
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending

The Matching Grant program is an alternative to traditional cash assistance that provides participants with services such as case management, job development, job placement and placement follow-up, and interim housing and cash assistance through grants awarded to participating national refugee resettlement agencies. These agencies provide a match (in cash and/or in-kind services) of one dollar for every two dollars of federal contribution. The purpose of the program is to help participants become self-sufficient within 180 days from the date of eligibility for the program. The actual result for the refugee self-sufficiency rate in FY 2021 indicates that 77.80 percent of program participants were self-sufficient at the end of the 180-day program service period, exceeding the FY 2021 target of 76.05 percent. This result is also an improvement of more than two percentage points over the previous year's actual result of 75.3 percent, though it remains below the pre-pandemic level of nearly 81 percent in FY 2019. ORR expects positive growth to continue in FY 2022 as grant recipients continue to refine their pandemic era methodologies and the U.S. economy recovers.

Increase the percentage of IV-D (child support) cases having support orders. (outcome) (Lead Agency - ACF; Measure ID - 20B)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	85%	85%	86%	87%	88%	90%	90%	90%
Result	86%[29]	87%	88%	88%	87%	Nov 30, 2022	Nov 30, 2023	Nov 30, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

Child support is one of the most significant financial resources available to children living apart from a parent. Child support receipt promotes family self-sufficiency, child well-being, and health from birth through adulthood, thereby reducing costs in other government programs. The annual performance measure regarding child support orders compares the number of IV-D child support cases with support orders established (which are required to collect child support) with the total number of IV-D cases. (The Social Services Amendments of 1975 (P.L. 93-647) established the federal child support enforcement program as Part D of title IV of the Social Security Act.) States continue to improve their performance with respect to this measure as the total number of cases with an order established was 11.5 million in FY 2020. The percent of cases with support orders was 87.2 percent, which is slightly below the target of 88 percent for FY 2020 and the most recent result of 88 percent in FY 2018 and FY 2019. This decline is most likely attributable to the COVID-19 pandemic. The target for fiscal year 2023 will remain at 90 percent.

Increase the median state share of federal TANF and state maintenance-of-effort (MOE) funds used for work, education, and training activities. (Lead Agency - ACF; Measure ID - 22F)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	6.6 %	7.8 %	7.4 %	6.8%	Prior Result +0.1PP	Prior Result +0.1PP
Result	N/A	6.5 %	7.7 %	7.3 %	6.7%	Oct 30, 2022	Oct 30, 2023	Oct 30, 2023
Status	Not Collected	Historical Actual	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending	Pending

The Temporary Assistance for Needy Families (TANF) program provides state flexibility in operating programs designed to help low-income families achieve independence and economic self-sufficiency. The performance measures for the TANF program assess the extent to which TANF work-eligible individuals and families transition from cash assistance to employment. Full success requires not only that recipients get jobs, but also that they stay in employment and increase their earnings in order to reduce dependency and enable families to support themselves. The state spending requirement of matching funds for the federal TANF payment is referred to as “maintenance-of-effort” or MOE. This performance measure reports on the median state share of federal TANF and state MOE funds used for work, education, and training activities. The most recent actual result decreased from 7.3 percent in

[29]The FY 2016 actual result should be considered preliminary pending final data validation.

FY 2019 to 6.7 percent in FY 2020, falling short of the target of 7.4 percent. Through intentional technical assistance , ACF encourages states to invest more resources towards engaging TANF work-eligible individuals in work and work preparation activities so that families with barriers to employment can reach the ultimate outcome of a stable, unsubsidized job.

Objective 3.2: Strengthen early childhood development and expand opportunities to help children and youth thrive equitably within their families and communities

HHS invests in strategies to strengthen early childhood development opportunities to help children and youth thrive equitably within their families and communities. HHS fosters the physical, emotional, intellectual, language, and behavioral development of children and youth while supporting their families and caregivers. HHS implements interventions and multidisciplinary programs to enhance and support early childhood development and learning. HHS also focuses its efforts to improve early childhood development programs, systems, and linkages through the application of data, evidence, and lessons learned.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, ASPE, CDC, CMS, FDA, HRSA, IHS, OASH, NIH, OGA, and SAMHSA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 3.2 Table of Related Performance Measures

Reduce the proportion of Head Start grantees receiving a score in the low range on the basis of the Classroom Assessment Scoring System (CLASS: Pre-K). (Lead Agency - ACF; Measure ID - 3A)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	25 %	24 %	15 %	17 %	15 %	16 %	16%	Prior Result -1PP
Result	24 %	16 %	18 %	16 %	17 %	N/A[30]	Jan 31, 2023	Jan 31, 2024
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Exceeded	Target Not Met	N/A	Pending	Pending

ACF strives to increase the percentage of Head Start children in high quality classrooms. Progress is measured by reducing the proportion of Head Start grant recipients scoring in the low range, below 2.5, in any domain of the Classroom Assessment Scoring System (CLASS: Pre-K). This research-based tool measures teacher-child interaction on a seven-point scale in three broad domains: Emotional Support, Classroom Organization, and Instructional Support. ACF began data collection using random samples for the CLASS: Pre-K in the first quarter of FY 2012. ACF assesses each Head Start grantee using the CLASS instrument during onsite monitoring reviews. This performance measure was developed to track the

[30] The FY 2021 CLASS® reviews were not conducted due to the COVID-19 pandemic.

proportion of grant recipients receiving a score in the low range on the basis of the CLASS with the goal of decreasing that proportion over time.

Data from the FY 2014 CLASS reviews indicated that 23 percent of grant recipients are in the low range on any domain, exceeding the revised target. The most recent data from the FY 2020 CLASS reviews indicate that 17 percent of grant recipients scored in the low range, not meeting the target of 15 percent. The target set for FY 2021 is 16 percent, a one percent improvement from the FY 2020 result. However, there are no results for this performance measure in FY 2021 since CLASS reviews were not conducted due to the COVID-19 pandemic. The targets for FY 2022 and 2023 are also set to a one percentage decrease from the prior year result. In response to data from CLASS reviews, ACF is providing more intentional targeted assistance to those grant recipients that score in the low range on CLASS. ACF is flagging grant recipients that score in the low range, conducting more analysis on the specific dimensions within the Instructional Support domain that are particularly challenging for those grant recipients, and working more directly with those grant recipients on strategies for improvement.

Increase the percentage of Head Start preschool teachers with an AA, BA, or Advanced degree in early childhood education or a related field. (Lead Agency - ACF; Measure ID - 3C)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	100%	100%	100%	100%	N/A	100%	100%	100%
Result	95.6%	95.6%	94.9%	94.8%	N/A[31]	94.8%	Jan 31, 2023	Jan 31, 2024
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	N/A	Target Not Met	Pending	Pending

Head Start grant recipients are required to develop plans to improve the qualifications of staff. Head Start has shown a steady increase in the number of Head Start teachers with an Associate Degree (AA), Bachelor's Degree (BA), or advanced degrees in early childhood education. The Head Start reauthorization requires that all Head Start preschool center-based teachers have at least an AA degree or higher with evidence of the relevance of their degree and experience for early childhood education by October 1, 2011, thus the goal for each fiscal year through 2023 is to reach 100 percent. The most recent FY 2021 data indicates that 94.8 percent of Head Start teachers had an AA degree or higher, slightly missing the target, but remaining stable compared to the FY 2019 actual result. Of the 38,607 Head Start preschool teachers in FY 2021, 36,615 had an AA degree or higher. Of these degreed teachers, 8,958 have an AA degree, 22,805 have a BA degree, and 4,852 have an advanced degree. Not included in these numbers are 1,158 teachers with a Child Development Associate (CDA) or state credential and 814 teachers who do not have a degree or CDA. About 21 percent of teachers without a BA or advanced degree are enrolled in a BA degree. ACF continues to provide training and technical assistance funds directly to grant recipients to increase the qualifications of teachers.

[31]There are no results to report for this performance measure in FY 2020 due to program closures from COVID-19.

Maintain the proportion of youth living in safe and appropriate settings after exiting ACF-funded Transitional Living Program (TLP) services. (Lead Agency - ACF; Measure ID - 4A)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	87 %	90 %	90 %	90 %	90 %	91 %	91 %	91%
Result	91.6 %	90.7 %	90 %	90 %	92%	Mar 30, 2022	Mar 30, 2023	Mar 30, 2024
Status	Target Exceeded	Target Exceeded	Target Met	Target Met	Target Exceeded	Pending	Pending	Pending

This annual performance measure pertains to safe and appropriate exit rates for youth from the Transitional Living Program (TLP). The TLP program provides shelter and services to meet the needs of homeless youth to promote long-term economic independence in order to ensure the well-being of the youth. All youth between the ages of 18 and 21 are eligible for up to 18 months of TLP services. This performance measure captures the percentage of TLP youth who are discharged from the program into an immediate living situation that is both safe and appropriate. This goal is achieved through the promotion and support of innovative strategies that help grantees to: 1) encourage youth to complete the program and achieve their developmental goals instead of leaving the program prior to completion; 2) stay connected with youth as they transition out of program residencies and provide preventive, follow-up, and aftercare services; 3) track exiting youth more closely; 4) report accurate data and maintain updated youth records to reduce the number of youth whose exit situations are unknown; and 5) analyze data to discover patterns of participation and opportunities for improved services. During FY 2020, the program exceeded the 90 percent target for this measure by attaining a 92 percent safe and appropriate exit rate. Because safe and stable housing is one of the core outcome areas, ACF proposes to maintain the target of 91 percent for FY 2023. ACF will continue to work to ensure appropriate service delivery and technical assistance systems are in place to support continued high performance on this performance measure.

Number of 0-8-year-old children screened for mental health or related interventions (Lead Agency - SAMHSA; Measure ID - 2.4.00)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	44,775	44,775	18,554	18,554	11,497	8,700	8,573	10,000
Result	22,472	18,554	27,824	27,922	12,390	8,573	Dec 31, 2022	Dec 31, 2023
Status	Target Not Met but Improved	Target Not Met	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Pending	Pending

Established in 2008, Project LAUNCH is a national grant program that seeks to promote the wellness of young children from birth to eight years of age by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. In 2018, SAMHSA funded a cohort of 14 Indigenous LAUNCH grants. This cohort includes sites of varying population size and capacity in Indian Country, two large Alaskan Native Organizations, and the Virgin Islands. A required activity for Project LAUNCH is to conduct screening and assessment to ensure the early identification of behavioral and developmental

concerns using validated screening instruments; to include screening for other behavioral health issues, such as perinatal/maternal depression and substance misuse among parents (including opioid use), as appropriate. Each Project LAUNCH local pilot community implements a set of "5 Core Strategies" that bring evidence-based mental health practices and expertise into the natural settings of early childhood. Grantees identify the evidence-based practices to implement for their population of focus.

The grantee reviews data on the number of children screened from previous years. For the following year, the grantee establishes a target of numbers of children that will be screened during each project year. The COVID-19 pandemic influenced the LAUNCH grantees' ability to reach and engage participants in the program. This impacted the grantee's ability to meet their expected targets in 2020. Additional funding for this program is not anticipated for 2022 and 2023.

Number of participants served by the Maternal, Infant, and Early Childhood Home Visiting Program (Lead Agency - HRSA; Measure ID - 3110.03)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	145,000	145,000	160,000	160,000	160,000	160,000	144,000[32]	163,000
Result	163,853	159,844	153,834	153,247	143,921	144,182[33]	Jan 31, 2023	Date TBD
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Pending	Pending

HRSA's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry living in at-risk communities.

Despite negative impacts to enrollment of new families in Q3 and continuing enrollment of families in Q4 of FY 2020, states reported serving more than 140,000 parents and children in 1,054 counties across all 50 states, the District of Columbia, and five territories. This is more than a 300 percent increase in the number of participants served since FY 2012. MIECHV state and jurisdictional grantees provided over 7.1 million visits from FY 2012 through FY 2020. In FY 2023, HRSA is increasing its target based on the President's Budget request. HRSA expects a gradual increase in numbers of families served for several years following a potential increase in appropriations starting in FY 2023.

Objective 3.3: Expand access to high-quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life

HHS is investing in several strategies to expand access to high-quality services and resources for older adults, people with disabilities, and their caregivers. HHS enhances system capacity to develop

[32]FY 2022 Target reflects FY 2020 results impacted by sequestration, COVID-19, and a reporting error in one state.

[33] Results reflect the most recent data available, which includes FY 2021 data for state, jurisdictional, and Tribal grants.

processes, policies, and supports that are person centered and provide quality care for older adults and individuals with disabilities across settings, including home and community-based settings. HHS ensures the availability and equitable access and delivery of evidence-based interventions that focus on research, prevention, treatment, and care to older adults and individuals with disabilities. HHS also supports development and implementation activities to better understand and address the needs of all caregivers across the age and disability spectrum.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, AHRQ, ASPE, CDC, CMS, IHS, NIH, OASH, and OGA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 3.3 Table of Related Performance Measures

Reduce the percentage of caregivers participating in the National Family Caregiver Support Program who report difficulty in obtaining services. (Lead Agency - ACL; Measure ID - 2.6)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	27%	26.8%	30%	30%	30%	30%	29%	28%
Result	34%	31%	31%	31%	N/A	Dec 31, 2022	Dec 31, 2023	Dec 31, 2024
Status	Target Not Met	Target Not Met but Improved	Target Not Met	Target Not Met	Not Collected[34]	Pending	Pending	Pending

This measure is atypical as a decline indicates improved performance. FY 2013 through 2016 performance indicates a slight increase in difficulties faced by caregivers. In FY 2015, aging network efforts resulted in a nearly three-percentage point improvement in caregivers reporting difficulties obtaining services. Although the target was not met that fiscal year and the rate increased slightly in 2016, the reduction to around 31% in 2017 has held steady and is a sign of improvement. ACL will continue to provide states with technical assistance and work with complementary programs such as Lifespan Respite and Alzheimer's Disease Supportive Services programs to advance system improvements to enhance and strengthen caregiver supports. This measure is calculated using data from the 2020 National Survey of Older Americans Act Participants. The survey was not conducted in 2021 due to the COVID-19 Pandemic. ACL anticipated receiving a result of approximately 31% which is a 3-year weighted average.

34 The result for ACL Measure ID - 2.6 is calculated using data from the 2020 National Survey of Older Americans Act Participants. The survey was not conducted in due to the COVID-19 Pandemic. ACL anticipated receiving a result of 31.03 which is a 3 year weighted average which would result in a target exceeded.

Increase the percentage of individuals with developmental disabilities whose rights were enforced, retained, restored, or expanded. (Lead Agency - ACL; Measure ID - 8F)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	79.55%	Prior Result +1%	Prior Result +1%	Prior Result +1%
Result	N/A	78.1%	78.9%	78.76%	77.95%	Jan 1, 2023	Jan 1, 2024	Jan 1, 2025
Status	Not Collected	Historical Actual	Historical Actual	Historical Actual	Target Not Met	Pending	Pending	Pending

Under the Developmental Disabilities Assistance and the Bill of Rights Act of 2000 (DD Act), each state and territory has a Developmental Disabilities Protection and Advocacy (P&A) program designated by the state's governor. The DD Act and other authorizing statutes give the P&A the authority to advocate for the rights of individuals with disabilities. The DD Act states that each P&A has the authority to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State."[35] P&As provide a range of legal services and use a range of remedies, including self-advocacy assistance, negotiation, investigation, and litigation, to advocate for traditionally unserved or underserved individuals with developmental disabilities. P&A authorities are critical to preventing abuse and neglect of people with disabilities and safeguarding individuals' right to live with dignity and self-determination.

In FY 2020, Administration on Disabilities program staff continued to work with ACL's Office of Performance and Evaluation to develop or improve logic models and performance measures for this program. ACL staff are piloting methods for collecting data and working on developing standard methods for analyzing the data to identify trends and results.

Increase the age-adjusted percentage of adults (age 18+) diagnosed with arthritis who were counseled by a doctor or other health professional to be physically active or exercise to help arthritis or joint symptoms, in states funded by the CDC Arthritis Program (Lead Agency - CDC; Measure ID - 4.10.1)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	Set Baseline	N/A	70.3 %	N/A	71 %
Result	N/A	N/A	N/A	70 %	N/A	Sep 30, 2022	N/A	Sep 30, 2024
Status	Not Collected	Not Collected	Not Collected	Baseline	Not Collected	Pending	Not Collected	Pending

Recent projections indicate that arthritis prevalence and arthritis-associated limitations are increasing and confirm that arthritis remains a top cause of morbidity, work limitations, and compromised quality of life. Arthritis affects more than 58.5 million adults, almost 60% of whom are working aged adults (< 65) and is projected to affect 78.4 million adults by 2040. There is good evidence that physical activity can reduce joint pain, improve function, and halt or delay physical disability among adults with arthritis, but physical activity levels are lower for adults with arthritis than adults without arthritis. Adults with

[35] 42 U.S.C. 15043

arthritis are more likely to engage in physical activity and self-management education programs when recommended by a health care provider. This strategy and an emphasis on provider recommendations are reflected in CDC's new state arthritis program and will be reflected in other, future activities of the arthritis program.

A new arthritis program state cooperative agreement began in FY 2018. This has given the program an opportunity to begin work with 13 states on innovative activities. The BRFSS 2019 age-adjusted pooled estimate for the 13 funded states serves as a baseline for the program performance measure and indicates 70% of adults with arthritis reported being counseled about the benefits of physical activity for managing arthritis by a health care provider that year.

The future targets were set to be consistent with an outcome measure in CDC's State Public Health Approaches to Addressing Arthritis Notice of Funding Opportunity. A 1% increase over 5 years for this outcome measure was reasonable given the scope of work required and the award amount per state.

Decrease the prevalence of hemophilia treatment inhibitors among Community Counts - Health Outcomes Monitoring System for People with Bleeding Disorders at HTCs (Lead Agency - CDC; Measure ID - 5.3.2)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	4.3 %	Set Baseline	5.7 %	5.6 %	5.5 %	5.4 %	4.8 %	4.4 %
Result	5.5 %	7 %[36]	6.4 %	5.8 %	5.1 %	Dec 31, 2022	Dec 31, 2023	Dec 21, 2024
Status	Target Not Met but Improved	Baseline	Target Not Met but Improved	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

CDC protects people and prevents complications of blood disorders by reducing the prevalence of inhibitors among hemophilia patients and increasing the proportion of very young hemophilia patients receiving early prophylaxis treatment. Through Community Counts, CDC collects data on health issues and medical complications for people living with bleeding disorders, incorporates screening for inhibitors, and monitors treatment use, including prophylaxis, to facilitate best practices that help prevent or eradicate complicated, costly, and debilitating health conditions.

Approximately 15-20% of people with hemophilia develop an inhibitor, a condition where the body stops accepting the factor treatment product (which helps the blood clot properly) as a normal part of blood. The body treats the "factor" as a foreign substance and mounts an immune system response to destroy it with an inhibitor. When people develop inhibitors, treatments to prevent and stop bleeding episodes are less effective. Special treatment is required until the body stops making inhibitors, which

[36]CDC established a new data soruce in FY 2017. Results cannot be compared to previous years.

can increase hospitalizations, compromise physical function, and exceed $1,000,000 a year for a single patient.

Discovering an inhibitor as soon as possible helps improve outcomes and reduce costs. Although hemophilia care providers widely accept that development of an inhibitor is a serious issue, routine screening for inhibitors is not current practice for local laboratories because of the high cost and the inability to perform the proper tests.

In FY 2020, the prevalence of hemophilia treatment inhibitors was 5.1% which surpassed the FY 2020 target by eight percent. The continued decrease in inhibitor prevalence demonstrates marked improvement for the population's management of complications, and preliminary results for FY 2021 are trending similarly.

Increase the percentage of older adults who receive appropriate clinical preventive services (Lead Agency - AHRQ; Measure ID - 2.3.7)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	Develop national estimates of receipt of high-priority clinical preventive services from MEPS	Continue to analyze MEPS pilot data to determine if the data can be used to provide national estimates of receipt of high-priority clinical preventive services. Use MEPS data and data from the evaluation of the USPSTF's recommendations implementation project in order to identify specific preventive	Prepare for and collect PSAQ data again in FY 2018	Continue PSAQ data collection through 2019. The panel design of the survey features several rounds of interviewing covering two full calendar years. Data should be available in 2020.	New data for the PSAQ prevention items available	2021 PSAQ data collection continues. Administer another round of the PSAQ.	Complete analysis of FY 2018/2019 data New data from FY 2020/2021 will be available Begin collecting FY 2022/2023 data	Begin analysis of FY 2020/2021 data Continue collecting FY 2022/2023 data

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
		services that can be targeted for improvement.						
Result	Began analysis of pilot data to assess whether it can be used to develop a clinical preventive services composite measure within the MEPS survey	Pilot data was found to be reliable and valid to provide national estimates of receipts of high-priority clinical preventive services. Survey results found that 8 percent of adults (35+) received all of the high priority, appropriate clinical preventive services (95% confidence interval: 6.5% to 9.5%). Analyses are underway to identify specific preventive services that can be targeted for improvement.	PSAQ data collection began and is underway.	Collected and began analysis of PSAQ data	Collected new data	Date TBD	Sep 30, 2022	Sep 30, 2023
Status	Target Extended	Target Met	Target Met	In Progress	Target Met	In Progress	In-progress	Not collected

In FY 2021, AHRQ continued to provide ongoing scientific, administrative and dissemination support to

the U.S. Preventive Services Task Force (USPSTF). The Task Force makes evidence-based recommendations about clinical preventive services to improve the health of all Americans (e.g., by improving quality of life and prolonging life). By supporting the work of the USPSTF, AHRQ helps to identify appropriate clinical preventive services for adults, disseminate clinical preventive services recommendations, and develop methods for understanding prevention in adults.

For several years, AHRQ has invested in creating a national measure of the receipt of appropriate clinical preventive services by adults (measure 2.3.7). A necessary first step in creating quality improvement within health care is measurement and reporting. Without the ability to know where HHS is and the direction HHS is heading, it is difficult to improve quality. This measure will allow AHRQ to assess where improvements are needed most in the uptake of clinical preventive services. It will help AHRQ support the USPSTF by targeting its recommendations and dissemination efforts to the populations and preventive services of greatest need. Thus, making sure the right people get the right clinical preventive services, in the right interval. The data from this measure can also identify gaps in the receipt of preventive services and therefore inform the Department's and the public health sector's prevention strategies.

AHRQ now has a validated final survey to collect data on the receipt of appropriate clinical preventive services among adults (the Preventive Services Self-Administered Questionnaire (PSAQ) in the AHRQ Medical Expenditure Panel Survey (MEPS)). The survey was fielded in a pilot test in 2015. It is a self-administered questionnaire that will be included as part of the standard MEPS starting in 2018. Additional years of data will allow for AHRQ to track and compare receipt of high priority, appropriate clinical preventive services over time.

The panel design of the survey, which features several rounds of interviewing covering two full calendar years, makes it possible to determine how changes in respondents' health status, income, employment, eligibility for public and private insurance coverage, use of services, and payment for care are related. Once data is collected, it is reviewed for accuracy and prepared to release to the public.

In FY 2021, AHRQ continued to analyze the FY 2018/2019 data. It also continued collecting the FY 2020/2021 data.

In FY 2022, AHRQ anticipates completing analysis of the FY 2018/2019 data. It also anticipates the FY 2020/2021 preventive items data will become available, and data collection for the FY 2022/2023 will begin.

In FY 2023, AHRQ anticipates it will begin analysis of the FY 2020/2021 data, and continue data collection for the FY 2022/2023 data.

Objective 3.4: Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence

HHS increases safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence. The Department continues its efforts to promote coordination across the government to address the full range and multiple forms of neglect, violence, trauma, and abuse across the life span. HHS is building a resource infrastructure to ensure equitable delivery of high-quality services to support affected individuals, families, and communities. HHS also leverages data to inform the development of effective and innovative prevention and intervention models to address neglect, abuse, and violence.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, ASPE, CDC, HRSA, IHS, NIH, OASH, and SAMHSA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 3.4 Table of Related Performance Measures

Increase the capacity of the National Domestic Violence Hotline to respond to increased call volume (as measured by percentage of total annual calls to which the Hotline responds). (Lead Agency - ACF; Measure ID - 14A)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	84 %	84 %	82 %	82 %	75 %	75 %	75 %	75 %
Result	75 %	75 %	74 %	62 %	56%	62%	Mar 1, 2023	Mar 1, 2024
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Not Met, but Improved	Pending	Pending

The staff and volunteers of the National Domestic Violence Hotline (Hotline) provide victims of family violence, domestic violence, and dating violence; family and household members; and other persons such as advocates, law enforcement agencies and the general public with crisis intervention, emotional support, safety planning, domestic violence information, and referrals to local service providers as well as national resources. Measurement of the Hotline's performance has historically focused on the percentage of total annual responses to calls in relation to the number of calls received. This performance measure acknowledges that tracking the answers or responses to calls is a better determinant of the Hotline's usefulness than reporting the number of calls received (as previously reported).

In FY 2021, the Hotline answered 396,803 total contacts across platforms (The Hotline and LIR), which is 49,322 more contacts than the Hotline answered in FY 2021. The Hotline's FY 2021 our overall answer

rate was sixty-seven percent (67 percent). On average, callers waited 5 minutes and 37 seconds for a connection to a Phone Services Advocate. Direct connect, which allows an Advocate to connect and transfer a caller to a local provider, was offered by Phone Services Advocates 16,740 times. In FY 2021, the Hotline experienced a significant increase in digital contacts compared to phone contacts. The Hotline's Digital Services Advocates answered a total of 107,399 Hotline chats in FY 2020, in FY 2021, Digital Services Advocates answered 151,671 Hotline chats. In FY 2021, the Hotline saw an increase in average talk time and wait times during this reporting period, which results in a decrease in advocate availability. The Hotline's advocates provide survivors with in-depth advocacy, lethalityassessment, support, and safety planning which leads to longer interaction times. Less advocate availability does ultimately impact the Hotline's answer rate and wait times. More survivors are choosing to reach out for the Hotline's services digitally (for safety reasons, especially during the continued COVID-19 pandemic), and the launch of Hotline text services provided an additional method to do so. On May 13, 2021, the Hotline launched text services by text-enabling the Hotline's toll-free phone number. On June 14th, the SMS short code- text Start to 88788- for Hotline text services became active. Previously, text services were only available through LIR. The success for answering more contacts can be attributed to efficiencies created through effective scheduling, technological enhancements, and training initiatives for advocates. It is not feasible for 100 percent of calls received to be answered due to unanticipated spikes resulting from media coverage promoting the Hotline phone number and increases in call volume during the rollover of state or local program crisis lines during an emergency or disaster. In addition, some situations require a caller to disconnect before an advocate can answer (e.g. the abuser enters the room). Given the expected continual rise in callers contacting the Hotline, increased hours of training for new advocates, and increased programmatic and financial support to StrongHearts Native Helpline, the Hotline is projected to have a performance rate of 75 percent through FY 2023.

Decrease the percentage of children with substantiated or indicated reports of maltreatment that have a repeated substantiated or indicated report of maltreatment within six months. (CAPTA) (Lead Agency - ACF; Measure ID - 7B)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	6.2%	6.3%	6.7%	6.5%	6.4%	Prior Result -0.2PP	Prior Result -0.2PP	Prior Result -0.2PP
Result	6.5%[37]	6.9%	6.7%	6.6%	6.2%	Oct 30, 2022	Oct 30, 2023	Oct 30, 2024
Status	Target Not Met	Target Not Met	Target Met	Target Not Met but Improved	Target Not Met	Pending	Pending	Pending

The annual performance measure regarding repeat child maltreatment evaluates the trend in the percentage of children with substantiated or indicated reports who experience repeat maltreatment. ACF has set a target of decreasing the percentage of child victims who experience repeat maltreatment by 0.2 percentage points per year. In FY 2017, the rate of repeat maltreatment increased to 6.9 percent, missing the target of 6.3 percent. There was improved performance on this measure for FY 2018 with

[37]The FY 2016 actual result for this performance measure was updated based on a technical correction to calculate the data based on the national population, which is consistent with previous results. The FY 2017 target was updated as a result of this change.

6.7 percent of victims having repeat maltreatment, which met the target of 6.7 percent. For FY 2019, the rate of recurrence decreased to 6.6 percent, just missing the target of 6.5 percent. For FY 2020, the rate of recurrence decreased to 6.2 percent, exceeding the target of 6.4 percent. ACF will continue to support states in their efforts to support children and families who are experiencing a crisis, while ensuring the safety of children. The CAPTA State Grant program provides formula grants to states to improve child protective service systems through a range of prevention activities, including addressing the needs of infants born with prenatal drug exposure, referring children not at risk of imminent harm to community services, implementing criminal record checks for prospective foster and adoptive parents and other adults in their homes, training child protective services workers, protecting the legal rights of families and alleged perpetrators, and supporting citizen review panels. The renewed emphasis on prevention efforts, in tandem with funding for the Community-Based Child Abuse Prevention (CBCAP) program that also assists states in their efforts to prevent child abuse and neglect while promoting healthy parent-child relationships, may also assist in improving performance in this area. By FY 2023, the program expects to work with states in again reducing the rate of repeat maltreatment by 0.2 percent from the previous year's actual result.

Increase the number of potential trafficking victims identified by the hotline. (Lead Agency - ACF; Measure ID - 17D)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	19,434 cases	16,255 cases	23,123 cases	26,322 cases	21,105 cases	Prior Result +10[38]	Prior Result +10[39]
Result	16,407 cases	21,644 cases	34,753 cases	30,684 cases	19,186 cases	Jan 31, 2022	Jan 31, 2023	Jan 31, 2024
Status	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

This performance measure demonstrates the continued work of the National Human Trafficking Hotline (NHTH) in identifying potential victims of human trafficking and increasing the number of incoming communications from victims and survivors. In FY 2019, the program funding level was increased by 100 percent and the hotline grantee launched an enhanced Interactive Voice Recognition system to prioritize calls directly from victims and those close in proximity to the potential trafficking situation. That year, the hotline identified 30,684 potential victims of trafficking[40]. In FY 2020, the total number of potential victims identified decreased to 19,186, a 37 percent decrease from the prior year. However, the total number of potential cases identified (case each could have one or more victims) only decreased by six percent from the prior year (11,852 potential cases identified in FY 2019 and 11,193

[38]The FY 2022 target is to increase by 10 percent over the average of the previous four years of actual results. This target has been set to address recent data trends that reflect a more modest increase to the number of potential trafficking victims identified by the hotline and to account for possible stagnation in performance numbers due to a possible change in grantee with the new funding award in FY 2021.
[39]The FY 2022 target is to increase by 10 percent over the average of the previous four years of actual results. This target has been set to address recent data trends that reflect a more modest increase to the number of potential trafficking victims identified by the hotline and to account for possible stagnation in performance numbers due to a possible change in grantee with the new funding award in FY 2021.
[40] It is important to note that federal funding represents only 72 percent of the total operating cost of hotline services.

potential cases identified in FY 2020). The total number of signals from potential victims increased by 27 percent (10,362 signals in FY 2019 and 13,129 signals in FY 2020). This result indicates that while more signals came in directly from potential victims of trafficking, the cases of potential trafficking may have involved fewer victims per case than in prior years. Some of these results may have also been impacted by challenges related to the COVID-19 pandemic, including quarantine and social-distancing measures. Other pandemic-related challenges that impacted the operation of the hotline included the move to remote operations that may have limited in-person supervisory support, staff wellness and increased turnover attributed to pandemic and/or secondary trauma on calls, increased mental health calls from the public requiring more time per call, and the spread of viral misinformation on human trafficking increasing overall call volume (which increased from 136,990 total signals in FY 2019 to 15,100 signals in FY 2020). While ACF did not meet this particular target for FY 2020, it increased the number of signals received directly from potential victims and responded to a record number of overall signals. In FY 2021, ACF provided supplemental funding for the hotline to increase staffing capacity, recruitment and retention, and mental health and wellness resources.

By FY 2023, ACF aims to increase incoming communications to the hotline from victims and survivors and the number of potential trafficking victims identified by the hotline by ten percent over the average of the previous four years of actual results. This growth is anticipated, at least in part, due to the award of a $1 million contract in September 2021 for Look Beneath the Surface Public Awareness and Outreach Campaign Strategy and Materials. The campaign reflects the diversity of the anti-trafficking community, and messages will be targeted to reach marginalized populations and encourage those experiencing human trafficking to seek help, which will hopefully translate to increased communications to the NHTH.

Increase the percentage of placement designation of referrals of Unaccompanied Children (UC) from Department of Homeland Security within 24 hours of referral. (Lead Agency - ACF; Measure ID - 19A)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	99 %[41]	99 %	99 %	99 %	99 %	99 %	99 %	99 %
Result	99.97 %	98.67 %	69.3 %	64.9 %	99.27%	Mar 1, 2022	Mar 1, 2023	Mar 1, 2024
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Target Met	Pending	Pending	Pending

Since 2014, ACF has expanded its network of care to be able to continue increasing the percentage of placement designation of referrals of unaccompanied children (UC) from the Department of Homeland Security (DHS) within 24 hours of referral. In FY 2017, ACF was able to designate placement within 24 hours of referral to 98.67 percent of the UC referred by DHS. This performance measure is calculated by taking the number of UC who were designated for placement within 24 hours of referral divided by the total number of referrals per fiscal year. In FY 2017, due to a lower number of referrals and a surplus in bed capacity, bed capacity was reduced by approximately 30 percent. FY 2018 referrals were 20 percent higher than FY 2017 with a further 42 percent increase in FY 2019. Changes to the overall bed capacity

[41]The target for this performance measure is to improve by 1 percent over the previous year's actual result until a maintenance rate of 99 percent is achieved.

were insufficient in FY 2018 to accommodate the increase in referrals and ACF was not able to meet the target of 99 percent (actual result of 69.3 percent), and again in FY 2019 (actual result of 64.9 percent did not meet the target of 99 percent).

In order to meet the number of referral of UC and to ensure the best placement based on the medical and/or mental health needs and safety of the children, ACF has since brought on additional bed capacity. The program's ability to avoid a buildup of children waiting in border patrol stations for placement in shelters is accommodated through the expansion of existing programs through the supplemental grant award process. In FY 2020, performance improved to 99.27 percent, meeting the performance target. In order to meet future targets, ACF will continue efforts to streamline operations and make changes to existing policies and procedures to decrease length of stay. The program also continues to experience a higher volume of referrals and is engaged in increasing the overall program capacity needs.

Increase Intimate Partner (Domestic) Violence screening among American Indian and Alaska Native (AI/AN) Females (Lead Agency - IHS; Measure ID - 81)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	41.6 %	41.6 %	41.5 %	37.5 %	36.3 %	TBD
Result	N/A	N/A	38.1 %	36.3 %	30.2%	27.2%	Jan 31, 2023	Jan 31, 2024
Status	Not Collected	Not Collected	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Pending	Pending

Domestic and intimate partner violence has a disproportionate impact on AI/AN communities. AI/AN women experience intimate partner violence at higher rates than any other single race or ethnicity in the United States. However, intimate partner violence is a preventable public health problem and screening for Intimate Partner (Domestic) Violence provides the ability to identify victims and those at risk for injury. The Intimate Partner (Domestic) Violence screening measure supports improved processes for identification, referral, and treatment for female victims of domestic violence. Starting in FY 2018, IHS began reporting the Intimate Partner (Domestic) Violence screening measure for females (age 14-46) using the IHS Integrated Data Collection System Data Mart (IDCS DM). FY 2021 represents the fourth year of IDCS DM reporting; IHS continues to monitor and adjust to reporting system changes and provide training for documentation in the electronic reporting system.

Although several IHS Areas met or exceeded the FY 2021 target, IHS did not meet the national target of 37.5 percent. The IHS COVID-19 pandemic response and the transition from in person primary care to virtual care at several sites, may have impacted screening women for DV/IPV. To avoid potential coronavirus exposure risk, there have been fewer in-person visits and many health care services for prevention and health maintenance were postponed by patients during the pandemic. While patients with acute illness or the need for emergency care were still seen at IHS facilities, the COVID-19 pandemic response limited healthcare provider – patient interactions and reduced opportunities to screen the general population. Due to the sensitivity of the DV/IPV screening, proper administration requires the health care provider to ensure the patient is comfortable responding without external influence. Therefore, increased telehealth visits that occur within a patient's home would not necessarily meet the safety and security recommendations to be applied during the DV/IPV assessment.

Due to COVID-19 response efforts, opportunities for facilities to participate and complete trainings were limited. As HHS resumes in-person office visits, IHS anticipates an increase in screening rates for intimate partner violence. Successful strategies as a pathway to success will focus on enhanced communication to staff, frequent data review; staff trainings that target the use of specific screening tools; and inclusion of this important measure in facility quality improvement projects. In FY 2021, IHS continued to provide technical assistance and training to IHS health care providers and encourage dissemination of these evidence-based strategies across all facilities and a particular focus on tribal community-based projects supported by the Domestic Violence Prevention Initiative. IHS provides outreach and assistance to tribal sites upon request with a virtual training made available in FY 2020 regarding a specific Intimate Partner Violence (IPV) lethality risk screening tool. In addition, in FY 2021 IHS released four webinars focused on improving the healthcare infrastructure to support victims of violence. IHS will continue to build upon these efforts during FY 2022 and FY 2023.

Increase the number of prevention and response strategies from CDC's resource Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence being implemented by state and local health departments funded through the multistate ACEs cooperative agreement. (Lead Agency - CDC; Measure ID –7.F (new))

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	15	20	30
Result	N/A	N/A	N/A	N/A	11	15	Dec 31, 2022	Dec 31, 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Baseline	Target Met	Pending	Pending

Strategies drawn from the Preventing ACEs Best Available Evidence resource are being implemented by each of the funded Preventing Adverse Childhood Experiences: Data to Action (PACE: D2A) recipients. This indicator tracks trends associated with implementing evidence-based strategies to prevent and respond to adverse childhood experiences (ACEs) and addresses the effectiveness of CDC's actions to translate science into action. CDC's mission with respect to ACEs is to prevent, identify, and respond to them using evidence-based strategies, and this indicator is the most direct measure of CDC success in that regard. The PACE: D2A initiative helps ensure states and intrastate partners have access to the best available evidence for ACEs prevention and response. In FY 2020 11 prevention and response strategies were being implemented by funded recipients. Future targets were set based on an assessment of what realistic growth may look like.

Expand the number of evidence-based resources on best practices and core components of trauma-informed care for clinical practice that are available on the National Center for Injury Prevention and Control website. (Lead Agency - CDC; Measure ID –7.G (new))

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	2	5

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Result	N/A	N/A	N/A	N/A	N/A	0	Dec 31, 2022	Dec 31, 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Baseline	Pending	Pending

CDC is leading efforts to prevent violence before it begins and reaching out to audiences with new prevention strategies. CDC adapts and disseminates actionable resources based on rigorous science to equip every available partner with the tools they need to build trauma-informed systems and infrastructure. Equipping partners with the tools and resources they need to move from principle to practice of trauma-informed care in school, healthcare, housing, justice-serving, and other behavioral and mental health service spaces will help amplify CDC's impact and equip its partners to do the same. This measure ensures CDC continues to push to generate and disseminate resources on trauma-informed care for clinical settings (and other partners), to ensure that its systems responses to people who have experienced trauma is not harmful.

Future targets were set based on the products and deliverables expected in relation to CDC's adverse childhood experiences (ACEs) and trauma informed care work that is underway.

Strategic Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All

HHS is dedicated to restoring trust and accelerating advancements in science and research. The Department is prioritizing science, evidence, and inclusion to improve the design, delivery, and outcomes of HHS programs. It is investing in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs. Strengthening surveillance, epidemiology, and laboratory capacity is another major focus to better understand and equitably address diseases and conditions. HHS is also increasing evidence-based knowledge through improved data collection, use, and evaluation efforts to achieve better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience.

Objective 4.1: Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion

HHS works on strategies to improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion. The Department leverages stakeholder engagement, communication, and collaboration to build and implement evidence-based interventions and approaches for stronger health, public health, and human services outcomes.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 4.1 Table of Related Performance Measures

By 2026, enhance understanding of how five health information technologies can be applied effectively to improve minority health or to reduce health disparities. (Lead Agency - NIH; Measure ID - SRO-5.18)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	Develop an adaptive smoking cessation intervention targeting adolescents of health disparity populations using the QuitStart mobile application.	Determine if a mobile phone app is effective in promoting physical activity or reducing weight among racial and ethnic minority populations.	Investigate the utility of a natural language processing (NLP) algorithm to identify patients from health disparity populations who are experiencing social isolation or other social stressors using clinical narratives in electronic health

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
								record (EHR) systems.
Result	N/A	N/A	N/A	N/A	N/A	NIH investigators developed a new smoking cessation mobile application, QuitJourney, based on QuitGuide (not QuitSTART, which is for adolescents) and conducted acceptability and usability testing with 48 young adults.	Dec. 2022	Dec 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Target Met	In Progress	In Progress

Health information technology (health IT) refers to a variety of electronic methods that can be used to manage information about people's health and health care. Although health IT holds much promise for reducing disparities in populations that are medically underserved by facilitating behavior change and improving quality of health care services and health outcomes, few studies have examined the impact of health IT adoption on improving health outcomes and reducing health disparities among racial and ethnic minority individuals, people of less privileged socioeconomic status, underserved rural populations, and sexual and gender minority populations. Thus, NIH is investing in research to explore the potential of health IT for improving the health of underserved populations and reducing health disparities using technologies such as decision support tools, mobile apps, and new technologies such as artificial intelligence and natural language processing.

In FY 2021, NIH investigators developed QuitJourney, a mobile health (mHealth) smoking cessation intervention for low socioeconomic young adult smokers using the mobile app QuitGuide. The investigators also recruited 48 low socioeconomic young adult smokers, ages 18 to 29, to ensure the features of QuitJourney would be acceptable to and usable by low socioeconomic young adult smokers. Now the investigators plan to conduct a pilot study that will help them develop an algorithm to accurately predict post-quit cravings in real time and deliver personalized messages to help low socioeconomic young adult smokers cope with their cravings. They also plan to conduct a proof-of-concept study to obtain preliminary evidence on QuitJourney's effectiveness in real-world settings. If QuitJourney is proven to be effective, it will provide a tool to help low socioeconomic young adult smokers quit smoking and stay smokefree.

In FY 2022, NIH is supporting research to determine if a mobile phone app is effective in promoting physical activity or reducing weight among racial and ethnic minority populations. In FY 2023, NIH will investigate the utility of a natural language processing (NLP) algorithm to identify patients from health disparity populations who are experiencing social isolation or other social stressors using clinical narratives in electronic health record (EHR) systems.

Increase the percentage of Community-Based Child Abuse Prevention (CBCAP) total funding that supports evidence-based and evidence-informed child abuse prevention programs and practices. (Lead Agency - ACF; Measure ID - 7D)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	62.4 %	57.3 %	56.4 %	64.5 %	65.8 %	Prior Result +3PP	Prior Result +3PP	Prior Result +3PP
Result	54.3 %	53.4 %	61.5 %	62.8 %	66.3%	Oct 30, 2022	Oct 30, 2023	Oct 30, 2024
Status	Target Not Met	Target Not Met	Target Exceeded	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

The most efficient and effective programs often use evidence-based and evidence-informed practices. ACF developed an efficiency measure to gauge progress towards programs' use of these types of practices. ACF is working closely with the states to promote more rigorous evaluations of their funded programs. Over time, ACF expects to increase the number of effective programs and practices that are implemented, thereby maximizing the impact and efficiency of Community-Based Child Abuse Prevention (CBCAP) funds. For the purposes of this efficiency measure, ACF defines evidence-based and evidence-informed programs and practices along a continuum, which includes the following four categories of programs or practices: Emerging and Evidence Informed; Promising; Supported; and Well-Supported. Programs determined to fall within specified program parameters will be considered to be implementing "evidence-informed" or "evidence-based" practices (collective referred to as "EBPs"), as opposed to programs that have not been evaluated using any set criteria. The funding directed towards these types of programs (weighted by EBP level) will be calculated over the total amount of CBCAP funding used for direct service programs to determine the percentage of total funding that supports evidence-based and evidence-informed programs and practices. A baseline of 27 percent was established for this measure in FY 2006. The target of a three percentage point annual increase in the amount of funds devoted to evidence-based practice was selected as a meaningful increment of improvement that takes into account the fact that this is the first time that the program has required grantees to target their funding towards evidence-based and evidence-informed programs, and it will take time for states to adjust their funding priorities to meet these new requirements.

In general, the majority of CBCAP funding is directed toward EBPs. In FY 2016, 54.3 percent of funds went to EBPs. The FY 2017 result represented a slight decrease in performance, at 53.4 percent, yet still with a majority of funds being used for EBPs. ACF is committed to continuing to work with CBCAP grantees to invest in known EBPs and focusing efforts to provide one-on-one and peer learning technical assistance to increase accuracy of data reporting for this measure. Fiscal year 2018 represented an increase with grantees reporting 61.5 percent of funds being directed at EBPs. Fiscal year 2019 also saw an increase with grantees reporting 62.8 percent of funds directed toward EBPs. Despite this increase, it did not meet the target of 64.5 percent. In FY 2020, however, the percentage spent on EBPs increased to 66.3 percent, exceeding the target of 65.8 percent. ACF will continue to promote evaluation and innovation, so as to expand the availability and use of evidence-informed and evidence-based practice

over time and continue to set the target of an annual three percentage point increase over the prior year.

Objective 4.2: Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs

HHS is investing in strategies to support the research enterprise and the scientific workforce. HHS works to build public trust by upholding scientific integrity and quality. HHS is also working to recruit, retain, and develop a diverse and inclusive scientific workforce to conduct basic and applied research in disease, healthcare, public health, and human services. HHS supports innovation in how research is supported, conducted, and translated into interventions that improve health and well-being.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, ASPE, ASPR, CDC, FDA, HRSA, NIH, OASH, OCR, and OGA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 4.2 Table of Related Performance Measures

By 2025, develop or evaluate the efficacy or effectiveness of new or adapted prevention interventions for substance use disorders (SUD). (Lead Agency - NIH; Measure ID - SRO-5.2)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	Conduct 3-5 pilot studies to test the efficacy of promising prevention interventions for SUD.	Launch 1-2 clinical trials, based on pilot study results, to test the effects of a prevention intervention for opioid use disorder.	Conduct 1-2 studies to test the effectiveness of prevention interventions focused on electronic nicotine delivery systems (including vaping).	Launch 1-2 clinical trials testing multi-level approaches to prevent opioid and other substance misuse by intervening on social determinants of health in addition to individual level risk factors.
Result	N/A	N/A	N/A	N/A	Nine prevention	Two clinical trials were	Dec. 2022	Dec. 2023

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
					pilot studies were conducted as part of the Helping to End Addiction Long-term (HEAL^{SM}) Initiative.	launched as part of the Helping to End Addiction Long-term (HEAL) Initiative®.		
Status	Not Collected	Not Collected	Not Collected	Not Collected	Target Exceeded	Target Met	In Progress	In Progress

Preventing the initiation of substance use and minimizing the risks of harmful consequences of substance use are essential parts of addressing SUD. NIH's prevention research portfolio encompasses a broad range of research on how biological, social, and environmental factors operate to enhance or lessen an individual's propensity to begin substance use, or to escalate from use to misuse to SUD. This line of research, along with rapidly growing knowledge about substance use and addiction (including tobacco, alcohol, illicit, and nonmedical prescription drug use), is helping to inform the development of evidence-based prevention strategies.

In FY 2021, NIH launched two clinical trials to test two opioid prevention interventions for adolescents and young adults. Both trials are part of the Helping to End Addiction Long-term (HEAL) Initiative® started by NIH to develop scientific solutions to stem the Nation's opioid public health crisis. In the first trial, researchers tested a videogame intervention, in school-based health centers, for preventing high-risk adolescents, aged 16-19, from starting to use opioids. In the second trial, researchers tested another videogame intervention for preventing opioid use disorder (OUD) in adolescents and young adults, aged 16-25, who are confined in a state juvenile justice system. The researchers chose a videogame intervention because it is more appealing to adolescents and young adults than standard interventions. In addition, it can reach large populations with consistent reliability at potentially lower cost. If proven effective, this may provide a promising approach to prevent adolescents and young adults in a variety of settings from starting to use opioids or escalating from use to misuse to OUD.

In FY 2022, NIH is conducting two studies to test the effectiveness of prevention interventions focused on electronic nicotine delivery systems (including vaping). In FY 2023, NIH will launch 1-2 clinical trials to test multi-level approaches to prevent opioid and other substance misuse by intervening on social determinants of health in addition to individual-level risk factors. (Social determinants of health refer to the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.)

Provide research training for predoctoral trainees and fellows that promotes greater retention and long-term success in research careers. (Lead Agency - NIH; Measure ID - CBRR-1.1)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Result	Award rate to comparison group reached 12%	Award rate to comparison group reached 12%	Award rate to comparison group reached 11%	Award rate to comparison group reached 11%	Award rate to comparison group reached 11%	Award rate to comparison group reached 10%	Dec, 2022	Dec. 2023
Status	Target Met	Target Met	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

A critical part of the NIH mission is the education and training of the next generation of biomedical, behavioral, and clinical scientists. The overall goal of the NIH research training program is to maintain a population of scientists that is well educated, highly trained, and dedicated to meeting the Nation's future health-related research needs. Success of NIH predoctoral research training programs can be measured, in part, by the number of trainees and fellows that go on to apply for and receive subsequent NIH career development and research awards. Subsequent support is an indicator of retention success in the research arena, and reflects the impact of NIH-funded training on the ability of trainees and fellows to be competitive and sustain a research career with independent funding.

Each year, NIH assesses the degree to which predoctoral trainees and fellows who received NIH-funded training through a National Research Service Award (NRSA) are more likely to remain in research careers and successfully compete for NIH funding after the completion of their degrees as compared to (a) other doctoral students at the same institutions over the same time period who did not receive NRSA support themselves, and (b) doctoral students at institutions not receiving RSA support. As part of this assessment, NIH determines the award rate to comparison group, which refers to the difference in percentage points between NRSA-funded individuals and other doctoral students at the same institutions who successfully compete for NIH funding after completion of their doctoral degrees. A 2001 assessment of the early progress of NRSA predoctoral trainees and fellows showed that the percentage of NRSA-funded individuals who applied for funding from NIH or the National Science Foundation was typically 10 percentage points higher than those who graduated from NIH-funded training institutions but who were not direct recipients of NRSA predoctoral funding. Tracking this measure annually provides NIH with an indication of whether NRSA support continues to play a key role in retaining predoctoral trainees and fellows in biomedical, behavioral, and clinical research careers.

In FY 2021, NIH-funded predoctoral trainees and fellows were 10 percentage points more likely to remain active in biomedical research than non-NIH trainees and fellows. In future years, NIH will continue to assess whether NIH-funded predoctoral trainees and fellows are at least 10 percentage points more likely to remain active in biomedical research than non-NIH trainees and fellows.

Increase the total number of mentored research career development experiences for trainees from diverse backgrounds, including groups underrepresented in biomedical research, to promote individual development and to prepare them for a range of research-related careers. (Lead Agency - NIH; Measure ID - CBRR-25)

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	3,505 career experiences across all career stages	3,522 career experiences across all career stages	3,539 career experiences across all career stages	3,540 career experiences across all career stages	3,545 career experiences across all career stages	3,550 career experiences across all career stages
Result	3,706 mentored research career development experiences for trainees from underrepresented backgrounds to promote individual development and to prepare them for a range of research-related careers were supported across all training related stages, exceeding the target.	Trainees from diverse backgrounds received a total of 3,797 career experiences across all career stages.	Trainees from diverse backgrounds received a total of 3,779 career development experiences across all career stages.	Trainees from diverse backgrounds received a total of 3,779 career development experiences across all career stages.	Dec, 2022	Dec. 2023
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	In Progress

NIH is committed to diversifying the Nation's biomedical research workforce. It funds numerous programs – at the undergraduate, graduate, postdoctoral, and faculty levels – that foster research training and the development of a strong and diverse workforce. The National Institute of General Medical Sciences, a component of NIH, develops and manages many of these programs. A key focus of the Institute is to provide trainees with mentored research training and career development experiences that help them acquire important knowledge and skills to drive scientific discovery and innovation.

This measure highlights a critical component in the development of trainees from underrepresented backgrounds and tracks that data across different career stages. Underrepresented backgrounds include historically underrepresented racial/ethnic minorities (e.g., Blacks or African Americans, Hispanics or Latinos, American Indians or Alaska Natives, Native Hawaiians, and other Pacific Islanders), individuals with disabilities, and individuals from disadvantaged backgrounds (through the undergraduate stage). In FY 2021, the Institute supported 3,779 career development experiences across all career stages for trainees from diverse backgrounds. The Institute aims to support 3,545 and 3,550 career development experiences across all career stages for trainees from diverse background in FY 2022 and FY 2023, respectively.

Maintain the yearly number of undergraduate students with mentored research experiences through the IDeA (Institutional Development Award) Networks of Biomedical Research Excellence (INBRE) program in order to sustain a pipeline of undergraduate students who will pursue health research careers. (Lead Agency - NIH; Measure ID - CBRR-26)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	Sustain the number of undergraduate mentored research experiences from 2017 level.	Sustain the number of undergraduate mentored research experiences from 2018 level.	Sustain the number of undergraduate mentored research experiences from 2019 level.	Sustain the number of undergraduate mentored research experiences from 2020 level.	Sustain the number of undergraduate mentored research experiences from FY 2021 level.	Sustain the number of undergraduate mentored research experiences from FY 2022 level.
Result	N/A	N/A	Approximately 1,450 undergraduate students participated in mentored research experiences, consistent with 2017 level.	Approximately 1,450 undergraduate students participated in mentored research experiences, consistent with 2018 level.	Approximately 1,450 undergraduate students participated in mentored research experiences, consistent with 2019 level.	An estimated 1,450 undergraduate students participated in mentored research experiences, consistent with 2020 level.	Dec, 2022	Dec. 2023
Status	Not Collected	Not Collected	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

Established by Congress in 1993, the goal of the Institutional Development Award (IDeA) program is to broaden the geographic distribution of NIH funding. The program supports faculty development and institutional research infrastructure enhancement in states that have historically received low levels of support from NIH. The purpose of the IDeA Networks of Biomedical Research Excellence (INBRE) is to augment and strengthen the biomedical research capacity of IDeA-eligible states. The INBRE represents a collaborative effort to sponsor research between research-intensive institutions and primarily undergraduate institutions (PUIs), community colleges, and tribally controlled colleges and universities (TCCUs).

A primary goal of the INBRE is to provide research opportunities for students from PUIs, community colleges, and TCCUs, and to serve as a "pipeline" for these students to continue in biomedical research careers within IDeA states. Offering these students mentored research experiences is crucial in developing their foundation in biomedical research and their interest in pursuing health research careers. Different types of mentored research experiences are available to these students. Examples include participating in INBRE-supported internship programs; attending research seminars, laboratory meetings, and journal clubs; and preparing oral or poster presentations of individual research projects and presenting them to the scientific community during the state's annual summer research conference. In FY 2021, an estimated 1,450 undergraduate students participated in mentored research experiences, consistent with the FY 2020 level. In FY 2022 and FY 2023, NIH aims to sustain the number of undergraduate mentored research experiences at the same level as previous years.

Percentage of scientists retained at FDA after completing Fellowship or Traineeship programs. (Lead Agency - FDA; Measure ID - 291101)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	40%	40%	50%	50%	50%	20%	20%	20%
Result	81%	72%	53%	86%	80%	Feb 28, 2022	Feb 28, 2023	Feb 28, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

The goal of GDUFA II is to enhance the efficiency of the generic drug review process, promote transparency between FDA and generic drug sponsors, and enhance access to high-quality, lower cost generic drugs. Through the reauthorization of the GDUFA program in 2017 (GDUFA II), FDA acquired additional performance goals and higher expectations for program enhancements and approvals. The value of this investment in the Generic Drug Review program is reflected by FDA's performance on its review goals under GDUFA, including the review of standard submissions reflected in this performance measure, as well as FDA's commitment to meet shorter review goals (8 months) for priority submissions under GDUFA II. Despite the unforeseen challenges due to the COVID-19 pandemic, having to transition to a remote work environment with an increased workload due to the expedited development and review of generic drug products to help address the public health emergency, FDA rose to the challenge and maintained its high level of performance in meeting GDUFA's goals and initiatives. HHS is confident that the new processes introduced through GDUFA II and activities taken under FDA's Drug Competition Action Plan will continue to help reduce review cycles, to improve approval times, and to boost competition, helping to ensure that safe, effective, high-quality generic drug products are available to the American public.

Conduct and disseminate policy relevant research reports on rural health issues. (Lead Agency - HRSA; Measure ID - 6010.01)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	35	39	14	39	39	43	47	47
Result	72	61	67	56	107	77	Sep 30, 2022	Sep 30, 2023
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

HRSA's Federal Office of Rural Health Policy has a statutory charge to advise the HHS Secretary on rural health and telehealth policy issues across the Department, including interactions with the Medicare and Medicaid programs, and support policy-relevant research on rural health issues, consistent with HRSA's broader focus on access and underserved populations. HRSA provides funding for the only Federal research programs specifically designed to provide publicly available, policy relevant research on rural health issues. The Rural Health Research Center (RHRC) Program funds eight core research centers to conduct policy-oriented health services research to assist providers and decision/policy-makers at the federal, state, and local levels to better understand the healthcare-related challenges faced by rural

communities and provide information that can be applied in ways that improve health care access and population health. HRSA supports four research projects per RHRC per year. The RHRCs produce policy briefs and peer-reviewed journal manuscripts based on their funded research projects. These publications are made available through the HRSA-funded Rural Health Research Gateway (www.ruralhealthresearch.org). The Rural Health Research Gateway disseminates and promotes the work of the RHRCs to rural health stakeholders with the goal of informing and raising awareness of key policy issues important to rural communities

Objective 4.3: Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions

HHS supports strategies to strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and health conditions. HHS is focused on expanding capacity to improve laboratory safety and quality, monitor conditions, understanding the needs of various sub-groups of people, and establishing the pipeline for future professionals. HHS is working to modernize surveillance systems for timeliness, accuracy, and analytic reporting while engaging and learning from partners and stakeholders to inform improvements and innovation.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: CDC, FDA, IHS, OASH, NIH, OGA, and SAMHSA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 4.3 Table of Related Performance Measures

Percentage of isolates of priority PulseNet pathogens (Salmonella, Shiga toxin-producing E. coli, and Listeria monocytogenes) sequenced and uploaded to the PulseNet National Database (Lead Agency - CDC; Measure ID - 3.D)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	Set Baseline	65.0	70.0	75.0	80.0	85.0
Result	N/A	N/A	59.0	77.0	87.0	Dec 31, 2022	Dec 31, 2023	Dec 31, 2024
Status	Not Collected	Not Collected	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

CDC estimates the burden of foodborne disease in the U.S. to be approximately 48 million cases per year (one out of every six Americans), 128,000 hospitalizations, and 3,000 deaths per year. Foodborne disease is mostly preventable, but controlling and preventing outbreaks requires that HHS understands the foods and settings that cause illness. Fast and effective outbreak investigations are needed to identify and remove contaminated food from the market to prevent additional illnesses and improve the safety of the nation's food supply.

In 2019, the standard method for outbreak detection in PulseNet changed to whole-genome sequencing (WGS) of bacteria in food that cause human illness. Tracking the progress of this new method is important because the degree to which it is adopted affects the sensitivity of outbreak detection, and multiple trends could affect PulseNet's ability to detect outbreaks in a positive or negative direction. Data indicates in FY 2020, 87% of isolates of priority PulseNet pathogens (*Salmonella, Shiga* toxin-producing *E. coli*, and *Listeria monocytogenes*) were sequenced and uploaded to the PulseNet National Database (Measure 3.D). These data exceeded the FY 2020 target, in part, because COVID-19 impacted the volume of isolates received by state laboratories, resulting in a lower isolate volume.

With the change in PulseNet to use WGS to detect foodborne outbreaks, CDC expects to see an increase in suspected clusters of foodborne disease, which, in turn, will need to be interviewed in order to determine if they are part of an outbreak. CDC invests in improving interview capacity in state and local health departments in order to also improve the availability of data for multistate foodborne outbreak investigations. Tracking state epidemiologic interview capacity is also important to help identify and address challenges in the availability of epidemiologic data critical for multistate foodborne outbreak investigations.

The percentage of laboratory test results reported within the expected turn-around time (two weeks) upon receipt by CDC labs (Lead Agency - CDC; Measure ID - 10.C.4)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	90%	90%	90%	90%	90%	90%	90%	90%
Result	97%	96%	96%	98%	97%	Apr 30, 2022	Apr 30, 2023	Apr 30, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

As a significant health concern in the U.S., malaria, and other parasitic diseases have a tremendous impact on global morbidity and mortality, due to increased international travel, importations, and domestically acquired infections. CDC's parasitic disease labs serve as global and national resources for ensuring efficient and high-quality analyses, which are essential to timely and accurate diagnosis and treatment. In FY 2020, CDC analyzed and reported results for 97% of submitted specimens in a timely manner (within the expected turnaround times posted in the CDC test directory for each test). This exceeded the target and the FY 2018 performance result despite challenges in supporting test development for malaria and neglected tropical diseases programs, such as laboratory slow downs and competing priorities that arose during the COVID-19 pandemic. Additionally, resource challenges have also slowed CDC's ability to engage in innovative laboratory research and evaluation. these challenges, CDC's targets will remain at 90%.

Number of medical product analyses conducted through FDA's Sentinel Initiative. (Lead Agency - FDA; Measure ID - 292203)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	50	55	60	65	65
Result	N/A	N/A	74	68	79	86	Jan 31, 2022	Jan 31, 2022
Status	Not Collected	Not Collected	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	Pending

The Sentinel Initiative is FDA's medical product surveillance program. The Initiative is comprised of multiple components including: the Sentinel System, and its Active Risk Identification and Analysis (ARIA) program; FDA Catalyst; and the Biologics Effectiveness and Safety System. The goal of the Sentinel Initiative is to provide high quality real-world evidence to support regulatory decision-making about the performance of medical products, and this performance measure provides an estimate for the program's impact on FDA's public health mission. This performance measure captures the quantity of analyses conducted in the Sentinel System by FDA investigators to monitor the safety of drugs and therapeutic biologics. The number of analyses is a function of multiple factors beyond FDA's control, such as the nature and number of medical product safety issues, which can vary year-to-year. FDA will continue reporting the total number of analyses conducted by the Sentinel Initiative to show the scientific productivity of the system and describe its impact on public health. Prior to 2018, the Sentinel performance measure captured the number of people for whom FDA was able to evaluate product safety, based on benchmarks outlined in the Food and Drug Administration Amendments Act of 2007. FDA consistently exceeded these benchmarks, and in 2018 FDA changed the performance measure to reflect Sentinel's role as a vital source of safety information that informs regulatory decision-making and expands FDA's knowledge of how medical products perform once they are widely used in medical practice. In 2019, Congress required that FDA build on Sentinel's core successes by establishing a new Real-World Evidence Medical Data Enterprise with access to at least 10 million electronic medical records. In 2020 the performance measure was updated to capture not only Sentinel's ARIA system, which is comprised of pre-defined, parameterized, reusable routine querying tools and the electronic data in the Sentinel Common Data Model, but also activities from these other components of the Sentinel Initiative, including those conducted in response to the COVID-19 pandemic.

Number of Tribal Epidemiology Center-sponsored trainings and technical assistance provided to build tribal public health capacity. (Lead Agency - IHS; Measure ID - EPI-5)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	Set Baseline	89	89	89	89	89	89	89
Result	89	210	216	242	137	937	Jan 31, 2023	Jan 31, 2024
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The Indian Health Service (IHS) provides core funding support to twelve Tribal Epidemiology Centers (TECs) across Indian Country. The TECs provide critical support to the tribal communities they serve by using epidemiological data to support local Tribal disease surveillance and control programs, producing a variety of reports annually or bi-annually that describe activities and progress towards public health goals, and providing support to Tribes who self-govern their health programs. This measure reports the number of completed trainings and technical support to Tribes and Tribal organizations and demonstrates the sustained efforts of the TECs to engage, support, train, and collaborate with the Tribes in their service area. In fiscal year (FY) 2016, the TEC program launched the training and technical assistance measure to coincide with the 5-year funding and cooperative agreement cycle and, as a way to strengthen and simplify performance tracking of TEC efforts to engage, support, train, and collaborate with Tribes in their service area. The TECs' direct support to Tribes translates emerging public health strategies, resources, and information to reduce the burden on the overall Indian health system through prevention. In FY 2021, TECs completed 937 TEC-sponsored trainings, largely driven by the Tribal demand for technical assistance with the COVID-19 pandemic. This represents a shift in focus from in-person trainings to more tailored technical support.

The measure target is informed by input from TEC partners, coincides with the 5-year TEC funding and cooperative agreement cycle, and has remained constant since first established in FY 2016. Actual performance among the TECs varies but overall performance has exceeded the target consistently. Because training and technical assistance events are driven largely by Tribal requests, which can vary greatly year-to-year in their frequency and complexity, the target has remained unchanged to support consistency throughout the 5-year funding and cooperative agreement period during FY 2016 – FY 2020. The 2021 Notice of Funding Opportunity announcing the current TEC funding cycle from FY 2021 – FY 2025 instituted a more robust and comprehensive evaluation plan, supported in part by this measure. This plan provides TECs with the flexibility to meet the training and technical assistance needs of their Tribal partners while also responding to the broader evaluation goals of the IHS. The IHS is committed to supporting TEC performance through partnership and direct technical assistance, performance metric tracking and feedback, as well as by providing resources sufficient to meet the training and technical assistance needs of supported Tribes through available appropriations.

Objective 4.4: Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience

HHS invests in strategies to improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience. HHS leverages different types of data, such as administrative data and research data, to guide its actions. HHS is establishing a Department-wide approach to improve data collection, close data gaps, transform data, and share data for better HHS analysis and evaluation. HHS also fosters collaborations to expand data access and sharing to create more opportunities to use HHS data to increase knowledge of health, public health, and human service outcomes. HHS is improving data collection and conducting evaluations to understand the drivers for

inequities in health outcomes, social well-being, and economic resilience while working to increase capacity and the use of evaluations at HHS to inform evidence-based decision making.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, AHRQ, ASPE, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, OCR, OGA, ONC, and SAMHSA. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 4.4 Table of Related Performance Measures

Sustain the percentage of Federal Power Users (key federal officials involved in health and healthcare policy or programs) that indicate that data quality is good or excellent (Lead Agency - CDC; Measure ID - 8.A.1.1b)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent
Result	92% Good or Excellent	100% Good or Excellent	100% Good or Excellent	80% Good or Excellent	100% Good or Excellent	Feb 28, 2022	Feb 28, 2023	Feb 28, 2024
Status	Target Not Met	Target Met	Target Met	Target Not Met	Target Met	In Progress	In Progress	In Progress

CDC uses several indicators to measure its ability to provide timely, useful, and high-quality data. CDC is improving access to NCHS online data sources, including integrating and simplifying existing points of access. Projects underway include developing a scalable data query system and a single data repository with standard and searchable metadata - with the goal of improving user experiences in accessing and using NCHS data. The number of visits to the NCHS website is nearly three times more than the average number of visitors since 2015, likely due to the increased focus on available data during the pandemic. CDC interviews Federal Power Users (key federal officials involved in health and health care policy or programs) to assess their satisfaction with CDC's Health Statistics products and services, including data quality, ease of data accessibility and use, professionalism of staff, relevance of data to major health issues, and relevance of data to user needs. One hundred percent of federal power users rated NCHS as "good" or "excellent" in data quality - reflecting a 20 percentage point improvement from the 2019 measure and meeting the 2020 target.

Number and percentage of Maternal, Infant, and Early Childhood Home Visiting Program grantees that meet benchmark area data requirements for demonstrating improvement (Lead Agency - HRSA; Measure ID - 3110.02)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target [42]	State/Territory: 53 (95%) Tribal: 20 (80%)	State/Territory: 53 (95%) [43] Tribal: 20 (80%)	State/ Jurisdiction: 53 (95%) Tribal: 20 (80%)	State/ Jurisdiction: 55 (98%) Tribal: 22 (88%)	State/ Jurisdiction: 55 (98%) Tribal: 20 (80%)	State/ Jurisdiction: 55 (98%) Tribal: 22 (88%)	State/ Jurisdiction: 47 (84%) Tribal: 22 (88%)	State/ Jurisdiction: 53 (95%) Tribal: 22 (88%)
Result	State/Territory: 55 (98%) (Target Exceeded) Target: 53 (95%) (Target Exceeded) Tribal: 24 (96%) (Target Exceeded) Target: 20 (80%) (Target Exceeded)	State/Territory (2016): 55 (98%), Tribal (2017): 24 (96%)	Data not collected	Data not collected	State/ Jurisdiction: 56 (100%) Tribal: 14 (74%)	Data not collected	Data not collected	Date TBD

[42] Per statute, an initial assessment of improvement occurred after three years of program implementation. Current statute required the following assessment of improvement for FY 2020, and every 3 years thereafter.

[43] In FY 2017, the denominator (total number of grantees) will be 56, which includes non-profits.

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Status	Target Exceeded	Target Exceeded	Not Collected	Not Collected	Target Not Met but Improved	In Progress	In Progress	In Progress

HRSA's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry living in at-risk communities.

Performance data collected to fulfill MIECHV statutory requirement of a three-year assessment of improvement were most recently updated following the conclusion of FY 2020. Performance data represent data submitted after three years of program implementation as required under the Social Security Act, Title V, § 511(d)(1)(B). These data indicate that 100 percent of states, jurisdictions, and non-profit grantees demonstrated improvement in at least four of the six benchmark areas as outlined in the legislation:

- Improving maternal and newborn health;
- Preventing child injuries, maltreatment, and emergency department visits;
- Improving school readiness and achievement;
- Reducing crime or domestic violence;
- Improving family economic self-sufficiency; and
- Improving service coordination and referrals for other community resources and supports.

Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability

HHS is dedicated to advancing strategic management across the Department to build trust, transparency, and accountability. A major focus of the Department is promoting effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices. HHS sustains strong financial stewardship of resources to foster prudent use of resources, accountability, and public trust. HHS works to uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission. The Department also ensures the security of HHS facilities, technology, data, and information, while advancing environment-friendly practices.

Objective 5.1: Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.

HHS is supporting strategies to promote effective enterprise governance and ensure programmatic goals are achieved. HHS is strengthening governance, enterprise risk management, and strategic decision making across the Department to better pursue opportunities and address risks while creating a culture of change to support continuous improvement in program and mission delivery.

Because this is a new objective, HHS will not include performance measures for Goal 5 Objective 1. Instead, HHS will provide an update on the Enterprise Risk Management maturity model in subsequent years.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 5.2: Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust

HHS supports strategies to sustain strong financial stewardship of resources. The Department continues to strengthen the financial management environment to prevent and mitigate deficiencies. HHS is focused on upholding accountability, transparency, and financial stewardship of HHS resources to ensure program integrity, effective internal controls, and payment accuracy. The Department is also building an enhanced financial management workforce that is better able to keep pace with changing contexts.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 5.2 Table of Related Performance Measures

Decrease improper payments in the title IV-E foster care program by lowering the national error rate. (Lead Agency - ACF; Measure ID - 7S)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	3.6 %[44]	6.6 %[45]	7 %[46]	7 %[47]	6 %	N/A[48]	TBD	TBD
Result	6.9 %	7.1 %	7.56 %	4.85 %	3.36 %	N/A	N/A	N/A
Status	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Target Not in Place[49]	Target Not in Place	Target Not in Place

The Foster Care program provides matching reimbursement funds for foster care maintenance payments, costs for comprehensive child welfare information systems, training for staff, as well as foster and adoptive parents, and administrative costs to manage the program. Administrative costs that are covered include the work done by caseworkers and others to plan for a foster care placement, arrange therapy for a foster child, train foster parents, and conduct home visits to foster children, as well as more traditional administrative costs, such as automated information systems and eligibility determinations. ACF estimates the national Foster Care payment error rate and develops an improvement plan to strategically reduce, or eliminate where possible, improper payments under the program. State-level data generated from the title IV-E eligibility reviews are used to develop a national error rate estimate for the program. Eligibility reviews are routinely and systematically conducted by ACF in the states, the District of Columbia, and Puerto Rico to ensure that foster care maintenance payments are made only for program-eligible children in eligible placements. The fiscal accountability promoted by these reviews has contributed to a general trend of reductions in case errors and program improvements.

The FY 2019 foster care error rate was 4.85 percent, which exceeded the target of 7 percent. In FY 2020, ACF set an error rate target of 6.00 percent, recognizing that changes in Title IV-E Foster Care eligibility requirements made by the Family First Prevention Services Act may contribute to increased improper payments as states adjusted to changes in law affecting eligibility, particularly for children placed in child care institutions. Due to the COVID-19 pandemic, ACF made the decision to postpone IV-E reviews beginning in the Spring of 2020 until it is again safe to travel and meet onsite. Therefore, ACF has not yet conducted reviews for states subject to the updated child care institution safety check requirements. The error rate for FY 2020 was, therefore, based on updated review data for six states as well as previous years' data for other states. Encouragingly, the improper error rate decreased from 4.85 percent in FY 2019 to 3.36 percent in FY 2020 because five out of the six states that were newly

[44]The revised target for FY 2016 is based on the actual FY 2015 improper payment rate and was updated to reflect improved performance in this area.
[45]The FY 2017 target for this performance measure was updated as the result of IPIA reporting process as approved by HHS and OMB.
[46]The FY 2018 target for this performance measure was updated as the result of the IPIA reporting process as approved by HHS and OMB.
[47]The FY 2019 target for this performance measure was updated as part of the Annual Financial Report process with the Office of Management and Budget (OMB).
[48]This target has not yet been established per OMB guidance.
[49] HHS has chosen not to set a target for this performance measure for 2021 due to policy changes and the unknown impact of the COVID-19 public health emergency.

reviewed had decreases in error rates. In particular, two states with large programs (and thus more impact) had substantial decreases of more than 13 percent in their state-level error rates.

ACF chose not to set an improper payment reduction target for FY 2021 and FY2022 given the ongoing COVID-19 public health emergency as it is uncertain when it will be safe to resume conducting onsite Title IV-E Reviews. In light of this uncertainty, as well as the unknown impact of the programmatic changes in title IV-E foster care eligibility made by the Family First Prevention Services Act on the improper payment rate, ACF will not report on the improper payment reduction rate in FY 2021 and FY 2022, and the target for FY 2023 will be determined at a later date. ACF will continue to work with all states to ensure that they have a clear understanding of changes in federal eligibility requirements and are prepared to successfully manage Title IV-E eligibility determinations for their Foster Care programs.

Increase the cost-effectiveness ratio (total dollars collected per $1 of expenditures). (OMB approved efficiency) (Lead Agency - ACF; Measure ID - 20.2LT and 20E)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	$5.20[50]	$5.20	$5.20	$5.20	$5.20	$5.20	$5.20	$5.20
Result	$5.33[51]	$5.15	$5.14	$5.06	$5.51	Nov 30, 2022	Nov 30, 2023	Nov 30, 2024
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Pending	Pending	Pending	Pending

The purpose of the Child Support Enforcement program is to provide funding to states to support state-administered programs of financial assistance and services for low-income families to promote their economic security, independence, and self-sufficiency. This performance measure calculates efficiency by comparing total IV-D dollars collected and distributed by states with total IV-D dollars expended by states for administrative purposes; this is the Child Support Performance and Incentive Act (CSPIA) cost-effectiveness ratio (CER). The formula for determining the CER is the total collections distributed, plus the collections forwarded to other states and countries for distribution, and fees retained by other states, divided by the administrative expenditures, less the non-IV-D administrative costs. In FY 2020 the national CER ratio was $5.51. ACF saw significant improvement due to the surge in collections in this year while expenditures remained relatively constant. Since states continue to struggle to increase child support spending, the FY 2021 target of $5.20 is maintained for FY 2023.

ACF will continue to focus on increased efficiency of state programs through approaches such as automated systems of case management and enforcement techniques, administration simplifications, improving collaboration with families and partner organizations, and building on evidence-based innovations. The Child Support Program has continued to promote and advance key priorities that have a direct and positive impact on states, territories, and tribes and, most importantly, families. Maintaining investments in vital programs that serve to reduce poverty and improve families' economic stability are effective ways to avoid public assistance costs and save money long-term. Furthermore, the Child Support Program serves mostly families with modest incomes who are more likely to spend the

[50]The FY 2016 target has been revised to reflect the most recent data trend. As state budgets continue to recover and state spending increases in some states, HHS anticipates seeing more realistic cost–effectiveness rates. Therefore the target ratio was revised downward to reflect a more accurate cost–effectiveness target.

[51]The FY 2016 actual result should be considered preliminary pending final data validation.

child support money quickly to meet basic household needs.

Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program (Lead Agency - CMS; Measure ID - MIP5)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	9.14 %	9.50 %	8.08 %	7.90 %	7.77 %	N/A[52]	9.69 %	TBD[53]
Result	9.99 %	8.31 %	8.10 %[54]	7.87 %	6.78 %	10.28 %	Nov 15, 2022	Nov 15, 2023
Status	Target Not Met	Target Exceeded	Target Not Met but Improved	Target Exceeded	Target Exceeded	Historical Actual	Pending	Target Not in Place

The Part C Medicare Advantage program payment error estimate reflects the extent to which plan-submitted diagnoses for a national sample of enrollees are substantiated by medical records. CMS performs a validation of diagnoses in medical records for sampled beneficiaries during CMS's annual Medical Record Review process, where two separate coding entities review medical records in the process of confirming discrepancies for sampled beneficiaries. To calculate the Part C program's error estimate rate, divide the dollars in error by the overall Part C payments for the year measured.

In FY 2021, CMS reported an actual improper payment estimate of 10.28 percent or $23.19 billion. During FY 2021, HHS implemented refinements to the denominator methodology to only include the population of MA payments reviewed and at risk for diagnostic error, which led to the increase in the FY 2021 error estimate. For prior years, the Part C denominator methodology reflected total MA payments, and included some payments that were non-risk adjusted or based on a different model resulting in a reported error rate that was biased downward, or potentially understated. Therefore, the FY 2021 reporting year is a baseline and should not be compared with prior reporting years.

The factors contributing to improper payments are complex and vary from year to year. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments in Medicare Part C. Detailed information on corrective actions can be found in the 2021 HHS AFR.

[52]The target for FY 2021 was not established.
[53] The FY 2023 target will be established in the 2022 HHS AFR.
[54]CMS uses Improper Payments Elimination and Reduction Act (IPERA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance on IPERA, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program (Lead Agency - CMS; Measure ID - MIP6) [55]

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	3.4 %	3.3 %	1.66 %	1.65 %	0.74 %	1.14 %	1.20 %	TBD[56]
Result	3.41 %	1.67 %	1.66 %	0.75 %	1.15 %	1.58 %	Nov 15, 2022	Nov 15, 2023
Status	Target Met	Target Exceeded	Target Met	Target Exceeded	Target Not Met	Target Met	Pending	Pending

The Part D program payment error estimate measures the payment error related to Prescription Drug Event (PDE) data, where most errors for the program exist. CMS measures inconsistencies between information reported on PDEs and supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication orders as appropriate) and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error. A representative sample of beneficiaries undergoes a simulation to determine the Part D improper payment estimate.

In FY 2021, CMS reported an improper payment estimate of 1.58 percent, or $1.37 billion.

The improper payment estimate due to lacking or insufficient documentation is 0.65 percent or $0.56 billion, representing 41.19 percent of total improper payments. The increase from the prior year's estimate of 0.43 percent is due to year-over-year variability, and is not statistically different from the prior year. As the rate is already low, variation in sampled error values or error category breakouts can cause minor shifts in the total estimated error rate.

The FY 2021 Medicare Part D improper payment root causes are drug or drug pricing discrepancies. Improper payments due to drug or drug pricing discrepancies occur when the prescription documentation submitted indicates that an overpayment occurred. Underpayments result when prescription record hard copies (or medication orders) indicates that CMS should have paid more.

The factors contributing to improper payments are complex and vary from year to year. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments in Medicare Part D. Detailed information on corrective actions can be found in the 2021 HHS AFR.

[55] CMS uses Improper Payments Elimination and Reduction Act (IPERA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance on IPERA, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

[56] Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year. Therefore, the FY 2023 target will be established in the FY 2022 HHS AFR.

Reduce the Improper Payment Rate in the Medicare Fee-for- Service (FFS) Program (Lead Agency - CMS; Measure ID - MIP1)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	11.50 %	10.40 %	9.40 %	8.00 %	7.15 %	6.17 %	6.16 %	TBD[57]
Result	11.00 %	9.51 %	8.12 %	7.25 %	6.27 %	6.26 %	Nov 15, 2022	Nov 15, 2023
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	Target Not in Place

CMS calculates the Medicare FFS improper payment estimate under the Comprehensive Error Rate Testing (CERT) program and reports the result in the HHS AFR. CMS initiated the CERT program in FY 2003 and produced a national Medicare FFS improper payment rate for each year since its inception. Please refer to the 2021 HHS AFR for information on the Medicare FFS improper payment methodology.

CMS met its target 2021 target. The Medicare FFS improper payment estimate for FY 2021 is 6.26 percent, or $25.03 billion. While the factors contributing to improper payments are complex and vary by year, the primary causes continue to be insufficient documentation and medical necessity errors. Per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

CMS develops and refines multiple preventive and detective measures for specific service areas with high improper payment estimates, such as hospital outpatient, SNF, home health, hospice, and other areas. CMS believes implementing targeted corrective actions will prevent and reduce improper payments in these areas and reduce the overall improper payment estimate. Please refer to the 2021 HHS AFR for detailed information on corrective actions.

Reduce the Improper Payment Rate in the Medicaid Program (Lead Agency - CMS; Measure ID - MIP9.1)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	11.53 %	9.57 %	7.93 %	N/A[58]	N/A	N/A	18.94 %	TBD[59]
Result	10.48 %	10.10 %	9.79 %	14.90 %	21.36 %	21.69 %	Nov 15, 2022	Nov 15, 2023
Status	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Historical Actual	Historical Actual	Historical Actual	Pending	Target Not in Place

[57]The FY 2023 target will be established in the FY 2022 HHS AFR.
[58]2019 is the first year the eligibility component measurement is resumed. Targets will not be established until all three cycles have been measured for eligibility. A target will be established in FY 2022.
[59]Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year. Therefore, the FY 2023 target will be established in the FY 2022 HHS AFR.

Reduce the Improper Payment Rate in the Children's Health Insurance (CHIP) (Lead Agency - CMS; Measure ID - MIP9.2)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	6.81 %	7.38 %	8.2 %	N/A[60]	N/A	N/A	27.88 %	TBD[61]
Result	7.99 %	8.64 %	8.57 %	15.83 %	27 %	31.84 %	Nov 15, 2022	Nov 15, 2023
Status	Target Not Met	Target Not Met	Target Not Met but Improved	Historical Actual	Historical Actual	Historical Actual	Pending	Target Not in Place

The Payment Error Rate Measurement (PERM) program measures improper payments for the FFS, managed care, and eligibility components of both Medicaid (MIP9.1) and CHIP (MIP9.2). CMS measures improper payments in 17 states each year to calculate a rolling, three-year national improper payment rate for both Medicaid and CHIP. CMS measures improper payments in 17 states each year to calculate a rolling, three-year national improper payment rate for both Medicaid and CHIP. The national Medicaid and CHIP improper payment rates reported in the FY 2021 HHS AFR is based on measurements that were conducted in FYs 2019, 2020, and 2021. Information on the Medicaid and CHIP statistical sampling process and review period can be found in the 2021 HHS AFR.

The national Medicaid improper payment estimate for FY 2021 is 21.69 percent or $98.72 billion. The national Medicaid component rates are 13.90 percent for Medicaid FFS, 0.04 percent for Medicaid managed care, and 16.62 percent for the Medicaid eligibility component.

Eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with federal eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated but the state provided no documentation to validate the verification process was completed.

The national CHIP improper payment estimate for FY 2021 is 31.84 percent or $5.37 billion. The national CHIP component rates are 13.67 percent for CHIP FFS, 0.48 percent for CHIP managed care, and 28.71 percent for the CHIP eligibility component.

One area driving the FY 2021 CHIP improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the PPACA requirements in the PERM eligibility reviews. CMS began utilizing the updated eligibility component beginning in the FY 2019 measurement cycle. Under the updated eligibility component, a federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of CHIP eligibility determinations and increased oversight of identified vulnerabilities.

The factors contributing to improper payments are complex and vary from year to year. In order to reduce the national Medicaid and CHIP improper payment rates, states are required to develop and

[60] 2019 is the first year the eligibility component measurement is resumed. Targets will not be established until all three cycles have been measured for eligibility. A target wil be established in FY 2022.
[61] The FY 2022 AFR will report a target established for 2023.

submit states-specific Corrective Action Plans (CAPs) to CMS. Each year, CMS also outlines actions the agency will implement to prevent and reduce improper payments for all error categories on a national level. Detailed information on corrective actions can be found in the 2021 HHS AFR.

Objective 5.3: Uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission

HHS supports strategies to uphold effective and innovative human capital resource management. HHS is focused on building and sustaining a strong workforce through improved recruitment, hiring, and retention efforts. The Department is leveraging training and professional development opportunities to develop and manage a high-performing workforce while providing leaders and managers with the insight and tools to effectively carry out change management, organizational learning, and succession planning.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 5.3 Table of Related Performance Measures

Intrinsic Work Experience. (Lead Agency - ASA; Measure ID – 2.8)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	80.0	80.5
Result	N/A	N/A	N/A	N/A	N/A	N/A	Dec 31, 2022	Dec 31, 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

Employee Satisfaction with Opportunities for Professional Development and Growth. (Lead Agency - ASA; Measure ID – 2.9)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	68.0	68.5
Result	N/A	N/A	N/A	N/A	N/A	N/A	Dec 31, 2022	Dec 31, 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

Employee Engagement Index. (Lead Agency - ASA; Measure ID – 2.6)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	77.0	77.5
Result	N/A	N/A	N/A	N/A	N/A	N/A	Dec 31, 2022	Dec 31, 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

The Office of Human Resources (OHR) is leading efforts to improve the different aspect of the workplace conditions that lead to engagement. OHR is focusing these activities in three key strategic areas for employees: (1) Intrinsic Work Experience, (2) Opportunities for Professional Development and Growth and (3) Engagement, which are aligned to the HHS Strategic Plan, OMB planning, and OPM human capital initiatives as well as unique HHS organizational priorities. The intent of these efforts is:

- To increase the Department's conditions conducive to engagement
- Develop opportunities for employees to improve skills and enhance professional development.
- Improve employees' feelings of motivation and competency relating to their role in the workplace.

Objective 5.4: Ensure the security of HHS facilities, technology, data, and information, while advancing environment-friendly practices.

HHS supports strategies to ensure the security of HHS facilities, technology, data, and information, while advancing environment-friendly practices. HHS is focused on shifting the culture of data use across the enterprise to maximize the power of data. The Department is leveraging modernization as a gateway to strengthened cybersecurity and enhanced risk management. HHS also captures and applies lessons learned from real-world experiences to strengthen operational resilience.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. The narrative below provides a brief summary of any past work towards these objectives and strategies planned to improve or maintain performance on these objectives.

Objective 5.4 Table of Related Performance Measures

Increase the percentage of systems with an Authority to Operate. (Lead Agency - ASA; Measure ID – 3.3)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%
Result	N/A	N/A	N/A	N/A	N/A	N/A	Dec 31, 2022	Dec 31, 2023

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

An ATO authorizes an information system to connect to or operate within the HHS network for a specified period based on the implementation of a set of security and privacy controls. Prior to issuing an ATO, HHS assesses the system to ensure that it will not compromise network data, cause technical support problems, and has the appropriate controls in place. The HHS Office of Information Security identifies the organizations and systems not in compliance with ATO requirements and diligently works with OpDiv's cybersecurity programs and Federal Information Security Management Act reporting leads across the Department to increase compliance.

Phishing Test Success Rate. (Lead Agency - ASA; Measure ID – 3.7)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	95%	95%
Result	N/A	N/A	N/A	N/A	N/A	N/A	12/31/2022	12/31/2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

Phishing is a fraudulent attempt to obtain sensitive information (e.g., usernames and passwords) to access a system or network. Statistics suggest phishing attacks remain one of the main threat vectors targeting the healthcare industry. HHS trains and educates its personnel to reduce the likelihood of staff mistaking phishing email attempts for legitimate communications through a combination or training, education, and tools.

Reduce HHS GHG emissions (Metric Tons CO2 Equivalent) from prior FY (Lead Agency - ASA; Measure ID – 1.4)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	2%	2%
Result	N/A	N/A	N/A	N/A	N/A	N/A	12/31/2022	12/31/2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

Increase HHS owned facilities municipal solid waste (MSW) diversion rate (Lead Agency - ASA; Measure ID – 1.5)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	44%	46%

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Result	N/A	N/A	N/A	N/A	N/A	N/A	12/31/2022	12/31/2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

Reduce energy intensity (MMBtu/kSF) from prior FY (Lead Agency - ASA; Measure ID – 1.6)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	2%	2%
Result	N/A	N/A	N/A	N/A	N/A	N/A	12/31/2022	12/31/2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

Reduce water intensity (Gal/kSF) from prior FY (Lead Agency - ASA; Measure ID – 1.7)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Target	N/A	N/A	N/A	N/A	N/A	N/A	2%	2%
Result	N/A	N/A	N/A	N/A	N/A	N/A	12/31/2022	12/31/2023
Status	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Not Collected	Pending	Pending

The HHS Sustainability Program, led by the HHS Chief Sustainability Officer (CSO), engages the HHS community to promote a culture of quality improvement and lead the advancement of human health, environmental stewardship, and sustainability through partnership and innovation. HHS uses an interdisciplinary, collaborative approach to sustainability with all employees, contract personnel, and the private sector, to develop and implement sustainability endeavors connected with agency functions.

The HHS Sustainability Program achieves sustainability goals with the help of appointed goal managers across the HHS OpDivs. Goal managers serve as champions for sustainability to promote widespread adoption of sustainable practices throughout the agency. Additionally, HHS has dedicated sustainability teams and workgroups that focus on efforts and initiatives for energy and water efficiency, high performance buildings, and employee outreach to reduce greenhouse gas (GHG) emissions.

Evidence Building Efforts

OMB Circular A-11, Section 210.11 requires the Annual Performance Reports to describe evaluations or other relevant evidence activities, and how a portfolio of evidence is used to inform decision-making. Evaluation and analysis provide essential evidence for HHS to understand how its programs work, for whom, and under what circumstances. HHS builds evidence through evaluation and analysis in order to inform decisions in the budget, legislative, regulatory, strategic planning, program, and policy arenas. Given the breadth of work supported by HHS, the Department conducts many evaluations and analyses each year that range widely in scope, scale, design, and methodology.

Implementation of the Evidence Act: HHS continues to implement Foundations for Evidence-Based Policymaking Act of 2018 ("the Evidence Act"). The Evidence Act requires the Department to develop and implement a four-year Evidence-Building Plan, with annual evaluation plans. These plans will guide HHS's progress towards addressing the questions and priorities articulated in the Evidence-Building Plan. HHS also designated the Deputy Assistant Secretary for Science and Data Policy in the Office of the Assistant Secretary for Planning and Evaluation as the Evaluation Officer for HHS.

Evaluation at HHS: Across HHS, evaluation comes in many forms including:

- Formal program evaluations using the most rigorous designs appropriate;
- Capacity-building initiatives to improve administrative data collection, accessibility, and use for management;
- Exploratory quantitative and qualitative analysis to build preliminary evidence;
- Pilots and demonstrations; and
- Statistical analysis of factors related to the implementation, performance, and outcomes of health and human services programs and policies.

HHS disseminates findings from a variety of evaluations and analyses to the public on HHS agency websites, such as those operated by ACF's Office of Planning, Research, and Evaluation and CMS's Innovation Center. HHS coordinates its evaluation community by regularly convening the HHS Evidence and Evaluation Council, which builds capacity by sharing best practices and promising new approaches across the department.

Disseminating Evidence: In addition to building evidence through a broad range of rigorous empirical studies, analysis, and evaluations, HHS supports multiple clearinghouses that catalog, review, and disseminate evidence related to programs. Examples include the ACF Research and Evaluation Clearinghouses on Self-Sufficiency, Pathways to Work, Home Visiting, and Child Care and Early Education; the AHRQ United States Preventive Services Task Force; the CDC Community Guide; and the SAMHSA Evidence-Based Practices Resource Center.

Cross-Government Collaborations

The Federal Government has a unique legal and political government-to-government relationship with tribal governments and provides health services for American Indians and Alaska Natives consistent with that special relationship. HHS works with tribal governments, urban Indian organizations, and other

tribal organizations to facilitate greater consultation and coordination between states and tribes on health and human services issues. The HHS Office of Intergovernmental and External Affairs (IEA) facilitates Regional Tribal Consultations, Annual Tribal Budget Consultation, and regular meetings of the Secretary's Tribal Advisory Council (STAC). The Indian Health Service (IHS) also regularly consults and confers with Tribes and Urban Indian Organizations on funding allocations and policy decisions that impact Indian Country.

Due to the COVID-19 pandemic, HHS increased the frequency of STAC meetings to ensure Tribal leaders have access to updated information and have adequate opportunities to raise concerns and provide feedback to HHS. HHS also participates in the White House bi-weekly Indian Country COVID-19 update call, which provides Tribal leaders with COVID-19 updates from across the Federal Government.

Major Management Priorities

The HHS OIG has identified the top management and performance challenges for FY 2020. HHS management is committed to working toward resolving these challenges. The performance measures in this document track such challenges safeguarding public health, ensuring the financial integrity of HHS programs, delivering value, quality and improved outcomes in Medicare and Medicaid, protecting the health and safety of HHS beneficiaries, harnessing data to improve the health and well-being of individuals, and improving collaboration to better serve our Nation. In addition, HHS employs a robust program integrity process. For further information about these challenges, please read the HHS Fiscal Year 2020 Top Management and Performance Challenges Identified by the Office of the Inspector General report located at https://oig.hhs.gov/reports-and-publications/top-challenges/2020.

Lower-Priority Program Activities

The President's Budget identifies the lower-priority program activities, where applicable, as required under the GPRAMA, 31 U.S.C. 1115(b)(10). The public can access the volume at: http://www.whitehouse.gov/omb/budget.