FISCAL YEAR 2014

Annual Performance Report and Performance Plan

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U.S. Department of Health & Human Services

HHS.GOV

Message from the HHS Performance Improvement Officer

The success of the Department of Health and Human Services in strengthening health care; advancing scientific innovation; and promoting the health, safety, and well-being of the American people is displayed in the following pages. This year HHS has managed six priority goals, and more than 900 performance measures that illustrate the benefits, responsible stewardship and effective use of tax dollars. Included in this report is a representative set of about 135 performance measures that illustrate progress toward achieving HHS goals. Each HHS component has reviewed their submissions and I confirm, to the best of my ability, that the data are reliable and complete. When results are not available because of delays in data collection, the date when the results will be available is noted in the report.

The delivery and administration of health and human services by the HHS staff, as well as grantees, contractors, volunteers and community members represent almost one quarter of all federal outlays and benefits for millions of citizens. Hundreds of programs ranging from human genome research to Low Income Home Energy Assistance and from hazards preparedness and response to Community Services Programs reflect the broad range of research, service and support offered by HHS. The Department seeks to be innovative and results-oriented, meeting both present and future challenges, especially for those least able to help themselves.

During the past year, HHS focused on organization-wide progress towards improving performance. Results from quarterly meetings on priority goals show progress on reducing cigarette smoking, improving patient safety by reducing healthcare-associated infections, and improving the quality of early childhood education. The information provided in this report spans HHS' eleven operational divisions and sixteen staff divisions and includes work across the country and throughout the world. High performance in organizations begins with dedicated, high quality employees. HHS is proud of the accomplishments of its workforce in improving results for Americans.

Ellen G. Murray
Assistant Secretary for Financial Resources
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Mission Statement

The mission of the U.S. Department of Health and Human Services (HHS) is to enhance the health and well-being of 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.

Strategic Plan Overview

HHS developed a new strategic plan in 2010, and made minor updates to the plan in the Fall of 2011. The plan, available at http://www.hhs.gov/secretary/about/priorities.html, identifies five strategic goals and 25 related objectives. The five strategic goals are:

Goal 1: Strengthen Health Care
Goal 2: Advance Scientific Knowledge and Innovation
Goal 3: Advance the Health, Safety, and Well-being of the American People
Goal 4: Increase the Efficiency, Transparency and Accountability of HHS Programs
Goal 5: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

This report is organized by HHS Strategic Plan goal and objective with further details about the progress towards goal achievement, trends, and summary of results included in subsequent pages.

HHS Organizational Structure

HHS is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The Department includes eleven operating divisions that administer HHS programs. These operating divisions are:

- 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)

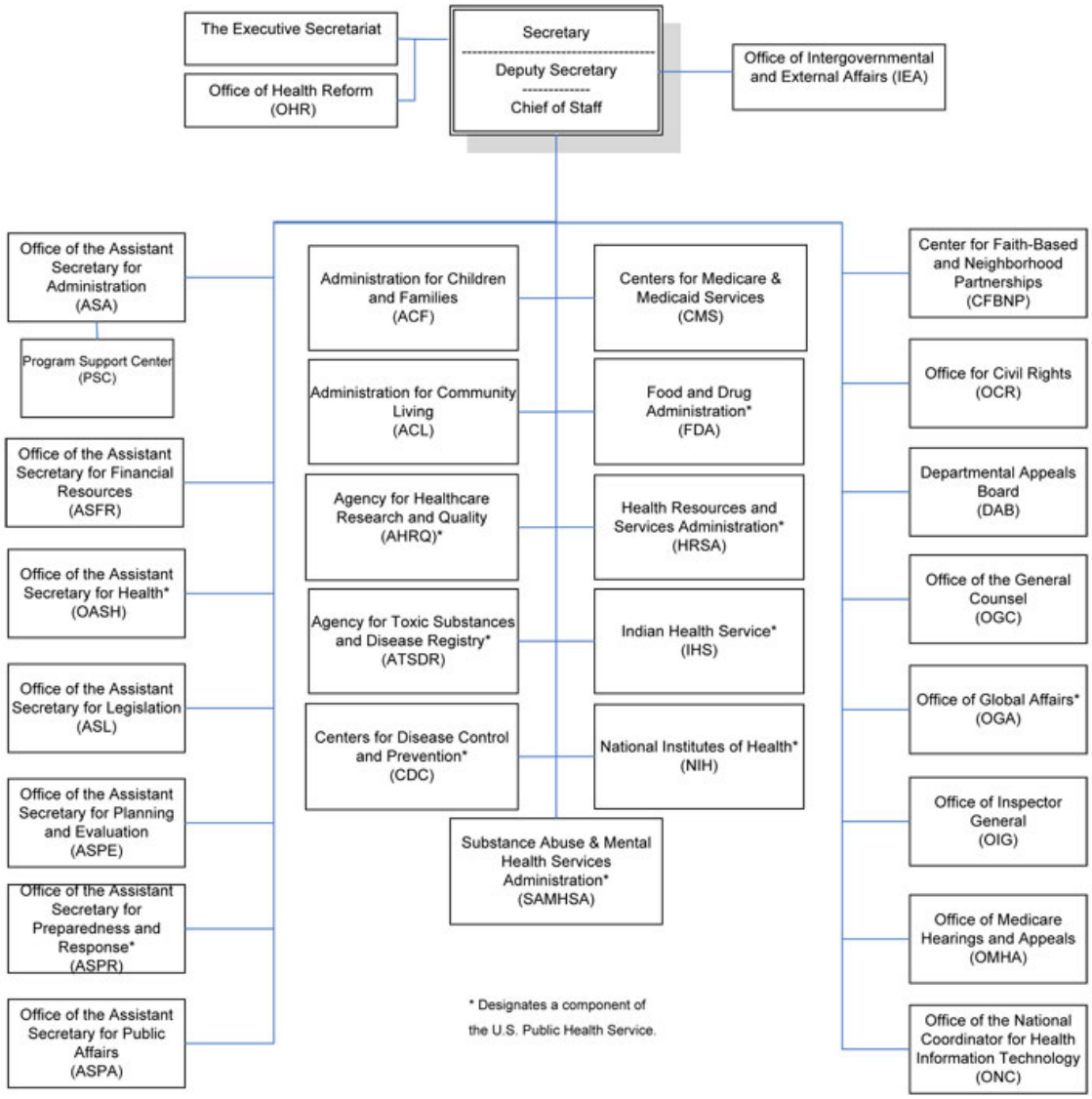
In addition, staff divisions provide leadership, direction, and policy and management guidance to the Department. Many of these divisions have responsibilities for achieving performance objectives, contained in this report, including,

- Office of the Assistant Secretary for Administration (ASA)
- Assistant Secretary for Preparedness and Response (ASPR)
- Immediate Office of the Secretary (IOS)
- Office of the Assistant Secretary for Health (OASH)
- Office of Inspector General (OIG)

- Office of Medicare Hearings and Appeals (OMHA)
- Office of the National Coordinator for Health Information Technology (ONC)

Throughout this document the operating divisions and staff divisions will be collectively referred to as HHS components. The HHS organizational chart is available at http://www.hhs.gov/about/orgchart/

Organizational Chart Department of Health and Human Services



Performance Management

Performance goals and measurement are powerful tools to advance effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions. HHS staff constantly strive to achieve meaningful progress and find lower-cost ways to achieve positive impacts, in addition to sustaining and spreading information on effective and efficient government programs.

Responding to opportunities afforded by the Government Performance and Results Modernization Act (GPRMA), HHS has instituted significant improvement in performance management since FY 2011 including:

- Development, analysis, reporting and management of six Priority Goals to be achieved by the end of FY 2013; implementation of quarterly performance reviews between HHS component staff and HHS leadership to monitor progress to achieving key performance objectives.
- In addition to these Priority Goals, HHS is working to improve the health of millions of Americans through implementation of the Affordable Care Act. To provide transparency to the public with regard to the Affordable Care Act, HHS launched www.HealthCare.gov on July 1, 2010. The website is the first of its kind to bring information and links to health insurance plans and other coverage options into one place, to make it easy for consumers to learn about their insurance choices.
- Development and support of a network of component Performance Officers, who support, coordinate, and implement performance management efforts across HHS.
- Sharing of best practices in performance management at HHS through webinars and other media.

HHS Priority Goals FY 2012 – FY 2013

HHS, along with other Federal agencies, uses Priority Goals to improve performance and accountability. HHS established a set of near-term (18 – 24 months) Priority Goals and began holding quarterly data-driven reviews to monitor progress towards its Priority Goals in FY 2011.

The Priority Goals below have been established for FY 2012 - 2013. These Priority Goals are largely cross-cutting in nature, requiring active management across HHS components for success. Priority Goals are included in the Strategic Plan and Annual Performance Plan with targets displayed until at least FY 2013. HHS actively monitors progress and manages towards achievement of these goals through quarterly data-driven reviews and other mechanisms. Please refer to www.Performance.gov for information on Agency Priority Goals and the HHS components' contributions to those goals.

Increase the number of health centers certified as Patient Centered Medical Homes (PCMH):

By September 30, 2013, the quality of care provided by health centers will be improved by increasing the proportion of health centers that are nationally recognized as Patient Centered Medical Homes (PCMH) from 1 percent to 25 percent.

> **Results Reported:** HRSA is on track to achieve the HHS priority goal for health center PCMH recognition. All targets and milestones were achieved for the FY 2013 first quarter, as 20 percent of health centers now have at least one site recognized as a PCMH (up from 4 percent in FY 2012 Q1), and 882 health centers grantees initiated surveys to become PCMH recognized.

Improve patient safety: By September 30, 2013, reduce the national rate of healthcare-associated infections (HAIs) by demonstrating significant, quantitative, and measurable reductions in

hospital-acquired central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI).

> **Results Reported:** Through the combined work of CMS, CDC, AHRQ, and OASH and by leveraging the programmatic efforts geared toward HAI prevention and reduction across the Department, to include working closely with public and private partners, all quarterly milestones through Q4 for this goal were achieved. The most recent indicator data available from September 2012 shows significant progress in reducing CLABSI rates and, additionally, AHRQ released (Q4) milestone results on October 25th that indicate this collaborative effort is paying off. Key results show more than 1,000 hospital ICUs achieved 41 percent reduction in CLABSI rate from baseline which equates to an estimate of more than 2,100 CLABSIs prevented, more than 500 lives saved, and over $36 million in excess costs avoided.

Improve health care through meaningful use of health information technology: By September 30, 2013, increase the number of eligible providers who receive an incentive payment from the CMS Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology to 230,000.

> **Results Reported:** CMS and ONC have pursued coordinated strategies that have resulted in a dramatic increase in the number of eligible providers who receive EHR incentive payments, from 10,700 in FY 2011 to 156,758 in FY 2012.

Improve the quality of early childhood education: By September 30, 2013, improve the quality of early childhood programs for low-income children through implementation of the Quality Rating and Improvement Systems (QRIS) in the Child Care and Development Fund (CCDF), and through implementation of the Classroom Assessment Scoring System (CLASS: Pre-K) in Head Start.

> **Results Reported:** Through a range of initiatives and programs, ACF built the foundation to begin meaningful performance measurement and achieve its goal of improving the quality of early childhood programs for low-income children. In FY 2012, the Office of Head Start began a completed one full program year of data collection for the CLASS: Pre-K data to establish a baseline and targets of 25 percent of grantees scoring in the low range and set future performance targets using this baseline. The Office of Child Care reported that nineteen states had a QRIS that met high quality benchmarks in 2012. Further progress was hampered by tight budget environments and implementation challenges of statewide roll-outs. Nonetheless, the Office of Child Care will provide ongoing training and technical assistance to at least 30 states/territories to support QRIS implementation.

Reduce cigarette smoking: By December 31, 2013, reduce annual adults' cigarette consumption in the United States from 1,281 cigarettes per capita to 1,062 cigarettes per capita, which represents a 17.1 percent decrease from the 2010 baseline.

> **Results Reported:** HHS has been making steady progress towards achieving its overall goal on per capita cigarette consumption—reaching the 2011 target exactly of 1,232 cigarettes per capita. The percentage of adult smokers aged 18 years and older who last smoked (within the past 6 months to 1) which tracks smoking cessation progress, has been trending positively since 2008 and will likely hit the 2012 target of 6.8 percent. In addition, there has been steady progress on the indicators that measure initiation among youth (12-17) and young adults (18-25). Delays in several FDA milestones and education campaigns may make it more difficult to

achieve the 2013 goal and put more emphasis on the success of other milestones, such as CDC's media campaign. This media campaign and investments in state quit-lines has impacted progress to date and is expected to continue to further increase smoking cessation.

Reduce foodborne illness in the population: By December 31, 2013, decrease the rate of Salmonella Enteritidis (SE) illness in the population from 2.6 cases per 100,000 (2007-2009 baselines) to 2.1 cases per 100,000.

Results Reported: The FDA and CDC are working collaboratively to achieve this goal, preliminary results for FY 2012 covering three quarters shows a reduced rate of 2.7. In the last quarter of FY 2012, the FDA conducted inspections of all registered large egg producers. As of August, 53 percent of those firms who had been issued a warning letter had received re-inspections within 6 months of the warning letter's issuance. In all, 100 percent of those firms have now been re-inspected. Work will continue to ensure these timeframes are met, all re-inspections are completed in a timely manner, and that these strategies serve to decrease the rate of Salmonella Enteritidis (SE) illness in the population.

Goal 1. Objective A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured

Today, millions of Americans lack access to affordable health insurance. Many who do have health insurance have gaps in coverage such as exclusions for pre-existing conditions, or they may be one step away from losing coverage because of a change in employment. Individuals with health insurance face increasingly high premiums and medical costs that drive some to bankruptcy or force choices between maintaining health insurance coverage and paying for other household essentials. HHS has been identified as the lead Federal Agency responsible for implementing the Affordable Care Act (ACA), which contained many new health insurance market reforms and programs to address these and other issues. Starting in 2010 and continuing in 2012, HHS has implemented new regulations aimed at increasing consumer protections and at creating a more competitive insurance market to both lower cost and improve quality. These new protections and increased oversight of the insurance industry helps ensure that individuals are getting what they pay for; this oversight also will make the healthcare system more responsive to the needs of its patients, providers, and other stakeholders.

Within HHS, agencies and offices such as CMS, HRSA, IHS, and ONC work to implement the reforms prescribed in the law to make affordable coverage more accessible.

Objective 1.A Table of Related Performance Measures

Increase the number of young adults ages 19 to 25 who are covered as a dependent on their parent's employer-sponsored insurance policy (Lead Agency - CMS; Measure ID - PHI2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	N/A	8.4 Million	8.7 Million	9.7 Million	9.7 Million
Result	7.3 Million	8.3 Million	9.5 Million	Nov 30, 2013	Nov 30, 2014	Nov 30, 2015
Status	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending	Pending

Maintain or exceed percent of beneficiaries in Medicare fee-for-service (MFFS) who report access to care (Lead Agency - CMS; Measure ID - MCR1.1a)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	90%	90%	90%	90%	90%	90%
Result	90%	90%	92%	90%	Dec 31, 2013	Dec 31, 2014
Status	Target Met	Target Met	Target Exceeded	Target Met	Pending	Pending

Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care (Lead Agency - CMS; Measure ID - MCR1.1b)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	90%	90%	90%	90%	90%	90%
Result	90%	91%	92%	91%	Dec 31, 2013	Dec 31, 2014
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		N/A	N/A	58.0%	55.0%	53.0%
Result		100.0%	57.0%	Feb 28, 2014	Feb 28, 2015	Feb 28, 2016
Status		Historical Actual	Historical Actual	Pending	Pending	Pending

Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Health Insurance Marketplaces (Exchanges) and Implementing Medicaid Expansion (Lead Agency - CMS; Measure ID - PHI4)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			Number of States in which stakeholder consultation has been performed to gain public input into Exchange planning process (50 States and DC)	Award all qualifying applications for Establishment Grants within 60 days of receiving the application	1. Release 2014 payment notice and payment parameters	Marketplaces: Establish Individual and Small Business Health Options Program Marketplaces in 50 States + DC
Result			45 States plus DC	Target met.	Sep 30, 2013	Dec 31, 2014
Status			Target Not Met	Target Met	In Progress	In Progress
Target					2. Data sharing agreements for hub use in place with every State	Medicaid Expansion: Percentage of States using streamlined application to enroll individuals in Medicaid and CHIP = 100%
Result					Sep 30, 2013	Jan 1, 2014
Status					In Progress	In Progress
Target					3. Health plans certified in all Federally-facilitated Exchange States	Medicaid Expansion: Percentage of States with an Approved Implementation Advanced Planning Document (APD) for Enhanced Funding for Eligibility and Enrollment systems that have a Dynamic Electronic Application = 100%
Result					Sep 30, 2013	Jun 1, 2014
Status					In Progress	In Progress

Analysis of Results

To strengthen health care, ensuring access to such care is a critical first step. Historically, Medicare has been committed to assuring high levels of health care access and health care satisfaction. For example, both Medicare Fee-for-Service and Medicare Advantage programs have demonstrated a high rate of success in achieving access to care for their beneficiaries, with at least 90 percent of beneficiaries consistently reporting access to care since 2009. These results demonstrate Medicare's ongoing commitment to continually high levels of access and care satisfaction through measures that are purposeful and meaningful. Beyond beneficiary reports, CMS data shows that Medicare Advantage beneficiary access to an MA plan remains strong and stable at 99.6 percent in 2013. For the 2013 plan year, people with Medicare Advantage will have access to more high quality plans than the previous year.

To further improve access to care, the Affordable Care Act (ACA) tasked CMS with overseeing the implementation of the provisions related to private health insurance. Of the various insurance reforms, the most important features, along with Medicaid expansion, are the Health Insurance Marketplaces (Marketplaces), also called Exchanges, which are being designed to help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, services, and quality. Because Marketplaces will not be fully in place until 2014, CMS is reporting on an interim process measure that tracks CMS' progress towards setting up the Marketplaces. We are on track to meeting our future milestones and targets. Another ACA provision designed to increase access to care allows young adults between 18 and 25 to be covered as dependents on their parent's employee-sponsored health plans. Since FY 2009, the number of adult children covered as dependents on a parent's insurance policy has increased by more than 2.2 million, reaching 9.5 million in FY 2011. This shows a significant increase in the availability of health insurance for a population that has traditionally experienced a high uninsured rate.

In terms of making coverage more affordable, the Affordable Care Act included changes that reduce the costs Medicare Part D enrollees are required to pay for their prescription once they reach the coverage gap (commonly known as the donut hole). In 2012, approximately 3.7 million beneficiaries reached the coverage gap and saved more than $2.7 billion on their medications due to the prescription drug discount program. These savings averaged about $724 per person. Since the law was enacted, 6.3 million beneficiaries have saved a total of more than $6.1 billion on prescription drugs.

Plans for the Future

HHS and CMS will continue to pursue high levels of access and satisfaction for both Medicare Fee-for-Service and Medicare Advantage beneficiaries. To do this, CMS will analyze data at the plan, enrollee subgroup, and geographic levels of enrollment in order to develop strategies and interventions that are both actionable and targeted towards achieving even better results. To expand access to affordable care for all Americans in accordance with the ACA, CMS will continue to work collaboratively with states to build the foundation for implementation of Marketplaces and to include new populations in the Medicaid program beginning in 2014. By September 30, 2013, CMS aims to have:

- 2014 payment notice and payment parameters released for Health Insurance Marketplaces
- Data sharing agreements for hub use in place with every state
- Health plans certified in all Federally-facilitated Marketplace states

Goal 1. Objective B: Improve healthcare quality and patient safety

HHS is committed to improving health care quality and patient safety by ensuring safe and effective medical products, promoting professional practices focused on improving quality of client care, and reducing healthcare-associated infections (HAI).

Several HHS components are committed to and focused on achieving goals that improve health care quality. FDA protects the Nation's health by ensuring the safety, effectiveness, and security of human and veterinary drugs, vaccines, and other biological products and medical devices. HHS also ensures quality of care and patient safety through HAI surveillance activities at FDA and CDC. Additionally, CDC's HAI program protects patients receiving care in U.S. healthcare settings through establishing prevention guidelines and supporting staffing to improve healthcare practitioner and hospital system practice. AHRQ develops strategies to strengthen quality and promotes improved practices through Patient Safety Organizations. IHS improves the quality of care in the clinical, public health, and preventive services it provides to American Indians and Alaska Natives by providing training and support for innovative uses of paraprofessionals to make available a wider range of culturally and linguistically appropriate services. IHS is demonstrating its commitment to quality of care by striving to have 100 percent of their hospitals and clinics maintain accreditation.

CMS is transforming into an agency that positively promotes and incentivizes the quality of care for its beneficiaries through the payment of claims. Examples include continued development of physician and hospital quality reporting systems that will support linking payments to the quality and efficiency of care, while also reducing healthcare-associated infections. CMS also has quality reporting systems in several other provider areas such as home health, skilled nursing facilities, and hospice. In addition, CMS is promoting state efforts to report on quality metrics related to care in the Medicaid and the Children's Health Insurance Program (CHIP). OMHA provides an independent and impartial forum for the adjudication of claims brought by or on behalf of Medicare beneficiaries related to their benefits and care. Within HHS, CDC, CMS, FDA, HRSA, AHRQ, IHS, and OMHA are working together to improve healthcare quality and patient safety for all Americans. Below are some related key performance measures.

Objective 1.B Table of Related Performance Measures

Actions taken on abbreviated new drug applications (Lead Agency - FDA; Measure ID - 223205)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	1900	1900	2000	2000	2000	2500
Result	2006	2079	2276	2313	Nov 26, 2013	Nov 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Voluntary electronic Medical Device Reporting (Lead Agency - FDA; Measure ID - 252202)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	55.0%	67.0%	87.0%	Discontinued	N/A
Result	46.0%	53.0%	80.0%	87.0%	N/A	N/A
Status	Historical Actual	Target Not Met but Improved	Target Exceeded	Target Met	Pending	N/A

Decrease the prevalence of pressure ulcers in nursing homes (Lead Agency - CMS; Measure ID - MSC1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	8.2%	8.1%	Set Baseline	6.9%	6.9%	6.9%
Result	7.6%	7.4%	7.1%	6.5%	Feb 28, 2014	Feb 28, 2015
Status	Target Exceeded	Target Exceeded	Baseline	Target Exceeded	Pending	Pending

Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis (Lead Agency - CMS; Measure ID - QIO5)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	54%	57%	58%	60.5%	61%	61%
Result	54%	56.8%	59.8%	Nov 30, 2013[1]	Nov 30, 2013	Nov 28, 2014
Status	Target Met	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

Increase percentage of timely antibiotic administration (Lead Agency - CMS; Measure ID - QIO4)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	89%	92%	95.5%	98%	98.5%	99%
Result	95.6%	97%	97.8%	Jun 30, 2013	Jun 30, 2014	Jun 30, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited (excluding tribal and urban facilities). (Lead Agency - IHS; Measure ID - 20)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	100%	100%	100%	100%	100%	100%
Result	100%	100%	100%	100%	Oct 31, 2013	Oct 24, 2014
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

Increase the number of Benefits Improvement and Protection Act of 2000 (BIPA) cases closed within 90 days. (Lead Agency - OMHA; Measure ID - 1.1.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	87%	88%	88%	56%	44%	39%
Result	94%	95%	73%	53%	Nov 15, 2013	Nov 7, 2014
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

[1] Reporting on this target is delayed until November 2013.

Increase the number of hospitals and other selected health care settings that report into the National Healthcare Safety Network (NHSN) (Lead Agency - CDC; Measure ID - 3.3.4)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		Set Baseline	5,000	6,500	12,000	13,500
Result		2,619	5,000	10,900	Jan 1, 2014	Jan 1, 2015
Status		Baseline	Target Met	Target Exceeded	Pending	Pending

Improve Adult Health Care Quality Across Medicaid (Lead Agency - CMS; Measure ID - MCD8)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			Publish recommended core set of adult quality measures in the Federal Register.	Publish initial core set of adult quality measures in the Federal Register.	Work with States to ensure that 60 percent of States report on at least three quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	Work with States to ensure that 65 percent of States report on at least five quality measures in the Affordable Care Act Adult Medicare core set of quality measures.
Result			Target Met	Target Met	Mar 31, 2014	Mar 31, 2015
Status			Target Met	Target Met	In Progress	In Progress

Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (Lead Agency - CMS; Measure ID - MCD6)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			Work with States to ensure that 70 percent of States report on at least one quality measure in the CHIPRA core set of quality measures.	Work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 85 percent of States report on at least seven quality measures in the CHIPRA core set of quality measures.	Work with States to ensure that 90 percent of States report on at least eight quality measures in the CHIPRA core set of quality measures.
Result			84 percent of States reported on at least one quality measure.	Mar 31, 2013	Mar 31, 2014	Mar 31, 2015
Status			Target Exceeded	In Progress	In Progress	In Progress

Increase the number of users of research using AHRQ-supported research tools to improve patient safety culture (Lead Agency - AHRQ; Measure ID - 1.3.38)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	500 users of research	580 users of research	900 users of research	1032 users of research	1300 users of research	1400 users of research
Result	622 users of research	885 users of research	1032 users of research	1128 users of research	Sep 30, 2013	Sep 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

Improving current medical products and medications and creating new ones is crucial to improving health care and patient safety. For its part, the FDA's voluntary electronic medical device reporting helps the FDA maintain safety surveillance of FDA-regulated products. Information obtained from these reports may prompt modification in the use or design of the product, improve the safety profile of devices, and lead to increased patient safety. The number of enrollees participating voluntarily in this program has increased dramatically from 13 percent in 2008 to 87 percent in FY 2012. Additionally, since 2008, the FDA's Center for Drug Evaluation and Research has consistently improved year over year with its ability to act on applications for review of generic drugs.

CMS is committed to strengthening and modernizing the Nation's health care system to provide access to high quality care and improved health at lower cost. To fulfill this commitment and ensure beneficiaries receive high quality, coordinated, effective, and efficient care, CMS is measuring a variety of strategies from multiple perspectives designed to improve quality of care. For instance, pressure ulcers or "bed sores" can cause damage to a patient's tissues and other serious complications like infection. Since 2007 there has been a steady decrease in the reported prevalence in pressure ulcers, dropping from 8.1 percent in FY 2007 to 6.5 percent in FY 2012. To put this result in perspective, a decrease of even 0.1 percent represents more than 1,000 fewer nursing home residents with pressure ulcers, not only reducing the cost of care but also improving nursing home residents' quality of life.

Another quality initiative at CMS aims to increase the percentage of End Stage Renal Disease (ESRD) patients who have access to arteriovenous fistula (AVF) for hemodialysis (the most common form of treatment for ESRD). Increasing the rate of AVF access for ESRD patients improves the quality of hemodialysis treatment, while decreasing unnecessary complications and hospitalizations. Since FY 2009, CMS has increased AVF access by over 6 percent, exceeding recent targets. CMS has also focused on administering effective antibiotics before surgery to prevent the establishment of infection during the time that the surgical incision is open, reducing both the rate of potentially fatal infections and unnecessary and costly rehospitalizations. Through Quality Improvement Organizations (QIOs) that work closely with states and other collaborative efforts, CMS surpassed its 95.5 percent FY 2011 target at a rate of 97.8 percent and is on track to reach its FY 2012 target of 98 percent.

HHS is using a number of targeted interventions that directly impact quality of care with AHRQ, CDC, OMHA, IHS, and CMS leading on a number of approaches which spread best practices. To illustrate, both IHS and OMHA are focusing on core services they deliver. For example, OMHA, although over capacity for the number of claims it can adjudicate while still maintaining program integrity, is measuring the rate at which it adjudicates cases within the 90-day statutory timeframe. OMHA's results show that it lacks enough Administrative Law Judges to provide hearings to all Medicare appeals within the 90-day statutory timeframe and has sought strategies in addition to increased funding to improve performance.

IHS, in turn, uses outside accrediting bodies, such as the Joint Commission and the Accreditation Association for Ambulatory Health Care, to develop national standards of quality of care and then manages IHS operated hospitals and ambulatory centers to meet these standards. Since 2007, IHS has maintained 100 percent accreditation of IHS-operated hospitals and clinics that voluntarily participate in accreditation visits.

In a similar capacity building effort, CDC's National Healthcare Safety Network (NHSN) is a surveillance system used for tracking and prevention of Healthcare Associated Infections across healthcare settings, including hospitals in all 50 states, and non-hospital settings (e.g. hemodialysis and long-term acute care facilities). In 2010, just 2,619 hospitals participated in CDC's NHSN. By 2012, however, the number of participating hospitals quadrupled to 10,900. More importantly, the success of this capacity building effort to measure quality of care more effectively has had the intended effect of supporting a whole host of quality improvement initiatives, such as CMS' aim to increase the percentage of End Stage Renal Disease (ESRD) patients who have access to AVF treatment for hemodialysis, and HHS's priority goal to reduce HAI infections (see Objective 1.D). The net result is that certain Healthcare-associated infections (HAIs), a leading preventable cause of illness and death in the U.S., have been reduced—saving billions in excess healthcare expenditures annually.

To complement HHS's efforts to improve health care quality through targeted interventions that directly impact quality of care, AHRQ, CDC, OMHA, IHS, CMS, and others are committed to building HHS's capacity to more effectively measure quality of care and spread best practices. To illustrate, AHRQ developed *The Hospital Survey on Patient Safety Culture: 2011 User Comparative Database Report* so hospitals could determine how well they were doing in establishing a culture of safety in comparison to other similar hospitals. In FY 2012, 1,128 hospitals participated in the report—a 45 percent increase in hospital participation over FY 2009. Meanwhile, CMS continues to work closely with states to increase the number of quality measures each state reports on across a number of programs, such as Medicaid and the Children's Health Insurance Program, consistently meeting its targets.

Plans for the Future

Going forward, the FDA plans to continue to increase the number of new drug applications that have actions taken, and to maintain the current rate of voluntary electronic medical device reporting. Because FDA's reporting goal has essentially reached its ceiling of encouraging voluntary electronic submissions, the FDA plans in FY 2013 to retire this measure and will now highlight performance related to reviewing within 72 hours of receipt certain high priority adverse event reports, including but not limited to: pediatric deaths, multiple deaths and serious injuries, device explosions, and electrocutions. For its part, IHS will continue its focus on improving healthcare quality by striving to meet nationally recognized health care standards, while CMS will not only track several key quality indicators, but expand mechanisms that reward patient quality of care. To this end, in FY 2013 CMS will continue to work collaboratively with states to increase the number of those who report quality measures in programs such as Medicaid and the Children's Health Insurance Program. Efforts such as these will serve as the groundwork for creating a structure to improve how care is measured and provided.

OMHA will continue to implement improvements to increase efficiency in case processing such as the recent establishment of a centralized docketing division. Unfortunately, and despite these gains in efficiency, OMHA is over capacity for the number of manageable claims each Administrative Law Judge can adjudicate. To make matters worse, the number of cases is only expected to increase in the coming years, which is why future years reflect lower targets for this measure.

Aside from aiming to increase the number of hospitals who participate in the comparative database report, the AHRQ plans to expand tools that improve patient safety by increasing participation in webinars describing its services and resources, while increasing electronic downloads and orders placed for quality improvement products. On another positive note, CDC exceeded its FY 2012 target to increase the number of facilities reporting to NHSN. In fact, CDC may exceed its FY 2013 target by extending tracking capacity from 5,200 facilities in December 2011 (CY) to over 11,1000 facilities, including more than 5,500 dialysis facilities (Measure 3.3.4).

Goal 1. Objective C: Emphasize primary and preventive care linked with community prevention services

Improved access to primary care services and more effective public health measures are critical to ensuring that individuals have access to high-quality services at the place and time that best meets their needs. As part of the effort to emphasize primary and preventive care, HHS is focused on creating key linkages between the healthcare system and effective community prevention services that support healthy living and disease management.

Within HHS AHRQ, ACL, CDC, CMS, FDA, HRSA, IHS, NIH, and SAMHSA are committed to accelerating their emphasis on primary and preventive care, with a focus on community prevention services. NIH research enables identification of the services that have the greatest potential to be effective in community settings. HRSA programs deliver healthcare services to millions of Americans, including vulnerable and underserved populations. CMS programs provide payment for recommended preventive services through Medicare, Medicaid, and CHIP.

The measures below demonstrate HHS's targets and results for primary and preventive care linked with community prevention services. Key features of the Affordable Care Act focus on preventive care. HHS and component managers use these and other related measures to focus attention on achieving positive preventive care results.

Objective 1.C Table of Related Performance Measures

Percentage of health centers with at least one site recognized as a patient centered medical home (Lead Agency - HRSA; Measure ID - 1.I.A.3)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		Set Baseline		13%	25%	TBD
Result		1%		13%	Dec 31, 2013	N/A
Status		Baseline		Target Met	Pending	Target Not In Place

Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. (Lead Agency - HRSA; Measure ID - 16.II.A.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	572,397	572,397	583,730	872,565	1,200,000	879,546
Result	871,696	1,200,000	May 31, 2013	Feb 28, 2014	Feb 28, 2015	Feb 29, 2016
Status	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

Increase percent of pregnant women who received prenatal care in the first trimester. (Lead Agency - HRSA; Measure ID - 10.III.A.3)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	86%	86.5%	69%[2]	70%	71%	72%
Result	Nov 30, 2013	Nov 30, 2014	Nov 30, 2015	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018
Status	Pending	Pending	Pending	Pending	Pending	Pending

By 2015, identify three (3) key factors influencing the scaling up of research-tested interventions across large networks of services systems such as primary care, specialty care and community practice. (Lead Agency - NIH; Measure ID - SRO-8.7)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Identify and test at least three (3) key variables for measuring implementation to improve the uptake of effective interventions in healthcare settings.	Identify at least three systemic (or services) intervention studies which utilize implementation mechanisms, strategies or techniques to improve the uptake of effective interventions in healthcare settings	Identify at least 3 mechanisms for tracking successful implementation within studies to improve the uptake of research-tested interventions in health care settings.	Complete target by identifying three effective implementation strategies that enhance the uptake of research-tested interventions in service systems such as primary care, specialty care and community practice.	Identify three key factors influencing the sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice.	Identify three effective implementation strategies that enhance the sustainability of research-tested interventions in service systems such as primary care, specialty care and community practice.
Result	Variables for measuring implementation include organizational culture and climate, capacity for organizational change, dimensions of supervisory adherence to treatment principles, and adherence to clinical guidelines.	Three intervention studies that utilize implementation mechanisms, strategies, or techniques were identified to improve the uptake of effective interventions for mental health services, HIV and drug use disorders, and alcohol screening and	Three mechanisms for tracking successful implementation within studies were identified to improve the uptake of research-tested interventions in health care settings.	NIH identified three approaches that enhance the uptake of research-tested interventions in service delivery systems addressing child mental health, attention deficit hyperactivity disorder, and depression.	Dec 31, 2013	Dec 31, 2014

[2] The FY 2007 – FY 2010 targets were established based on use of the 1989 unrevised Birth Certificate. Therefore, the targets and results should not be compared until FY 2011 when targets and results are both based on the Revised Birth Certificate.

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
		treatment in healthcare or community settings.				
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

Achieve and sustain immunization coverage in children 19 to 35 months of age for one dose of measles, mumps, and rubella (MMR) vaccine. (Lead Agency - CDC; Measure ID - 1.2.1c)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	90%	90%	90%	90%	90%	90%
Result	90%	92%	92%	Sep 30, 2013	Sep 30, 2014	Sep 30, 2015
Status	Target Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	N/A	64.2 %	68 %	68.3 %	68.6 %
Result	67.5 %	67.4 %	68.3 %	Dec 30, 2013	Dec 30, 2014	Dec 30, 2015
Status	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending	Pending

Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit (Lead Agency - CMS; Measure ID - MCR25)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			N/A	N/A	2.8 million[3]	TBD
Result			2.3 million	Jun 30, 2013[4]	Jun 30, 2014	N/A
Status			Historical Actual	Pending	Pending	Target Not In Place

Analysis of Results

More than 133 million Americans have at least one chronic illness, and many Americans have several chronic conditions. Cardiovascular disease is the most deadly, accounting for one of every three deaths in the United States and costing approximately $503 billion annually to treat. One in three American adults is obese, a condition that increases the risk of heart disease, stroke, type 2 diabetes, and certain types of cancer. Medical costs associated with obesity are estimated at $150 billion per year. Moreover, these chronic diseases disproportionately affect low-income communities and individuals. Therefore, HHS components are committed to improving primary and preventive care that address chronic diseases

[3] The FY 2013 target is 2.8 million. The goals/targets set forth are based on rudimentary projections resulting from a review of 2010, 2011 and some 2012 data. These projections do not take into account any outreach campaigns, future recommendations or other efforts to change use of these services. The rate of eligible beneficiaries to use a service has not been projected.

[4] CY 2011 data. The actual number of beneficiaries reveiving an AWV was 2,335,992 Million. Please note that this number could change, although very slightly, as old claims are submitted.

in communities, especially those communities with underserved populations. The new Priority Goal to increase the number of health centers with at least one site recognized as a Patient Centered Medical Home (PCMH) demonstrates this commitment. A PCMH is a new model of care that focuses on coordinated care and quality outcomes. As the lead agency, HRSA is on track to achieve the HHS priority goal for Health Center PCMH recognition. All targets and milestones were achieved for the FY 2012 fourth quarter, as 13 percent of Health Centers had at least one site recognized as a PCMH (up from 4 percent in FY 2012 Q1), and 595 health centers grantees initiated surveys to become PCMH recognized.

As a disease that is easier to treat with early detection and intervention, HRSA is focused on reducing the spread of HIV. By 2010, 1.2 million uninsured or underinsured individuals were able to determine their HIV status through Ryan White HIV/AIDS programs—contributing to slowing the spread of the disease, allowing treatment to start earlier, and vastly improving the quality and length of the HIV positive patient's life. Prenatal care is yet another area where early detection matters, as early interventions help ensure the health of pregnant women and their newborn babies. HRSA supports the State Maternal and Child Health Block Grant Program that, among other objectives, seeks to ensure access to comprehensive prenatal and postnatal care. Other HRSA programs, including Health Centers and Health Start programs, support early entry into prenatal care.

Rising to the challenge of translating research into healthcare practice, NIH has broadened its dissemination and implementation research portfolio by working with scientists, health care providers, and other stakeholders to identify, develop and test innovative approaches to the implementation of research-tested interventions within clinical and community settings. For the past five years, NIH has hosted a trans-NIH conference to facilitate dialogue and identify strategies for overcoming obstacles for dissemination and implementation research and evaluation. Additionally, NIH has trained 35 investigators a year through the Training Institute in Dissemination and Implementation Research in Health. In FY 2012, NIH again met its target and identified three additional approaches that enhance the uptake of research-tested interventions in service delivery systems addressing child mental health, attention deficit hyperactivity disorder, and depression. For example, one team of researchers studied the use of Evidence-Based Quality Improvement (EBQI) strategies to foster the adoption of collaborative care for depression and found an increased uptake of evidence-based care.

The CDC also seeks to improve the health of children, and routine immunizations represent a cost-effective public health measure that prevents a number of serious child illnesses. In fact, it is estimated that $10.20 in medical costs are saved for every $1 invested in childhood immunizations. Since 2008, measles, mumps and rubella (MMR) vaccinations have met or exceeded 90 percent coverage rates for children 19-35 months of age. To curtail obesity, CDC invests in population-level approaches to improve nutrition as well as physical education practices and standards. As a result of CDC's efforts, the proportion of adults (age 18 and older) who engaged in leisure-time physical activity increased from 63.8 percent in 2008 to 68.3 percent in 2011, exceeding the 2008 target.

Additionally, CMS, in coordination with HRSA, encouraged Health Centers to participate in Medicare Federally Qualified Health Centers (FQHCs) – an Advanced Primary Care Practice Demonstration to enhance patient centered, comprehensive, and coordinated care by providing supplemental payment for Medicare patients in demonstration sites. This Demonstration is testing the value of providing financial and technical assistance to achieve Level 3 National Committee on Quality Assurance recognition as a Primary Care Medical Home. Meanwhile, Medicare beneficiaries now have a variety of screenings that are available with no out-of-pocket costs to the beneficiary. As of January 2011, beneficiaries may have an Annual Wellness Visit to outline what steps are recommended to protect or

improve their health. In CY 2011, more than 2.3 million beneficiaries received these visits. This places CMS on the path of reaching its FY 2013 target of 2.8 million beneficiaries with wellness visits.

Plans for the Future

To reach its FY 2013 Priority Goal target, HRSA will continue to provide training and technical assistance to Health Centers and project officers. In addition, HRSA will conduct a technical assistance webinar on PCMH lessons learned in March to further refine its strategies, while striving to process all PCMH certification Notices of Intent submitted in year 2 of PCMH Initiative by July. CMS will continue to offer beneficiaries preventive screening procedures that are available with no out-of-pocket costs, as well as enhance patient centered care by providing supplemental payment for Medicare patients in certain demonstration sites. The CDC, in turn, will carry on with its strategies and interventions designed to encourage physical activity, improve nutrition, and prevent illness.

Goal 1. Objective D: Reduce the growth of healthcare costs while promoting high-value, effective care

Healthcare costs consume an ever-increasing amount of our Nation's resources, straining family, business, and Government budgets. In the United States, the sources of inefficiency that are leading to rising healthcare costs include payment systems that reward medical inputs rather than outcomes, contain high administrative costs, and lack focus on disease prevention. The Affordable Care Act provides the framework to make healthcare safer and less costly by reducing harm to patients and reducing unnecessary healthcare costs.

As part of health reform implementation, HHS is lowering costs for American families and individuals through insurance market reforms that ensure that preventive care is available for all Americans and builds on its experience in improving the quality of care. HHS is transforming Medicare from a system that rewards volume of service to one that rewards efficient, effective care; reduces delivery system fragmentation; and better aligns reimbursement rates with provider costs. Within HHS, AHRQ, CDC, CMS, FDA, HRSA, IHS, and SAMHSA each play a distinct role in achieving this objective. HHS has identified the following measures as indicators for reducing healthcare costs while promoting high-value, effective care.

Objective 1.D Table of Related Performance Measures

Reduce by 25 percent hospital-acquired central-line associated bloodstream infections (CLABSI) by the end of FY 2013. (Lead Agency - CMS; Measure ID - MCR28.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target				12.5[5]	25[6]	TBD
Result				Mar 31, 2013	Mar 31, 2014	N/A
Status				Pending	Pending	Target Not In Place

Reduce by 20 percent hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2013. (Lead Agency - CMS; Measure ID - MCR28.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target				10[7]	20[8]	TBD
Result				Mar 31, 2013	Mar 31, 2014	N/A
Status				Pending	Pending	Target Not In Place

[5] The Standardized Infection Ratio (SIR) for FY 2010 is 0.68. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.68 x 0.875). Projected FY 2013 SIR calculation (0.68 x 0.75).

[6] The Standardized Infection Ratio (SIR) for FY 2010 is 0.68. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.68 x 0.875). Projected FY 2013 SIR calculation (0.68 x 0.75).

[7] The Standardized Infection Ratio (SIR) for FY 2010 is 0.94. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.94 x 0.9). Projected FY 2013 calculation (0.94 x 0.8).

[8] The Standardized Infection Ratio (SIR) for FY 2010 is 0.94. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.94 x 0.9). Projected FY 2013 calculation (0.94 x 0.8).

Reduce all-cause hospital readmission rates for Medicare beneficiaries by one percent per year (Lead Agency - CMS; Measure ID - MCR26)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target				N/A	18.5% Percent[9]	18.3% Percent[10]
Result				18.7% Percent[11]	18.6% Percent[12]	Mar 1, 2014
Status				Historical Actual	Target Not Met but Improved	Pending

Review potentially misvalued codes and unreviewed misvalued codes (Lead Agency - CMS; Measure ID - MCR22)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target				Review 20% of potentially misvalued codes identified 2008 to 2011	Review 20% of unreviewed potentially misvalued codes identified 2008 to 2011 and review 40% of potentially misvalued codes identified in 2012	Review 20% of unreviewed potentially misvalued codes identified 2008 to 2011, 20% of potentially misvalued codes identified in 2012, and 40% of potentially misvalued codes identified in 2013
Result				78%	Dec 31, 2013	Dec 31, 2014
Status				Target Exceeded	In Progress	In Progress

Analysis of Results

Healthcare-acquired conditions (HACs) and healthcare-associated infections (HAIs) are among the leading causes of death in the United States. At any given time, about one in every 20 hospitalized patients has a healthcare-associated infection (an HAI); while over 1 million HAIs occur across the U.S. health care system every year. These infections can lead to significant morbidity and mortality, with tens of thousands of lives lost each year. Of these hospital-acquired events, central line-associated bloodstream infections (CLABSI) have a strong potential to cause serious illness or death and catheter-associated urinary tract infections (CAUTI) are among the most common. Research has shown that a significant portion of these infections can be prevented. Applying these evidenced-based guidelines to prevent these infections requires a robust and coordinated approach among multiple stakeholders in the healthcare community to spread and sustain reductions in HAIs on a broad scale. HHS uses a number of strategies to more effectively coordinate these CLABSI and CAUTI prevention and reduction efforts and leverage the combined programmatic efforts of multiple stakeholders, including those of the Department of Defense (DoD), the Veterans' Administration (VA), state governments, academia, and provider and patient groups, HHS made CLABSI and CAUTI reduction and prevention a Priority Goal. Through the combined work of CMS, CDC, AHRQ, OASH, and their partners all quarterly milestones through FY 2012 were achieved. Although the indicators for this Priority Goal will not be available until Spring 2013, AHRQ released key milestone results on October 25 that show more than 1,000 hospital

[9] Based on CY 2011 data.

[10] Based on CY 2012 data.

[11] Based on CY 2010 data.

[12] Based on CY 2011 data.

ICUs achieved a 41 percent reduction in CLABSI rate from the baseline. It is estimated more than 2,100 CLABSIs were prevented, more than 500 lives saved, and over $36 million in excess costs were avoided.

To achieve results for FY 2012 (and reach the FY 2013 targets) various agencies and programs coordinated their efforts in a number of ways. For example, CMS' Quality Improvement Organizations (QIOs) completed a national recruitment of hospitals to participate in directed assistance to reduce CLABSI and CAUTI in both ICU and non-ICU settings. In continued efforts to link safer, efficient healthcare to payment, mandatory reporting of CAUTI in ICUs began as part of CMS' Hospital Inpatient Quality Reporting (IQR) Program, with CDC's National Healthcare Safety Network (NHSN) serving as the database to ensure standardized reporting. The CDC also issued annual state-level CLABSI and CAUTI SIR figures to track interim progress and guide further reduction efforts. OASH and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) sponsored a national "HAI Data Summit" gathering Federal and non-Federal stakeholders across multiple settings to focus on optimizing the use of electronic technology in HAI data collection, analysis, validation, reporting, and sharing that improves transparency and minimizes reporting burden. Finally, AHRQ's Comprehensive Unit Based Safety Program (CUSP) provided evidence-based safety practices and tools to improve teamwork among doctors, nurses, and other members of the health care team.

A mechanism to reduce the growth of healthcare costs is to appropriately value services. To this end, CMS procured analytic contractors to identify and analyze potentially misvalued payment codes in the Medicare Physician Fee Schedule. In FY 2012, CMS far exceeded its target of reviewing 20 percent of potentially misvalued codes identified in 2008 to 2011 by reviewing 78 percent of potentially misvalued codes— identifying as potentially misvalued just under 1,167 codes. The purpose of this effort is to make appropriate adjustments to potentially misvalued physician services based on the data, thus helping to ensure accurate reimbursement for services rendered.

In order to reduce Medicare expenditures and improve quality of care, CMS has chosen to measure preventable Medicare inpatient hospital readmissions. A "hospital readmission" occurs when a patient, who has recently been discharged from a hospital (within 30 days), is once again readmitted to a hospital. Discharge from a hospital is a critical transition point in a patient's care, and incomplete handoffs at discharge can lead to adverse events for patients and avoidable rehospitalizations. CMS established the Hospital Readmissions Reduction Program which began in FY 2013, which would reduce a portion of Medicare's payment amounts to certain hospitals based on the hospital's excess Medicare readmissions in the conditions included in the program. In addition to the Hospital Readmissions Reduction Program, CMS leverages efforts of other programs to reduce hospital readmissions. Among these is the Partnership for Patients (PfP) to reduce preventable complications during a transition from one care setting to another which includes partnership with the Community-Based Care Transitions Program and Quality Improvement Organizations. CMS' efforts to reduce readmissions also extend to Accountable Care Organizations (ACOs), which must report on 33 quality measures if they wish to receive incentives under the Medicare Shared Savings Program. CMS targets reduction of all-cause Medicare hospital readmissions by one percent per year by 2015, beginning with a baseline of 18.7 percent on CY 2010 data. The readmission rate will be updated annually through FY 2015.

Plans for the Future

The HAI Priority Goal team will continue its efforts to reduce CLABSI and CAUTI in our Nation's hospitals through several coordinated strategies. Importantly, rigorous efforts will be made to ensure that HAI data is accurate, while optimizing the process of HAI data reporting through emerging technologies. To this end, CMS is conducting its first national validation of CLABSI data from August 2012 through July 2013, and will begin validating CAUTI data beginning in May 2013. These efforts are heavily modeled

after, and will complement, ongoing CDC and state validation efforts. In turn, CDC is actively working with healthcare facilities and vendors to increase and refine electronic HAI data capture and transmission to improve data accuracy, simplify reporting, and identify facilities showing the least progress in reducing CLABSI and CAUTI, shape HAI programs, and drive region-specific interventions to reduce CLABSI and CAUTI. For more information on accomplishments and future actions, please see http://goals.performance.gov/agency/hhs.

The most important strategies will revolve around effective collaboration, because meaningful collaboration provides the opportunity to share both evidence-based infection prevention best practices and data-driven results on a broader scale. For this reason, CMS will continue to lead regular interagency meetings to ensure continued knowledge and coordination between QIOs and Partnership-for-Patients Hospital Engagement Networks at the state, local, and facility-level. In working to promote CUSP principles nationwide, CUSP and QIO partners are contractually obligated to work together to educate recruited facilities on CUSP principles. Continuing this collaborative theme, CDC's most recent funding opportunity announcement sets forth that one of the primary responsibilities of HAI coordinators is to ensure coordination of state-based prevention initiatives (e.g. CUSP, QIO, Partnership for Patients) and facilitate connections with leads of the various federally-supported prevention efforts going forward.

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

With the growing diversity of the U.S. population, healthcare providers are increasingly called on to address their patients' unique social and cultural experience and language needs. Provision of culturally competent care can increase quality and effectiveness, increase patient satisfaction, improves patient compliance, and reduces racial and ethnic health disparities. A number of HHS programs help make health care more accessible to people whose circumstances call for special attention, including older adults; children; people with disabilities; uninsured populations; persons with Limited English Proficiency; low income individuals; and those who live in remote areas. The 2012 National Healthcare Disparities Report issued by AHRQ finds that many racial and ethnic minorities have more limited access to care and receive lower quality care. Data from some HRSA supported Health Centers indicates that disparity gaps exist for racial and ethnic minorities regardless of economic status.

CMS programs facilitate health services for older adults, people with disabilities, and many low-income adults and children. CMS sets requirements for providers that support a minimum level of healthcare quality for all patients. Service delivery programs in HRSA, IHS, and SAMHSA enhance the availability of care in areas of high need. These HHS components strive to improve the quality of care their programs deliver. AHRQ regularly monitors healthcare quality and disparities, and through its grants and contracts, it focuses on improving how care is delivered. Given the federal government's unique legal and political relationship with tribal governments, it has a special trust obligation to provide health services for American Indians and Alaska Natives (AI/ANs). HHS follows the President's 2009 tribal consultation policy to partner with tribes to ensure access to quality health care.

Within HHS AHRQ, ACL, CMS, HRSA, IHS, and SAMHSA have significant roles to play in realizing this objective.

Objective 1.E Table of Related Performance Measures

Number of patients served by Health Centers (Lead Agency - HRSA; Measure ID - 1.I.A.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	18.95 million	20.15 million	19.7 million	20.6 million	21.6 million	22.6 million
Result	18.8 million	19.5 million	20.2 million	Aug 31, 2013	Aug 31, 2014	Aug 31, 2015
Status	Target Not Met but Improved	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

Increase the number of people receiving direct services through Outreach Grants. (Lead Agency - HRSA; Measure ID - 29.IV.A.3)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Set Baseline	380,000	385,000	390,000	395,000	400,000
Result	375,000	383,776	615,849	Oct 31, 2013	Oct 31, 2014	Oct 31, 2015
Status	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Amount of savings by State ADAPs participation in cost-savings strategies on medications. (Lead Agency - HRSA; Measure ID - 16.E)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	$374.2 M	$487.3 M	$551.2 M	Prior Result +0	Prior Result +0	Prior Result +0
Result	$487.3 M	$551.2 M	Apr 30, 2013	Apr 30, 2014	Apr 30, 2015	Apr 29, 2016
Status	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

Increase the number of children served by the Maternal and Child Health Block Grant. (Lead Agency - HRSA; Measure ID - 10.I.A.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	29 M	30 M	31 M	33 M	30 M	31 M
Result	33.3 M	34.5 M	37.4 M	Nov 30, 2013	Nov 30, 2014	Nov 30, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the number of children receiving Maternal and Child Health Block Grant services who are enrolled and have Medicaid and CHIP coverage (Lead Agency - HRSA; Measure ID - 10.I.A.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	11.2 M	12 M	13 M	14 M	15 M	14 M
Result	15.2 M	14.3 M	14.8 M	Nov 30, 2013	Nov 30, 2014	Nov 30, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	N/A	N/A	43,212,512 children	45,592,385 children	46,617,385 children
Result	40,009,570 children	42,146,940 children	43,542,385 children	Mar 31, 2013	Mar 31, 2014	Mar 31, 2015
Status	Historical Actual	Historical Actual	Historical Actual	Pending	Pending	Pending

Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24. (Lead Agency – HRSA and OASH; Measure ID - 36.II.B.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	1,348,000	1,413,000	1,324,000	1,296,300	1,340,300	1,353,000
Result	1,407,691	1,417,219	1,333,149	Oct 31, 2013	Oct 31, 2014	Oct 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the percentage of adults receiving services who had no past month substance use (Lead Agency - SAMHSA; Measure ID - 1.2.33)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	81%	82%	82%	83%	83%[13]	81%
Result	81%	82.9%	82.1%	84.1%	Oct 31, 2013	Oct 31, 2014
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Increase the percentage of clients receiving services who had a permanent place to live in the community (Lead Agency - SAMHSA; Measure ID - 3.4.25)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	23.6 %	25.6 %	25.6 %	25.6 %	25.6 %[14]	24.6 %
Result	24.6 %	29.4 %	33 %	35.7 %	Oct 31, 2013	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Increase the percentage of children receiving Systems of Care mental health services who report positive functioning at 6 month follow-up (Lead Agency - SAMHSA; Measure ID - 3.2.26)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	59.6 %	62.9 %	66.1 %	63.1 %	64.2 %[15]	64.2 %
Result	62.9 %[16]	66.1 %[17]	63.1 %[18]	64.2 %	Dec 31, 2013	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending

Implement recommendations from Tribes annually to improve the Tribal consultation process (Lead Agency - IHS; Measure ID - TOHP-SP)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			3 recommendations	3 recommendations	3 recommendations	3 recommendations
Result			7 recommendations	4 recommendations	Sep 30, 2013	Sep 30, 2014
Status			Target Exceeded	Target Exceeded	Pending	Pending

[13] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

[14] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

[15] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

[16] Previously reported as 50.2%. Correction to running data report made which now accounts for all follow–up interviews.

[17] Previously reported as 51.3%. Correction to running data report made which now accounts for all follow–up interviews.

[18] Previously reported as 53.0%. Correction to running data report which now accounts for all follow–up interviews.

Proportion of adults ages 18 and over who are screened for depression. (Lead Agency - IHS; Measure ID - 18)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	35%	53%	51.9%	56.5%	58.6%	60.4%
Result	44%	52%	56.5%	61.9%	Oct 31, 2013	Oct 31, 2014
Status	Target Exceeded	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Pending

American Indian and Alaska Native patients with diagnosed diabetes achieve Good Glycemic Control (A1c Less than 8.0%). (Lead Agency - IHS; Measure ID - 2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	30%	33%	30.2%	32.7%	Set Baseline	TBD
Result	31%	32%	31.9%	33.2%	Oct 31, 2013[19]	N/A
Status	Target Exceeded	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Target Not In Place

Analysis of Results

Through its mission to improve health and achieve health equity through access to quality services, HRSA plays a vital role in ensuring access to quality, culturally competent care for vulnerable populations. HRSA's community-based and patient-directed Health Centers served 20.9 million patients in FY 2011—2.1 million more than the 18.8 million patients served in FY 2009. Success in increasing the number of patients served has been due in large part to the development of new Health Centers, new satellite sites, and expanded capacity at existing clinics. Through the Office of Rural Health Policy, HRSA improves access to care in rural communities by utilizing Outreach grants that focus on community coalitions and partnerships. In FY 2011, 487,535 persons received direct services from these Outreach grants. At the same time, HRSA is striving to support its services in a cost effective manner, and thus potentially help more vulnerable populations. For example, HRSA supports state AIDS Drug Assistance Programs (ADAPs), through the Ryan White HIV/AIDS program, to provide assistance to low-income persons living with HIV/AIDS who have limited or no access to needed medications. State ADAPs use a variety of strategies to contain costs and achieved savings of $551.2 million in FY 2010—an additional 63.9 million dollars in drug cost saving over the previous year.

HRSA's contribution to this objective also includes the Maternal and Child Health (MCH) Block Grant Program, which serves vulnerable populations by seeking to improve the health of all mothers, children, and their families. In FY 2011, 37.4 million children were served by Title V programs—an increase of 2.9 million over the previous year. In a similar vein, the number of children receiving Maternal and Child Health services who are covered by Medicaid and CHIP increased from a baseline of 5.9 million in FY 2002 to 14.8 million in FY 2011. Growth in the number of children served in recent years is attributable to a shift towards more population-based services, such as screenings provided to school-age children, while reflecting state MCH programs outreach efforts to populations eligible for Medicaid and CHIP coverage. To complement this effort, beginning in FY 2013, CMS will track combined Medicaid and CHIP enrollment of children in both the Children's Health Insurance Program (CHIP) as well as Medicaid. CHIP

[19] In FY 2013 this measure changes from Ideal Glycemic Control to Good Glycemic Control with an A1c (blood sugar) value of less than 8.0%. Prior to 2013, the A1c value for Ideal Glycemic control was set at less than 7.0%

funding provides options for states to maintain state programs and to cover more uninsured children. The Affordable Care Act provides funding through FY 2015 and will require the maintenance of eligibility standards for children in Medicaid and CHIP through 2019. Many factors affect enrollment in CHIP and Medicaid, including states' economic situations, programmatic changes; and the reported enrollment results can be affected by the accuracy and timeliness of state reporting.

Another example of HHS's support for providing care to a vulnerable population can be seen through the steady progress of Title X family planning clinics, within which young women are screened for Chlamydia to reduce the likelihood of pelvic inflammatory disease and sterility.

In line with SAMHSA's mission to reduce substance abuse and mental illness in America's communities, SAMHSA strives to impact vulnerable populations, some of whom are disproportionately affected by substance abuse and mental illness. For example, increasing the percentage of adults who have had no substance use in the past month should lead to more positive health outcomes. The data for this measure has consistently improved over time, showing an increase from 78 percent in FY 2005 to 84.1 percent in FY 2012. In a related area, SAMHSA strives to reduce homelessness and is focused on increasing the number of clients receiving services who have a permanent place to live in the community. Again, the results are positive with the data showing an increase from 23.6 percent in FY 2008 to 35.7 percent in FY 2012. These results are important because permanent residence has been shown to indicate a lower chance of experiencing mental illnesses, substance misuse, or other abuse.

Another SAMHSA initiative seeks to increase the percentage of children receiving Systems of Care mental health services who report positive functioning at 6 month follow-up. A "System of Care" is an organizational philosophy and framework that involves collaboration across agencies, families, and youth, while positive functioning relates to the general ability of the child to perform the tasks associated with routine life activities. Since beginning the use of the SAMHSA's System of Care reporting system in 2008, grantee performance has shown a 7.71 percent improvement.

The Indian Health Service, which incorporates tribal consultation to improve services for American Indians and Alaska Natives, has focused on some key health related issues for vulnerable tribal members. These include increasing the number of adults screened for depression when visiting IHS facilities, and enabling diabetic patients to maintain good glycemic control. As a result of IHS' efforts to increase program accountability for achieving targets at the regional and local levels, and a more focused educational campaign conveying the benefits of depression screening, results for depression screening and Tribal consultations improved by more than 5 percent between FY 2011 to FY 2012. Meanwhile, FY 2012 results for achieving good glycemic control among diabetic patients exceeded its target; glycemic control results have been maintained between 31 percent and 33 percent despite a 15.8 percent increase in the number of diagnosed diabetics from FY 2007 to FY 2012.

Plans for the Future

As funding is available, HRSA's long-term strategy for Health Center Program's includes opening new health centers in areas in the country where they do not currently exist. HRSA will also continue its outreach efforts to populations eligible for Medicaid and CHIP coverage. By 2013, HRSA expects 1.4 million more vulnerable individuals to be served through Health Centers than were served in FY 2011. However, once the data for FY 2012 becomes available, it is expected that approximately 1.2 million fewer young women will be able to receive screening for Chlamydia due to decreased funding. For its part, SAMHSA will continue to collaborate across agencies, families, and youth, with an increased focus on preventive strategies. IHS will continue to expand depression screening through the use of health IT,

in addition to its ongoing combination of clinical and public health approaches designed to address the problem of diabetes and its complications. In FY 2013, as a response to changes in patient care standards, IHS' measure changes from ideal glycemic control to good glycemic control.

Goal 1. Objective F: Promote the adoption and meaningful use of health information technology

At the heart of HHS's strategy to modernize the healthcare system is the use of data to improve healthcare quality, reduce unnecessary healthcare costs, decrease paperwork, expand access to affordable care, improve population health, and support reformed payment structures. HHS has taken a leading role in realizing health information technology's potential benefits. Within the last few years there has been unprecedented investment in health information technology propelled by a range of initiatives, including incentive payments for the adoption and meaningful use of health information technology and standards; and the funding of regional extension centers, state health information exchanges, and Beacon communities. The rapid "wiring" of American health care, will do more than simply digitize paper-based work. It will facilitate new means of improving the quality, efficiency, and patient-centeredness of care.

HHS has identified the nationwide adoption and meaningful use of health information technology as a top priority for changing the healthcare system and for making health care more accessible, affordable, and safe for all Americans. The Office of the National Coordinator for Health Information Technology (ONC) serves as the Secretary's principal advisor charged with coordinating nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. ONC is working closely with CMS to implement the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs which encourage hospitals and health professionals to move from paper-based records systems to EHRs. In addition to ONC and CMS, many HHS agencies and offices play significant roles in advancing health information technology with the goal to improve healthcare quality and efficiency and reduce costs. These components, including AHRQ, ASPE, CDC, HRSA, IHS, and SAMHSA, are contributing to this objective by integrating these principles at the program level.

Objective 1.F Table of Related Performance Measures

Increase the number of eligible providers who receive an incentive payment from the CMS Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology (Lead Agency - ONC; Measure ID - 1.B.4)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			N/A	80,000	230,000	314,000
Result			10,700	156,758	Oct 31, 2013	Oct 31, 2014
Status			Historical Actual	Target Exceeded	Pending	Pending

Increase the percent of office-based primary care physicians who have adopted electronic health records (basic). (Lead Agency - ONC; Measure ID - 1.A.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	23% adoption of "basic" EHRs	35% adoption of "basic" EHRs	45% adoption of "basic" EHRs	55% adoption of "basic" EHRs	65% adoption of "basic" EHRs
Result	21% adoption of "basic" EHRs	30% adoption of "basic" EHRs	39% adoption of "basic" EHRs	44% adoption of "basic" EHRs	Dec 31, 2013	Dec 31, 2014
Status	Historical Actual	Target Exceeded	Target Exceeded	Target Not Met but Improved	Pending	Pending

Analysis of Results

The wide scale adoption of appropriate health information technology will enable providers to communicate with fewer errors to pharmacies, better coordinate care across settings, alert physicians and caregivers of preventive care options that would benefit the patient, and reduce duplicative testing results—among many other potential benefits. To promote wide scale adoption of health IT, the Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals as they adopt, implement, upgrade or demonstrate "meaningful use" of certified EHR technology. Because the EHR Incentive Program is seen as key to HHS's goal to strengthen healthcare, it has been chosen as one of HHS's six Priority Goals. This increased focus has led to the pursuit of coordinated strategies that have resulted in a dramatic increase in the number of eligible providers who received EHR incentive payments, from 10,700 in FY 2011 to 156,700 in FY 2012. In other words, ONC and CMS increased the number of eligible providers by more than 146,000.

ONC and CMS attribute this dramatic increase in eligible providers to an improved ability to effectively coordinate their strategies. While CMS developed and disseminated extensive educational outreach materials, ONC continued to implement a number of grant programs, such as the Regional Extension Centers (RECs) and state Health Information Exchange cooperative agreement programs, both of which assist providers and states to become meaningful users of health IT in accordance with EHR Incentive Program criteria. In December 2012, ONC continued this coordination effort by hosting its annual meeting between ONC, CMS, HITECH grantees, states, and federal health IT stakeholders. Armed with this information, ONC and CMS are on track to make 230,000 EHR payments to qualified health care providers by the end of FY 2013.

HHS also measures the percentage of office-based primary care physicians who have adopted electronic health records. The results for this indicator, in line with the success the EHR Incentive Program experienced, are steadily improving. In 2008, primary care provider adoption of basic EHRs was estimated to be 20 percent, with the adoption of basic EHRs nearly doubling to 39 percent in 2011 and reaching 44 percent in 2012. Through collaboration with various agencies, such as the CDC and the National Center of Health Statistics, and a targeted strategy that funded 62 RECs who have helped more than 100,000 primary care providers, ONC estimates that the nationwide rate of EHR adoption will reach or surpass 55 percent in 2013.

Plans for the Future

ONC, CMS, and its partners will continue to work collaboratively, coordinate with each other, and implement strategies that seek out, demonstrate, and increase IT-infused health care reforms enabling measurable improvements in patient care and population health, such as the EHR Incentive Program. More specifically, ONC and its partners will conduct an in depth analysis of EHR Incentive Program registration, attestation, and payment data to evaluate the characteristics of providers at each of the different program milestones. For example, by April 2013 Medicaid meaningful use incentive payments will be analyzed to identify the margin between providers who received adopt, implement and upgrade (AIU) payments in 2011 and those who did not return for payment in 2012. Analysis of this kind of program data will enable states and HITECH grantees to establish goals and accelerate progress towards meaningful use of electronic health records and the ultimate goal of improved healthcare quality.

Goal 2. Objective A: Accelerate the process of scientific discovery to improve patient care

Medical breakthroughs, fueled by scientific discovery, have made the difference between life and death for countless Americans. Nevertheless, the need for better health interventions remains. Continuing to improve the health and well-being of Americans requires ongoing investments, with goals that range from improving our understanding of fundamental biological processes to identifying the best modes of prevention and treatment. HHS investments have improved the health of many Americans, but the path from basic discovery into safe, effective patient care can be long. This is why HHS is expanding the knowledge base in biomedical and behavior sciences and investing in fundamental science and service system research to improve detection, treatment and prevention.

The Department has identified several leverage points to accelerate movement along the pipeline from scientific discovery to more effective patient care. NIH supports basic, clinical, translational, and early-stage drug development for promising new therapies. In addition, research and dissemination activities through NIH, AHRQ and other HHS components will help enhance the evidence-base for preventive, screening, diagnostic, and treatment services and facilitate the use of this information by clinicians, consumers, and policymakers.

HHS will continue to support ethical and responsible research practices, including ensuring the protection of the humans and animals participating in health research. AHRQ, FDA, and NIH have significant roles to play in advancing science to improve health and well-being for Americans. Below is a sample of performance measures that HHS will use to guide activities and achieve improved results for patient care.

Objective 2.A Table of Related Performance Measures

By 2012, reduce the fully loaded cost of sequencing a human genome to $15,000. (Lead Agency - NIH; Measure ID - CBRR-12)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		New sequencing machines in routine production at centers.	Reduce the fully-loaded cost of sequencing a human genome to $25,000.	Reduce the fully-loaded cost of sequencing a human genome to $15,000.		
Result		New sequencing machines are in routine production at centers and are on track to meet sequencing targets.	The current cost of a fully-loaded human genome was reduced to $10,497.	The current cost of a fully-loaded human genome was reduced to $5,985.		
Status		Target Met	Target Exceeded	Target Exceeded		

By 2015, make freely available to researchers the results of 400 high-throughput biological assays screened against a library of 300,000 unique compounds, and the detailed information on the molecular probes that are developed through that screening process. (Lead Agency - NIH; Measure ID - CBRR-10)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Establish repository of 300,000 compounds.	Establish 35 new assays in the Molecular Libraries Program (MLP) Portfolio.	Increase depositions of bioassays in PubChem to a rate of five (5) per month.	Deposit chemical structure and biological data for 200 new small molecule probes in PubChem.	Establish 400 primary biochemical, cell-based or protein-protein interaction assays that can be miniaturized and automated as high throughput screens in the Molecular Libraries Program (MLP) Portfolio.	Increase the Molecular Libraries Program (MLP) inventory to 350small molecule probes that can be used in biological research to interrogate basic biological processes or disease.
Result	The Molecular Libraries Small Molecule Repository (MLSMR) contains 341,830 unique compounds.	98 new high-throughput assays were added to the MLP Portfolio.	NIH increased the assay deposition into PubMed to a rate greater than eight HTS assays per month, resulting in a total deposit of 103 assays.	The Molecular Libraries Program deposited chemical structure and biological data for 294 new small molecule probes in PubChem since the program began.	Dec 31, 2013	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	In Progress

By 2020, identify two molecular-targeted therapies for disorders of the immune system in children. (Lead Agency - NIH; Measure ID - SRO-3.9)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		Begin accrual of two patient cohorts presenting in childhood, one with a monogenic autoinflammatory disorder and one with a genetically complex autoinflammatory disorder.	Complete phenotypic characterization of a patient cohort.	Complete genetic, biochemical, or cellular studies aimed at identifying a molecular pathway underlying the disease in the patient cohort.	Identify at least one molecular pathway suitable for targeting in the patient cohort by performing detailed genetic mapping and confirmatory analyses for markers and pathways identified through genome-wide association. *Previous Target*	Design a clinical trial testing an agent for a disorder of the immune system in children (e.g., Still's disease).

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
					Identify at least one molecular pathway suitable for targeting in the patient cohort.	
Result		Two cohorts are being accrued by NIH investigators – one with neonatal-onset multisystem inflammatory disease and another with systemic-onset juvenile idiopathic arthritis.	NIH researchers completed recruitment of a cohort of well-characterized patients with systemic-onset juvenile idiopathic arthritis through an international consortium of investigators.	A genome-wide association study has been performed on the cohort of 982 systemic-onset juvenile idiopathic arthritis patients and over 7000 healthy controls for 1.4 million genetic markers.	Dec 31, 2013	Dec 31, 2014
Status		Target Met	Target Met	Target Met	In Progress	In Progress

By 2015, identify and characterize two molecular pathways of potential clinical significance that may serve as the basis for discovering new medications for preventing and treating asthma exacerbations. (Lead Agency - NIH; Measure ID - SRO-6.4)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Identify single nucleotide polymorphisms (SNPs) in DNA that may be associated with AE in children.	Describe phenotypic characteristics of a group of asthma patients prone to exacerbations.	Characterize cellular and molecular inflammation in the distal lung that may contribute to severe disease with frequent exacerbations.	Investigate the role of mucus gel formation in healthy controls and asthma patients.	Conduct investigations to elucidate the dynamic, pathophysiologic phenotypes of severe asthma.	Investigate the disease processes involved in asthma exacerbations and/or severe asthma using state-of-the-art pulmonary imaging techniques.
Result	A SNP(-251) in the Interleukin-8 gene was identified and found to be associated with exacerbations of asthma in children.	Histoblood group antigens were explored as susceptibility factors for asthma exacerbations. O-secretor mucin glycan phenotype was identified as a risk factor for asthma	Scientists characterized the molecular pathways in fibroblasts (the principal active cells of connective tissue) from two regions of the lung. Their findings suggest that fibroblasts	Researchers investigated two proteins associated with mucus formation, CLCA1 and TMEM16A that may serve as potential targets for treating asthma.	Dec 31, 2013	Dec 31, 2014

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
		exacerbations.	from the distal lung may be the more important fibroblast cell type in processes that contribute to disease progression and severity in asthma.			
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

By 2015, establish and evaluate a process to prioritize compounds that have not yet been adequately tested for more in-depth toxicological evaluation. (Lead Agency - NIH; Measure ID - SRO-5.13)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		Establish a >7000 compound library for testing in quantitative high throughput screens (qHTS) and test in >20 qHTS, test >50 compounds (a subset of the main library) in at least 50 mid-throughput assays.	Identify an additional 3,000 compounds to the library for testing, complete compound analytical analysis, and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 50 qHTS and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 25 qHTS and test 180 compounds in densely sequenced human lymphoblastoid cell lines to assess genetic diversity in response to toxicants.	Test 10,000 compound main library in an additional 25 qHTS and test 30 subsets of possible high risk chemicals in high-content screens.
Result		7,000 compounds were selected and collected as an establishment of the compound library. A subset of this library, "the 1408 compound library," has screened an additional 20 qHTS assays. 50 compounds were identified for testing in 50 mid-throughput assays but testing was not conducted and was rescheduled for 2011.	The 10K library was completed. Performance on mid- throughput assays surpassed the target. Analytical or chemical analysis is in progress but not yet completed.	The library containing 10,000 compounds was screened in 65 quantitative high throughput screens (qHTS) or assays. Fifty compounds were screened in approximately 600 mid-throughput assays.	Dec 31, 2013	Dec 31, 2014
Status		Target Not Met	Target Not Met	Target Met	In Progress	In Progress

Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease. (Lead Agency - HRSA; Measure ID - 3.III.A.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	BRM 4, CM 4	Demonstrate defective nerve function in infected armadillos.	Use DNA evidence to link leprosy transmission from armadillos to humans.	Pursue the integration of BRM, CM and molecular reagent breakthroughs	Pursue relevant animal model for human leprosy.	Pursue relevant animal model for human leprosy
Result	BRM 4, CM 4	Defective nerve function demonstrated	leprosy link demonstrated	Mar 31, 2013	Mar 31, 2014	Mar 31, 2015
Status	Target Met	Target Met	Target Met	In Progress	In Progress	In Progress

Increase the number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers. (Lead Agency - AHRQ; Measure ID - 4.4.5)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	32 EHC products	23 EHC products	65 EHC products	26 EHC products	65 EHC products	35 EHC products
Result	35 EHC products	51 EHC products	68 EHC products	128 EHC products	Sep 30, 2013	Sep 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

Accelerating the process of scientific discovery for the purpose of improving health outcomes is important to Americans wellbeing and health. Many of these efforts focus on investigating the impact of genes on our health. Improvements in process and technology have enabled decreases in DNA sequencing costs that have gone beyond linear and NIH highlighted this research as a priority goal for FY 2011 – FY 2012. The cost of sequencing a human genome was approximately $50,000 at the beginning of 2010, and NIH has reduced the cost to $5,985 by the end of FY 2012. The key challenges are to develop the most efficient production workflow and operation, and to stimulate field-altering technological leaps that will continue to drive down the cost of human genome sequencing. The performance of instrumentation does not solely determine the costs of human genome sequencing; very high throughput centers of the kind supported by NIH optimize costs for efficiency, much like in a factory. High-throughput work requires highly standardized methods, robust laboratory information management systems, and other features not associated with small labs. In addition to large centers, NIH manages a portfolio of Advanced Sequencing Technology grants which aim to harness nanoscale technologies to cut DNA sequencing costs.

Using emerging biomedical techniques, NIH has expanded efforts to advance the development of small molecules with therapeutic potential to prevent and treat diseases. The Molecular Libraries Probe Production Centers Network (MLPCN) as a nationwide scientific resource to accelerate the discovery of small molecule probes for use in biological research. Exceptional progress has been made by depositing chemical structure and biological data for 294 small molecule probes in PubChem. By disseminating results in PubChem, the NIH enhances one of the largest sets of publicly available chemical biology information to be used by both governmental and private researchers.

Advances in technology and reductions in cost make it possible to study the genetic origins of disease. For example, a number of illnesses affecting the immune system in children tend to run in families. They include relatively common illnesses such as juvenile idiopathic arthritis (JIA) as well as rare conditions such as the recently discovered deficiency of IL-1 receptor antagonist (DIRA). These types of illnesses may present with either excessive or impaired immune responses, and may lead to significant disability and even death. Systemic-onset JIA (SOJIA) is a genetically complex autoinflammatory disease. During FY 2012, NIH performed a genome-wide association study of SoJIA. This research identified multiple genetic loci potentially associated with SoJIA. These discoveries provide avenues for greater insight into the causes and into the biology of inflammation and immunity in humans.

Complementary to the potential of the genetic study of disease are more traditional methods of disease investigation, which continue to experience technical advancement. Asthma attacks are a significant cause of morbidity in patients with asthma and represent a substantial public health burden. NIH researchers studied the biology of asthma exacerbations to inform the development of effective treatment of asthma patients who are prone to this condition.

In addition to the cataloging of data about naturally-occurring biological chemicals, NIH manages a program to investigate and catalog the health effects of many of the estimated 125,000 man-made chemicals in use commercially. NIH and the EPA began the program, titled Tox21, in early 2008 to collaborate on the research, development, validation, and translation of new and innovative test methods that characterize how chemicals interact with cellular pathways, determining chemical toxicity, as well as danger to human health. This is important for development of prevention or mitigation strategies. Tox21 has a library of 12,174 substances/formulations with 8,307 unique compounds. NIH exceeded expectations in FY 2012 by screening 65 quantitative high throughput screens (qHTS) or assays in the Tox21 library. Also, 1,368 substances were screened in 39 qHTS assays as part of the assay validation process prior to screening the complete library and 50 compounds were screened in approximately 600 mid-throughput assays. In an effort to determine individual susceptibility, an analysis of genetic diversity in sensitivity to toxicants (based on data for 179 compounds screened for cytotoxicity in 1086 human cell lines) was initiated ahead of schedule.

HRSA made progress toward developing an animal model (the armadillo) for Hansen's disease, more commonly known as leprosy. Once the model is developed, researchers can further explore potential advances in scientific knowledge related to questions associated with pathogenesis, early diagnosis, vaccine development, and transmission of the disease.

Finally, HHS enhanced information available to the public through the Effective Health Care Program. AHRQ manages this program, which seeks to improve patient care through patient-centered health research. State-of-the-science reviews of existing information that compare the effectiveness of health care interventions are produced. Examples of recent reviews include "Antipsychotic Medicines for Children and Teens: A Review of the Research for Parents and Caregivers" and "Treating Chronic Pelvic Pain: A Review of the Research for Women". These systematic reviews typically include a description of the findings of the collection of research studies. The number and type of products produced, including translational products and statistical briefs, increased in FY 2012. These products serve to inform and facilitate evidence-based decision-making on treatments and health care services as well as identify knowledge gaps and future research needs.

Plans for the Future

In 2014 HHS plans to build upon the successes of 2012 by: providing additional Effective Health Care (EHC) Program products, investigating the disease processes involved in asthma exacerbations and/or severe asthma using state-of-the-art pulmonary imaging techniques, continuing research into molecular-targeted therapies for child immune system disorders, conducting more in-depth testing of the toxicology of thousands of compounds, pursuing a viable animal model for the full spectrum of clinical complexities of human Hansen's Disease, and increasing the inventory to 350 small molecule probes available to researchers that can be used in biological research to interrogate basic biological processes or disease.

Goal 2. Objective B: Foster innovation to create shared solutions

HHS depends on collaboration to realize its goals. Every day, HHS agencies work collaboratively with their Federal, state, local, tribal, urban Indian, nongovernmental, and private sector partners to improve the health and well-being of Americans. HHS is using technology to identify new approaches to enable citizens to contribute their ideas to the work of government that will yield innovative solutions to our most pressing health and human service challenges. HHS employs an array of innovative participation and collaboration mechanisms to improve delivery of consumer information on patient safety and health, provide for medical research collaborations on patient engagement, provide technology for teamwork, and find creative ideas in the workplace. These innovations include engaging Web 2.0 technologies with several functional capabilities, including blogging to rate and rank ideas and priorities, crowdsourcing to identify public opinion and preferences, group collaboration tools such as file-sharing services, idea generation tools, mobile technologies such as text messaging, and online competitions.

Innovation is a key element of HHS's intra-agency Open Government initiative. Through this initiative, the administration is promoting agency transparency, public participation, and public-private collaboration across Federal departments. Every part of the Department contributes to making HHS more open and innovative.

Objective 2.B Table of Related Performance Measures

Increase number of identified opportunities for public engagement and collaboration among agencies (Lead Agency - IOS; Measure ID - 1.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		311	317	340	346	350
Result		311	334	343	Oct 31, 2013	Oct 31, 2014
Status		Target Met	Target Exceeded	Target Exceeded	Pending	Pending

Increase number of high-value data sets and tools that are published by HHS (Lead Agency - IOS; Measure ID - 1.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		117	122	285	288	400
Result		179	282	366	Oct 31, 2013	Oct 31, 2014
Status		Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice (Lead Agency - IOS; Measure ID - 1.3)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		7	8	10	12	13
Result		6	8	10	Oct 31, 2013	Oct 31, 2014
Status		Target Not Met	Target Met	Target Met	Pending	Pending

Analysis of Results

Enhancing opportunities for public participation and collaboration in HHS activities is a key priority for the HHS Open Government efforts. It is widely understood that to deliver effectively on our mission, we must leverage the collective creativity and wisdom of our stakeholders. Federal Advisory Committees are one key way of ensuring public and expert involvement and advice in Federal decision-making. Another way to involve the public in helping HHS to solve pressing agency problems is through the use of challenges and competitions in which members of the public can participate. An additional important vehicle to engage our stakeholders is through the development and release of application programming interface. Application programming interfaces allow external websites and services to interface with HHS databases -- thus allowing external partners to mix information and media from HHS services and datasets into their sites and applications. In 2012, HHS anticipated 340 engagement opportunities and secured 343 opportunities in that year. In addition to the number of engagements secured, HHS experienced notable success in the quality of public participation and collaboration.

Developing new types of effective collaboration and participation initiatives at HHS often involves a focused effort by a select group of individuals. HHS's approach takes two forms: in some instances members of the HHS OS's Innovations Team have seeded these new initiatives; and in others HHS operating and staff divisions have led. Each of the projects is labor-intensive, and thus only a few are selected in each year. In 2012, the HHS Innovations Staff and its consulting team (in collaboration with relevant HHS operating and staff divisions) undertook ten projects. These projects ranged from identifying and deploying technology to facilitate communication and collaboration, to bringing together innovators to exchange ideas and work to develop and implement new ideas.

In addition to engaging the public, a high priority for the HHS Open Government Plan is to make HHS data more easily and broadly available. The HHS Data Council is working with the CIO Council to enhance opportunities for publishing data and tools. This information can be used to increase agency accountability and responsiveness, improve public knowledge of the agency and its operations, further the core mission of the agency, create economic opportunity, or respond to need and demand as identified through public consultation. Also, researchers and analysts may use these data sets to add knowledge and understanding to existing health and human service issues. In 2012, HHS published 84 additional datasets, exceeding initial projections, bringing the total number of datasets to 366.

Plans for the Future

HHS has accelerated the development of tools to further foster collaboration and participation. In FY 2013, HHS plans more work developing engagement opportunities and collaboration initiatives. Additionally, under the guidance of the Chief Technology Officer, HHS will focus increasingly on data education and stakeholder engagement, developing new mediums of educating our data communities on the content of HHS data, such as codeathons and on-line chat sessions. HHS will also continue to increase the number of high value data sets and tools made available to the public.

Goal 2. Objective C: Invest in the regulatory sciences to improve food and medical product safety

Regulatory science is the development and use of scientific tools, standards, and approaches necessary for the assessment of products including medical products and foods to determine safety, quality, and performance. Without advances in regulatory science, promising therapies may be discarded during the development process simply for the lack of tools to recognize their potential; moreover, outmoded review methods can delay approval of critical treatments. Advancements in regulatory science will help to prevent foodborne illnesses, and when outbreaks of foodborne illness occur, to identify the source of contamination quickly and to limit the impact of the outbreak. Regulatory science innovations will allow for faster access to new medical technologies that treat serious illnesses and improve quality of life. These advances will benefit every American by increasing the accuracy and efficiency of regulatory review and by reducing adverse health events, drug development costs, and the time-to-market for new medical technologies.

Advancing regulatory science and innovation is an objective shared by a number of agencies within HHS. FDA and NIH are collaborating on an initiative to fast-track medical innovation to the public. Other agencies promoting regulatory science and innovation include AHRQ and HRSA. Below are several performance measures that are indicative of the types of achievements that HHS and its components expect to achieve related to improving regulatory science and food and medical product safety.

Objective 2.C Table of Related Performance Measures

The average number of days to serotype priority pathogens in food (Screening Only). (Lead Agency - FDA; Measure ID - 214306)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	N/A	9.0 working days	6.0 working days	5.0 working days	4.0 working days
Result	14.0 working days	10.0 working days	7.0 working days	6.0 working days	Dec 26, 2013	Dec 31, 2014
Status	Historical Actual	Historical Actual	Target Exceeded	Target Met	Pending	Pending

Develop biomarkers to assist in characterizing an individual's genetic profile in order to minimize adverse events and maximize therapeutic care. (Lead Agency - FDA; Measure ID - 262401)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	Identify patterns in serum biomarkers to use in monitoring dietary intervention protocols to reduce obesity	Identify target genes that can predict potential for obesity and type 2 diabetes to provide individually tailored	1) Develop analytical methods to assess drug-induced heart damage 2) Identify target genes for obesity and the consequent development of metabolic	1) Analyze urine, blood, and tumor tissues samples to identity biomarkers that will facilitate early detection in new cases and in the reemergence of	1) Conduct a thorough review of existing drug-specific information endorsed by FDA to determine if some drugs cause a higher

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
			therapeutic treatment and dietary guidelines for use in improving health	syndrome diseases and heart disease	pancreatic cancer. 2) Develop a new targeted therapeutic approach to improve clinical management of breast cancer.	incidence of liver toxicity in women than men 2)Identity biomarkers that will facilitate early detection in new cases and in the reemergence of pancreatic cancer
Result	Incorporate the linkage between physical responses to a healthier diet and genetic analyses via the Community Based Participatory Research project resulting in 45 blood samples and approx. 660,000 genotypes (genetic makeup) identified for each participant.	Patterns were identified from analysis of 2009 CBPR data and preliminary analysis of 2010 CBPR data in serum biomarkers that can be used to monitor dietary intervention protocols to reduce obesity.	Statistical analyses of gene-phenotype interactions and nutrient levels were conducted and target genes identified, further results are pending a final analysis and publication.	1) A translational mouse model of drug-induced heart damage was developed and is being used to identify new predictive molecular biomarkers of early stages of drug-induced cardiac tissue injury. 2) Gene expression experiments have been completed and preliminary results suggest the involvement of a number of genes involved in lipid metabolism and sugar transporters.	N/A	N/A
Status	Target Not In Place	Target Met	Target Met	Target Met		

Promote innovation and predictability in the development of safe and effective nanotechnology-based products by establishing scientific standards and evaluation frameworks to guide nanotechnology-related regulatory decisions. (Lead Agency - FDA; Measure ID - 293206)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			Initiate multi-year studies on safety issues (1) for evaluating nanoparticles that	Continue regulatory science studies on evaluating nanomaterials	Continue regulatory science studies on evaluating nanomaterials	Maintain CORES Program

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
			cross multiple product areas and (2) surrounding use of nano-particles in cosmetic products.	from 2011.	from 2011.	
Result			FDA implemented the Collaborative Opportunities for Research Excellence in Science (CORES) Program to promote cross-center and external collaborative regulatory science research opportunities, focusing on studies evaluating nano-materials.	FDA implemented the Collaborative Opportunities for Research Excellence in Science (CORES) Program to promote cross-center and external collaborative regulatory science research opportunities, focusing on studies evaluating nano-materials. An additional, new component of this activity included inviting external experts to review proposals.	N/A	N/A
Status			Target Met	Target Met	In Progress	

Analysis of Results

HHS supports an extensive set of efforts to protect and promote food and medical product safety. FDA Foods Program scientists are evaluating commercially available instrumentation that can be adapted to support the FDA mission to prevent and treat foodborne illnesses. The Center for Food Safety and Applied Nutrition has advanced two of these technology platforms to Field laboratories. The instrumentation is laboratory-based and provides broad-range and strain-specific identification of infectious organisms for multiple applications (clinical and environmental). These detection platforms are enhancing FDA regulatory activities and shortening FDA response time during foodborne outbreaks involving Salmonella. In FY 2012, the FDA reduced the average number of days to identify priority pathogens in foods to six days.

The FDA does not focus on the protection of the food supply alone. The National Center for Toxicological Research's goal is to define the correlations between an individual's nutrition, genetic profile, health, and susceptibility to chronic disease in support of personalized nutrition and health. This research will provide baseline data that supports the FDA goal of providing consumers clear and timely information to

help promote personalized nutrition and health. Identifying biomarkers of health, susceptibility to chronic disease, and gene-micronutrient interactions is essential to gaining a more complete scientific understanding of health. NCTR is implementing a novel research program for personalized nutrition and health that relies on the "challenge homeostasis" concept for identifying markers of health and susceptibility. Since 2008, FDA/NCTR and USDA/ARS have had an ongoing partnership with a community development center in the Mississippi Delta region of Arkansas to conduct community-based participatory research (CBPR) that studies the effects of dietary intake and its influence on the development of obesity-associated diseases. This ongoing collaboration analyzes dietary intake patterns, micronutrient levels in the blood samples of children and adults, and calories expended. In FY 2012, the FDA sought to 1) Develop analytical methods to assess drug-induced heart damage and 2) Identify target genes for obesity and the consequent development of metabolic syndrome diseases and heart disease. The results produced include: 1) A translational mouse model of drug-induced heart damage was developed and is being used to identify new predictive molecular biomarkers of early stages of drug-induced cardiac tissue injury and 2) Completed gene expression experiments with preliminary results that suggest the involvement of a number of genes involved in lipid metabolism and sugar transporters.

In addition to addressing present health concerns, the FDA anticipates potential future issues with emerging technologies, such as nanotechnology, which pose regulatory challenges. Like many emerging technologies, there is the potential benefit that nanotechnology can bring to food, medicine, and other FDA-regulated product areas, but the risks to human and animal health are not yet completely identified or understood. Establishing scientific standards and evaluation frameworks to guide nanotechnology-related regulatory decisions will promote innovation and predictability in the development of safe and effective nanotechnology-based products. In February 2010, the FDA Nanotechnology Task Force developed and published the agency's FY 2011 regulatory science research plan for nanotechnology that enables regulatory science studies relevant for the development of safe and effective nanotechnology-based products (http://www.nano.gov/node/219). In FY 2011, FDA implemented its proposed regulatory science research plan for nanotechnology, including developing the CORES (Collaborative Opportunities for Research Excellence in Science) to support studies that can serve as a platform for the targets above, building laboratory capacity to assess nanotechnology products, and investing in training and staff development in the area of nanotechnology. In FY 2012, FDA continued the CORES Program and presented its work to its Advisory Board to the Commissioner of Food and Drugs (Science Board). The Science Board reviewed the agency's efforts and concurred with its regulatory science approach to foster the responsible development of safe and effective nanotechnology-based products.

Plans for the Future

The FDA plans to continue to coordinate testing and refinement of the technology to reduce the average number of days to identify pathogens in food. The improvements in sample throughput, along with the high degree of specificity built into this technology, will dramatically improve response and traceback capabilities. When fully deployed, this technology holds the promise of reducing the time to conduct these analyses from 14 days to less than a week. In addition, the FDA plans to continue studying the potential health impacts of nanomaterials as well as continue the investigation of biomarkers of disease, including 1) Analyzing urine, blood, and tumor tissues samples to identify biomarkers that will facilitate early detection in new cases and in the reemergence of pancreatic cancer and 2) Developing a new targeted therapeutic approach to improve clinical management of breast cancer.

Goal 2. Objective D: Increase our understanding of what works in public health and human service practice

Working together with its public and private partners, HHS is committed to improving the quality of public health and human service practice by conducting applied, translational, and operations research and evaluations. HHS uses research and evaluation findings to inform policy and program implementation efforts. HHS has identified approaches that help people make healthy choices, assist communities as they work to improve the health and well-being of their residents, support safety and stability of individuals and families, and help children reach their full potential. HHS also monitors and evaluates programs to assess efficiency and responsiveness and to inform the effective use of information in strategic planning, program or policy decisions, and program improvement.

HHS investments in public health and human service research have yielded many important findings about what works. HHS will work to identify promising, effective approaches that are culturally competent and effective for populations with varying circumstances and needs.

A number of HHS agencies promote the adoption of evidence-based programs and practices including ACF, AHRQ, ACL, CDC, HRSA, IHS, NIH, and SAMHSA. Below are representative measures which HHS and its components will use to guide performance.

Objective 2.D Table of Related Performance Measures

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 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	40%	52%	60%	65.3%	Prior Result +3PP	Prior Result +3PP
Result	49%	57%	62.3%	Oct 31, 2013	Oct 31, 2014	Oct 30, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase access to and awareness of the Guide to Community Preventive Services, and Task Force Findings and Recommendations, using page views as proxy for use (Lead Agency - CDC; Measure ID - 8.B.2.5)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			Set Baseline	973,724	1,032,147	1,220,956
Result			927,357	1,220,956	Oct 31, 2013	Oct 31, 2014
Status			Baseline	Target Exceeded	Pending	Pending

Analysis of Results

The most efficient and effective programs often use evidence-based and evidence-informed practices. The Community-Based Child Abuse Prevention program developed an efficiency measure to gauge progress towards programs' use of these types of practices. For the purposes of this efficiency measure, the ACF Children's Bureau defines evidence-based and evidence-informed programs and practices within four levels (from least to most): Emerging and Evidence Informed; Promising; Supported; and

Well-Supported. The funding directed towards these types of programs (weighted by "evidence-informed" or "evidence-based" practices level) will be calculated over the total amount of funding used for direct service programs to determine the percentage of total funding that supports evidence-based and evidence-informed programs and practices. HHS selected the target of a three percentage point annual increase in the amount of funds devoted to evidence-based practice through FY 2014 as a meaningful increment of improvement. This performance expectation 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. ACF has made steady progress on this measure, with the percent of Community-Based Child Abuse Prevention funding directed toward evidence-based or evidence-informed practices exceeding targeted increases for those years data is available (from FY 2009 to FY 2011).

Systematic reviews of scientific literature by the CDC form the basis for evidence-based Community Preventive Services Task Force (Task Force) recommendations about effective programs, services, and policies for improving health and preventing many chronic and infectious diseases and injuries. To achieve their maximum health impact, Task Force recommendations must be disseminated, adopted, and used by public health leaders, practitioners, and partners. Pursuing that purpose, CDC publishes the Guide to Community Preventive Services. Currently, awareness and use of this guide is tracked via a proxy measure—page views of the Community Guide website (www.thecommunityguide.org). In FY 2012, CDC experienced 1,220,956 page views, a 32 percent increase over the FY 2011 baseline.

Plans for the Future

Over time, the Community-Based Child Abuse Prevention program expects to increase the number of effective programs and practices that are implemented, thereby maximizing the impact and efficiency of CBCAP funds. ACF is committed to continuing to work with CBCAP grantees to invest in known evidence-based practices, while continuing to promote evaluation and innovation, so as to expand the availability of evidence-informed and evidence-based practice over time.

The CDC is also currently developing a new survey that will measure use of the Community Guide's recommendations and findings. This represents an improved measure of awareness and use over the current proxy of page views.

Goal 3. Objective A: Promote the safety, well-being, resilience and healthy development of children and youth

Children and youth depend on the adults in their lives to keep them safe and to help them achieve their full potential. Yet too many of our young people—our Nation's future workforce, parents, and civic leaders—are at risk of adverse outcomes.

HHS partners with state, local, tribal, urban Indian, and other service providers to sustain an essential safety net of services that protect children and youth, promote their resilience in the face of adversity, and ensure their healthy development from birth through the transition to adulthood. Health and early intervention services ensure children get off to a good start from infancy. Early childhood programs, including Head Start, enhance the school readiness of preschool children. Child welfare programs, including child abuse prevention, foster care, and adoption, target those families in which there are safety or neglect concerns. Services for children exposed to trauma or challenged with mental or substance use disorders provide support for those with behavioral healthcare needs. Several HHS programs also promote positive youth development and seek to prevent risky behaviors in youth. Vital research funded by agencies across HHS seeks to understand the risks to children's safety, health, and well-being and to build evidence about effective interventions to mitigate these risks. For example, CDC tracks data on children's health including prevalence of disease, injuries, and violence among children and youth and develops recommendations on effective medical interventions.

A wide range of HHS agencies support these activities, including ACF, CDC, CMS, HRSA, IHS, NIH, OASH, and SAMHSA. Below is a list of several performance measures which will be used by HHS agencies to manage performance and ensure the safety and well-being of children and youth:

Objective 3.A 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 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target				Set Baseline	23%	21%
Result				25%	Jan 31, 2014	Jan 30, 2015
Status				Baseline	Pending	Pending

Increase the number of states that implement Quality Rating and Improvement Systems (QRIS) that meet high quality benchmarks (Lead Agency - ACF; Measure ID - 2B)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			Set Baseline	20 states	25 states	27 states
Result			17 states	19 states	Jan 30, 2014	Jan 30, 2015
Status			Baseline	Target Not Met but Improved	Pending	Pending

Decrease the number of antibiotic courses prescribed for ear infections in children under five years of age per 100 children. (Lead Agency - CDC; Measure ID - 3.2.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	55	50	49	48	49	48
Result	59.2	55.8	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Target Not Met	Target Not Met but Improved	Pending	Pending	Pending	Pending

Decrease the percentage of middle and high school students who report current substance abuse (Lead Agency - SAMHSA; Measure ID - 3.2.30)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	20.0 %	20.0 %	20.0 %	20.0 %[20]	20.0 %
Result	19.0 %	24.0 %	21.5 %	19.1 %	Dec 31, 2013	Dec 31, 2014
Status	Historical Actual	Target Not Met	Target Not Met but Improved	Target Exceeded	Pending	Pending

Increase the proportion of youth living in safe and appropriate settings after exiting ACF-funded Transitional Living Program (TLP) services. (Lead Agency - ACF; Measure ID - 4.1LT and 4A)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	85%	85%	85%	86%	86%	86%
Result	86%	87%	87%	89%	Dec 30, 2013	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Of all children who exit foster care in less than 24 months, increase the percentage who exit to permanency (reunification, living with relative, guardianship or adoption) (Lead Agency - ACF; Measure ID - 7P1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Set Baseline	N/A	N/A	91.9 %	Prior Result +0.2PP	Prior Result +0.2PP
Result	91.3 %	91.5 %	91.7 %	Oct 30, 2013	Oct 30, 2014	Oct 30, 2015
Status	Baseline	Historical Actual	Historical Actual	Pending	Pending	Pending

[20] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

Of all children who exit foster care after 24 or more months, increase the percentage who exit to permanency (reunification, living with relative, guardianship, or adoption). (Lead Agency - ACF; Measure ID - 7P2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Set Baseline	N/A	N/A	73.3 %	Prior Result +0.5PP	Prior Result +0.5PP
Result	72.4 %	72.5 %	72.8 %	Oct 30, 2013	Oct 30, 2014	Oct 30, 2015
Status	Baseline	Historical Actual	Historical Actual	Pending	Pending	Pending

For those children who had been in foster care less than 12 months, maintain the percentage that has no more than two placement settings. (Lead Agency - ACF; Measure ID - 7Q)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	80%	80%	80%	80%	80%	80%
Result	85%	85.1%	84.6%	Oct 30, 2013	Oct 30, 2014	Oct 30, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the percentage of children receiving trauma informed services who report positive functioning at 6 month follow-up (Lead Agency - SAMHSA; Measure ID - 3.2.02a)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	N/A	N/A	N/A	76.1[21]	76.1
Result	67.4	79.0	73.5	76.1	Dec 31, 2013	Dec 31, 2014
Status	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending	Pending

Analysis of Results

Strengthening the quality of early childhood education programs can provide a stronger foundation for each child's future. Because improving Head Start and the Child Care Development Fund will help achieve a more solid foundation for each child, ACF has made this endeavor a Priority Goal by committing to improve the quality of early childhood programs for low-income children through implementation of the Quality Rating and Improvement Systems (QRIS) in the Child Care and Development Fund, and through implementation of the Classroom Assessment Scoring System (CLASS: Pre-K) in the Head Start program. For the ACF Child Care program, the goal is to increase the number of states with a QRIS that meets the seven high quality benchmarks for child care and other early childhood programs developed by HHS, in coordination with the Department of Education. ACF has provided ongoing training and technical assistance to at least 30 states/territories on QRIS implementation; as of FY 2012, a total of 19 states had a QRIS that met high quality benchmarks. Currently, many states meet some, but not all seven, of the outlined benchmarks. The ACF Office of Head Start completed a comprehensive data collection effort and analysis of a full program year of CLASS: Pre-K data as part of an ongoing effort to improve training and assistance, and thus enhance children's school readiness. In support of this effort, ACF is measuring the proportion of Head Start

[21] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

grantees that score in the low range on any of the three domains of the CLASS: Pre-K. In FY 2012 ACF's baseline indicated 25 percent of its grantees scored in the low range.

ACF is also committed to establishing permanency for some of our most vulnerable citizens—children who are in foster care and runaways. ACF has a suite of performance measures focused on ensuring positive permanent living situations for children in foster care, while ensuring children are placed in safe living arrangements. Since trauma can be aggravated further when a child is moved from one placement setting to another, ACF strives to have no more than two placement settings during the first 12 months of foster care. In FY 2011, ACF again exceeded its 80 percent target with 84.6 percent of children experiencing no more than two placement settings during their first year in care. Similarly, establishing permanency for children who are in foster care is a priority for ACF since children who remain in care for longer periods of time are less likely to exit to permanency and experience the benefits of stable living arrangements. Both measures 7P1 and 7P2 show positive trends. Measure 7P1 showed an increase in the percentage of foster children who stayed in care less than 24 months and who exited to permanency from 91.3 percent rate in FY 2009 to 91.7 percent in FY 2011. Meanwhile, measure 7P2 showed an increase in the percent of foster children staying longer than 24 months and who exited to permanency with a rate that started at 72.4 percent in FY 2009 and improved to 72.8% by FY 2011.

Through individuals, families, schools and other organizations, SAMHSA is promoting emotional health and reducing mental illness and substance abuse in children and adolescents. Between FY 2007 to FY 2009 there were decreases in the number of middle and high school students reporting current substance abuse. In FY 2010, the reported rate of substance abuse increased to 24 percent. However, results for FY 2012 were promising with SAMHSA exceeding its target by achieving a rate of 19.1 percent. SAMHSA's National Child Traumatic Stress Initiative (NCTSI) added 77 new grants in FY 2012 which will expand access for children and adolescents to trauma informed services. The program has also shown clinically significant improvements of more than 8 percent since FY 2009 by measuring the percentage of children receiving trauma informed services who report positive functioning at 6 month follow-up. This Initiative is a critical outlet to develop, test, and implement evidence-based practices in trauma-related care for children.

The over usage of antibiotics can have a profound effect on children and their future, as more drug-resistant strains of infection develop. Ear infections (acute otitis media) are the most common reason children under age five receive antibiotics. Antibiotic prescription rates for ear infections in children under five years of age declined 2005-2007, but increased from 2008-2009. Although the rate improved in 2010, it remains high at 55.8 prescriptions per 100 children in this age group.

Plans for the Future

ACF will continue to have aggressive targets and improve results for laying a stronger foundation for each child's future through strengthening the quality of early childhood education programs, despite the challenging economic environment. Throughout FY 2013, the ACF Office of Head Start will provide training and technical assistance to grantees based on CLASS: Pre-K scores, as well as conducting inter-rater reliability checks to ensure reliability of CLASS: Pre-K assessments. In a similar vein, to further improve the quality of early childhood education programs for low-income children, the QRIS benchmarks will continue to be evaluated based on experience and feedback. For children in care, ACF will provide technical assistance to states to improve placement stability, while states employ a number of strategies, such as increasing the use of relatives as placement resources and improving training and support for foster parents to improve retention and prevent placement disruptions. For older youth in care (age 16-21), ACF will continue to employ a number of strategies through its Transitional Living

Program, to include staying connected with youth as they transition out of program residencies, while maintaining more updated youth records to reduce the number of youth whose exit situations are unknown.

The CDC will further enhance national, regional, state, and local surveillance capacity to better characterize both the incidence of specific infections and the use of antibiotics in children under five years of age. It will continue to target physician prescribing behavior through appropriate antibiotic-use messages as well as identify ways for physicians to incorporate messages, reminders, and education into the clinical workflow. CDC will also continue to current technology (social media, television ads, YouTube) to educate the general public about when it is appropriate to request antibiotics from their (or their children's) provider. SAMHSA, in turn, will take a number of steps to improve its approach to violence and trauma that develop, test, and utilize evidence-based practices in trauma-related care for children.

Goal 3. Objective B: Promote economic and social well-being for individuals, families, and communities

Strong individuals, families, and communities are the building blocks for a strong America. Many vulnerable Americans live in poverty, lack the skills needed to obtain good jobs, need supportive services to get or retain jobs, experience unstable family situations, or live in unsafe, unhealthy communities. Community disorganization and poverty can reduce the social capital of residents and can lead to a lack of accountability of, and trust in, public institutions like those dedicated to public safety and education. Lack of employment opportunities and low levels of academic achievement can lead to juvenile delinquency, substance abuse, and criminal activity that are major drivers of community violence and family disruption.

Promoting economic and social well-being requires attention to a complex set of factors, through the collaborative efforts of agencies, policymakers, researchers, community members and providers. HHS agencies work together and collaborate across departments to maximize the potential benefits of various programs, services, and policies designed to improve the well-being of individuals, families, and communities. Many HHS agencies fund essential human services for those who are least able to help themselves, typically through the Department's state, local, and tribal partners.

ACF is the principal agency responsible for promoting the economic and social well-being of families, children, and youth through income support, financial education and asset-based strategies, job training and work activities, child support and paternity establishment, and assistance for the provision of child care. State Temporary Assistance for Needy Families (TANF) and Child Support Enforcement programs provide critical income assistance to some of the Nation's poorest families, while helping mothers and fathers prepare for and secure employment. ACL, IHS, SAMHSA and HRSA also provide essential supportive services to highly vulnerable individuals and families.

HHS and the U.S. Department of Labor are developing strategies to integrate and enhance skills development opportunities to help low-income individuals enter and succeed in the workforce. HHS is collaborating with the U.S. Department of Agriculture to expand access to nutritional supports for low-income youth and families. Below are a sample of the performance measures that are used by HHS to promote economic and social well-being for individuals, families, and communities.

Objective 3.B Table of Related Performance Measures

Increase the recipiency targeting index score for Low Income Home Energy Assistance Program (LIHEAP) households having at least one member five years or younger. (Lead Agency - ACF; Measure ID - 1.1LT and 1B)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	122	110[22]	110	123	Prior Result +2%	Prior Result +0%[23]
Result	114[24]	118[25]	121	Nov 30, 2013	Nov 30, 2014	Nov 30, 2015
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the recipiency targeting index score for Low Income Home Energy Assistance Program (LIHEAP) households having at least one member 60 years or older. (Lead Agency - ACF; Measure ID - 1.1LT and 1A)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	96	78	75	80	Prior Result +2%	Prior Result +0[26]
Result	76[27]	74[28]	78	Nov 30, 2013	Nov 30, 2014	Nov 30, 2015
Status	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending	Pending

Maintain the IV-D (child support) collection rate for current support. (Lead Agency - ACF; Measure ID - 20C)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	62%	62%	61%	62%	62%	62%
Result	62%	62%	62%	Nov 30, 2013	Nov 30, 2014	Nov 30, 2015
Status	Target Met	Target Met	Target Exceeded	Pending	Pending	Pending

[22] Adjustments to the performance target index scores were made in order to reflect the trend in actual index scores over recent years for low income elderly and young child households.

[23] The FY 2014 target is to maintain the prior year result.

[24] The FY 2009 actual result for this measure excludes nonuniform data from three states. The FY 2009 actual result for this measure was updated as a result of further editing of the state data for the LIHEAP Report to Congress for FY 2009.

[25] The FY 2010 actual result for this measure has been updated based on further data editing and review.

[26] The FY 2014 target is to maintain the prior year result.

[27] The FY 2009 actual result for this measure excludes nonuniform data from one state.

[28] The FY 2010 actual result for this measure has been updated based on further data editing and review. (Previously reported as 73.)

Increase the percentage of adult TANF recipients who become newly employed. (Lead Agency - ACF; Measure ID - 22.2LT and 22B)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	38%	38.4%	27.5%[29]	30.4%	Prior Result +0.3PP	Prior Result +0.1PP[30]
Result	27.5%[31]	29%[32]	30.1%	Oct 31, 2013	Oct 30, 2014	Oct 31, 2015
Status	Target Not Met	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

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

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	80.5%	67.88%	68.79%	71.75%	70.84%	Prior Result +1%
Result	67.21%	68.11%	71.04%	70.14%	Nov 30, 2013	Nov 30, 2014
Status	Target Not Met	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

Increase the percentage of refugees entering employment through ACF-funded refugee employment services. (Lead Agency - ACF; Measure ID - 18.1LT and 18A)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	49.98%	40.87%	42.97%	51.02%	52.5%[33]	54%[34]
Result	40.07%	42.13%	50.02%	Dec 31, 2013	Dec 30, 2014	Dec 31, 2015
Status	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the percentage of Family Violence Prevention and Services Act (FVPSA) state subgrant-funded domestic violence program clients who report improved knowledge of safety planning. (Lead Agency - ACF; Measure ID - 14D)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	Set Baseline	89.4 %	89.7 %	90 %[35]	90 %
Result	89.1 %	89.3 %	90.7 %	May 30, 2013	May 30, 2014	May 30, 2015
Status	Historical Actual	Baseline	Target Exceeded	Pending	Pending	Pending

[29] This target has been updated as a result of a technical correction made to the previous year's actual result, which was used in the target calculation.

[30] The FY 2014 target for this performance measure has been updated given the most recent trend data.

[31] The FY 2009 actual result for this performance measure has been updated based on a technical correction.

[32] The FY 2010 actual result for this performance measure has been updated due to a technical correction

[33] The FY 2013 performance target for this measure has been revised to maintain rigor and better align with the most recent trend data.

[34] The FY 2014 target for this measure has been revised to maintain rigor and better align with the most recent data trend.

[35] Due to a larger increase in the actual performance number in FY 2011, the performance target for FY 2013 was increased.

Increase the likelihood that the most vulnerable people receiving OAA 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 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	56	61	61	62	63	62
Result	61	60.53	62.79	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending	Pending

Increase the number of caregivers served. (Lead Agency - ACL; Measure ID - 3.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	731,545	560,000	790,000	792,000	796,000	790,000
Result	855,000	761,000	819,598	Oct 31, 2013	Oct 31, 2014	Oct 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Analysis of Results

HHS implements a number of programs to promote economic and social well-being. ACF annually calculates Low Income Home Energy Assistance Program (LIHEAP) recipiency targeting index scores at the national level. Of particular focus for success in this program are those households with vulnerable populations, such as young children and the elderly. The targeting index scores are ratios that compare the percent of LIHEAP heating recipiency households that are members of the target group (households with at least one young child or at least one elderly member) to the percent of all LIHEAP income-eligible households that are members of the target group. LIHEAP targeting to low income households with young children continued on an upward trend, registering an index score of 121 in FY 2011. LIHEAP targeting to low income households with seniors logged an index score for FY 2011 of 78. This index score exceeded the target for FY 2011 (75), representing a statistically significant increase of over two percent from the recipiency targeting index score for FY 2010.

The collection rate for current child support is an important proxy for the regular and timely payment of support. This measure compares total dollars collected for current support in IV-D cases with total dollars owed for current support in IV-D cases. This yielded a collection rate for current support of 62 percent, which exceeded the target of 61 percent for FY 2011. The Child Support Program strives to improve the current support collection rate by working with parents to ensure that they have the tools and resources they need to provide for their children, focusing on new and improved enforcement techniques, and preventing and addressing accumulated child support debt.

The Temporary Assistance for Needy Families measure assesses the extent to which recipients move from welfare to work. 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. ACF performance measure 22D addresses the rate of job entry for TANF recipients. In FY 2011, 30.1 percent of TANF adult recipients became newly employed, exceeding the FY 2011 target of 27.5 percent.

Economic self-sufficiency means earning a total family income at a level that enables a family to support itself without receipt of a cash assistance grant. ACF tracks the percentage of Matching Grant program refugees not reliant on cash assistance within the first six months (180 days) of arrival in the U.S. In FY

2012, the result was just over 70 percent, falling short of the FY 2012 target of 71.75 percent, a consequence of increased competition for jobs in a still recovering job market, particularly for those newly arriving refugees with low levels of English and limited work experience. Crucial to building economic self-sufficiency is gaining stable employment. ACF also measures the percentage of refugees entering employment through ACF grant-funded refugee employment services. In FY 2011, this measure exceeded the target of 42.97 percent with a result of 50.02 percent.

ACF programs provided technical assistance to grantees related to developing mechanisms for collecting outcome data directly from domestic violence survivors. One measure of performance is the percentage of domestic violence program clients who report improved knowledge of safety planning as a result of work by Family Violence and Prevention Services Act grantees and subgrantees. In FY 2012, ACF did not meet its target of 71.75 percent, falling a little more than 1 percent short after meeting the targets during the two prior years.

Health and community based services and caregiver support services are crucial to enabling frail elderly clients to delay or defer nursing home placement. ACL tracks performance using a "nursing home predictor" index which measures the prevalence of select characteristics of the service population that research has shown to be predictive of nursing home placement. An increase in the nursing home predictor index means an increase in the prevalence of characteristics that are associated with nursing home placement. This is a strong proxy for nursing home diversion. To construct this score, characteristics predictive of nursing home placement are:

1) Percentage of caregivers reporting services helped them provide care longer,
2) Percentage of transportation clients who are transportation disadvantaged,
3) Percentage of congregate meal recipients who live alone, and
4) Percentage of home-delivered meal recipients with 3 or more limitations of activities of daily living.

In FY 2011, the results exceeded its target with a resulting score of 62.79. The related information about increasing the number of caregivers served shows that ACL continues to assist family and informal caregivers in caring for their loved ones at home for as long as possible. Increasing the number of caregivers served is a critical component of ACL's efforts to prolong the ability of vulnerable elderly persons to live in their homes. In FY 2011, nearly 820,000 caregivers received services, exceeding the performance target.

Plans for the Future

ACF plans to increase the recipiency index score for the Low Income Home Energy Assistance program in FY 2012 and FY 2013 for households with young children or the elderly by two percent over the previous year's actual performance. The target for FY 2014 is to maintain targeting performance at the FY 2013 level.

ACF also plans to maintain the current child support percent collection rate target for FY 2013 and FY 2014 to 62 percent in anticipation of modest improvements in economic conditions in the near term.

Future targets related to Temporary Assistance for Needy Families include increasing the percentage of newly employed recipients to 30.4 percent in FY 2012 and subsequently increasing the rate in FY 2013 by 0.3 percentage points and FY 2014 by 0.1 percentage points above the prior year result.

In the area of refugee self-sufficiency, ACF seeks to make progress despite a challenging job market and refugees who significant cultural and language barriers. By FY 2014, the goal is to improve by at least 1 percent over the prior year's actual result for measures of cash assistance dependency and employment.

By FY 2013, ACF aims to meet the target of 89.8 percent of domestic violence program clients reporting improved knowledge of safety planning. ACF will coordinate with ACF-funded National Resource Centers and state Domestic Violence Coalitions to provide ongoing technical assistance in order to achieve new performance targets.

ACL believes that OAA Home and Community-based and Caregiver Support Services measure will continue to remain relatively stable over the next few years. ACL will strive to maintain the improvements that have been realized over the past few years of serving a growing population of frail homebound seniors.

Goal 3. Objective C: Improve the accessibility and quality of supportive services for people with disabilities and older adults

HHS is committed to strategies that streamline access to a full complement of integrated services across the lifespan of elderly and persons with disabilities. Over the past decade, a number of policy reforms and initiatives have improved the effectiveness of efforts to promote home and community-based services and to decrease unnecessary reliance on institutional care. The Supreme Court's landmark 1999 Olmstead ruling requires states to place qualified individuals with disabilities in community settings whenever such placements are appropriate. ACL provides a number of services to older adults including those with disabilities; services include, for example, transportation, personal care, meals, supportive services for family caregivers and senior rights protective services. Through grants, technical assistance, and information-sharing, the Administration on Intellectual and Developmental Disabilities (AIDD) within ACL works with a network of state Developmental Disabilities Councils, state Protection and Advocacy Systems, National University Centers on Excellence in Developmental Disabilities, and Projects of National Significance to ensure that individuals with developmental disabilities and their families have access to culturally competent services and supports that promote independence, productivity, integration, and inclusion in the community. SAMHSA has been working with homeless clients who have mental health and/or substance abuse problems to overcome these conditions and improve their living situation.

Among the agencies and offices contributing to the achievement of this objective are ACF, AHRQ, ACL, CMS, HRSA, IHS, OCR, and SAMHSA. The following performance measures exemplify how HHS is improving the quality and accessibility of supportive services for seniors and people with disabilities.

Objective 3.C Table of Related Performance Measures

Reduce the percent of caregivers who report difficulty in getting services. (Lead Agency - ACL; Measure ID - 2.6)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	35%	30%	30%	28%	28%	28%
Result	30%	29%	30%	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Met	Pending	Pending	Pending

90% of Family Caregiver Support Services clients rate services good to excellent. (Lead Agency - ACL; Measure ID - 2.9c)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	90%	90%	90%	90%	90%	90%
Result	95.3%	94%	96%	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

90% of transportation clients rate services good to excellent. (Lead Agency - ACL; Measure ID - 2.9b)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	90%	90%	90%	90%	90%	90%
Result	96.6%	98%	97%	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

90% of home delivered meal clients rate services good to excellent. (Lead Agency - ACL; Measure ID - 2.9a)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	90%	90%	90%	90%	90%	90%
Result	91.1%	90.08%	90%	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Met	Pending	Pending	Pending

Increase the number of older persons with severe disabilities who receive home-delivered meals. (Lead Agency - ACL; Measure ID - 3.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	378,613	325,000	297,000	311,000	320,000	320,000
Result	342,084	348,669	358,376	Oct 31, 2013	Oct 31, 2014	Oct 31, 2015
Status	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the number of PATH providers trained on SSI/SSDI Outreach, Access, Recovery (SOAR) to ensure eligible homeless clients are receiving benefits. (Lead Agency - SAMHSA; Measure ID - 3.4.20)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	4,927	4,927	5,420	5,420	5,420[36]	4,591[37]
Result	5,104	5,163[38]	4,459	4,781	Dec 31, 2013	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met but Improved	Pending	Pending

[36] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

[37] Target has been revised from previously reported.

[38] This result has been updated from previously reported due to an error that caused a cumulative number to be reported which was incorrect.

Increase percentage of complaints of alleged abuse, neglect, and rights violations substantiated and not withdrawn by the client that resulted in positive change through the restoration of client rights, expansion or maintenance of personal decision-making, elimination of other barriers to personal decision-making, as a result of PAIMI involvement (Lead Agency - SAMHSA; Measure ID - 3.4.21)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	87.0 %	87.0 %	87.0 %	87.0 %[39]	87.0 %
Result	88.0 %	90.0 %	92.0 %	Jul 31, 2013	Jul 31, 2014	Jul 31, 2015
Status	Historical Actual	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Analysis of Results

HHS implements a number of programs to improve the accessibility and quality of supportive services for people with disabilities and older adults. The Family Caregiver Support Services program provides grants to states and territories to fund a range of supports that assist family and informal caregivers in caring for their loved ones at home for as long as possible. One of the basic components of the program is Access Assistance. ACL seeks to reduce the percent of caregivers who report difficulty in getting services, an important measure of the success of the Access Assistance Services. In the FY 2011 results, the latest reported, ACL met the performance target of 30 percent. Caregivers are frequently under substantial strain with the responsibilities of caring for their ill relative while also caring for children or other family members. A random sample of caregivers are surveyed and report on the quality and impact of service. According to most recent reported results, 96 percent of caregivers rated services good to excellent, exceeding the target of 90 percent.

ACL also funds transportation services for elderly individuals who have mobility challenges including those who are no longer able to drive their own car or who do not have access to public transportation. More than 71 percent of senior transportation users indicated that they use this transportation services to get to their doctor or medical appointments; nearly 50 percent of senior transportation users say that they use the transportation service for the majority of their trips in a month. The transportation service is key to enabling seniors to remain not only in their own home, but to be able to get out, go to appointments so they can remain healthy and connected to their community. For FY 2011, 97 percent of transportation users rate services good to excellent as compared to a target of 90 percent.

Additionally, ACL funds home delivered meals for elderly individuals who are too ill or too frail to be able to prepare their own meals. Obtaining adequate nutrition is important to recovery from recent illness or hospitalization, is important in managing chronic conditions including diabetes and heart disease, and enables individuals to remain at home and live independently in the community. For FY 2011, 90 percent of clients reported the quality of their service was good to excellent. Another measure of performance associated with this program is the increase in the number of older persons with severe disabilities who receive home-delivered meals. For FY 2011, the target of 297,000 individuals was exceeded substantially with more than 350,000 frail seniors served.

HHS provides support to the homeless through a number of avenues to assist their transition into more secure situations. PATH providers are trained on Supplemental Security Income/Social Security Disability

[39] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

Insurance Outreach, Access, and Recovery (SOAR) in a federally-funded technical assistance program designed to improve access to Social Security Income and Social Security Disability Insurance for people who are homeless with disabling conditions. Once trained, PATH providers are better able to assist clients in applying for and receiving the income benefits for which they are eligible. In FY 2012, the result fell short of the target, but showed improvement over the previous year.

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) program addresses abuse, neglect, and exploitation of individuals in state psychiatric institutions as well as related challenges in the delivery of mental health services in community-based settings. SAMHSA measures the percentage of complaints of alleged abuse, neglect, and rights violations not withdrawn by the client that resulted in positive change for the client in the safety or welfare of their environment, as a result of PAIMI involvement. In FY 2011 the result increased to 92 percent, which exceeded the target of 87 percent.

Plans for the Future

HHS will continue its efforts to enhance support services for people with disabilities and older adults. Based on performance improvements, ACL plans to reduce the percentage of caregivers who report difficulty getting services to 28 percent caregivers for FY 2012- FY 2014. Program performance has reduced caregivers reporting difficulty to such a low level that further reductions are expected to be more modest. ACL plans to maintain the current high quality of performance for the measures of client satisfaction with Family Caregiver Support Services, transportation, and home delivered meals at current levels for FY 2012 – 2014. The challenge of increasing the number of older persons with severe disabilities is compounded by the uncertain budget climate. In FY 2013 ACL plans are in place to continue to increase services gradually to the number of older persons with severe disabilities but because of expected reductions in funding by FY 2014 the number of severely disabled seniors served is expected to decline.

SAMHSA plans to maintain its targets for the number of PATH providers trained in the SOAR process at about the 2012 level of service.

Goal 3. Objective D: Promote prevention and wellness

HHS is focusing on creating environments that promote healthy behaviors to prevent chronic diseases and health conditions including tobacco use, being overweight or obese, and mental and substance use disorders. These conditions result in the most deaths, disability, and substantial human and fiscal costs for Americans. HHS works to promote prevention and wellness across its programs, with CDC identified as the Nation's principal prevention agency. CDC's goals for chronic disease prevention and health promotion include reducing the onset of chronic health conditions; improving health equity; accelerating the translation of scientific finding into community practice; and promoting social, environmental, and systems approaches that support healthy living.

Across HHS agencies including ACL, CDC, FDA, HRSA, IHS, and SAMHSA contribute to these efforts. For example, FDA has committed to increasing compliance with tobacco products regulations. SAMHSA is working to reduce underage drinking, while IHS is striving to reduce heart disease among American Indian and Alaska Native patients.

Objective 3.D Table of Related Performance Measures

Reduce annual adult's cigarette consumption in the United States (per capita) (Lead Agency - OASH; Measure ID - 1.4)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	Set Baseline	1,232.0 per capita	1,150.0 per capita	1,062.0 per capita	
Result	1,367.0 per capita	1,281.0 per capita	1,232.0 per capita	Jun 30, 2013	Jun 30, 2014	
Status	Target Not In Place	Baseline	Target Met	Pending	Pending	

Reduce the proportion of adults (aged 18 and over) who are current cigarette smokers. (Lead Agency - CDC; Measure ID - 4.6.3)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	N/A	20.5%	20%	19%	18%
Result	20.6%	19.3%[40]	19%	Jun 30, 2013	Jun 30, 2014	Jun 30, 2015
Status	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending	Pending

[40] FY 2010 historical data was incorrectly reported as 19.4 percent in the FY 2013 President Budget and has been updated to reflect the correct result of 19.3 percent.

Reduce the proportion of adolescents (grade 9 through 12) who are current cigarette smokers. (Lead Agency - CDC; Measure ID - 4.6.5)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A		18.9%	18.6%	18.2%	17.9%
Result	19.5%		18.1%[41]	Jun 30, 2013	Jun 30, 2014	Jun 30, 2015
Status	Historical Actual		Target Exceeded	Pending	Pending	Pending

The total number of tobacco compliance check inspections of retail establishments in states under contract. (Lead Agency - FDA; Measure ID - 280005)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			N/A	84,000	75,000	80,000
Result			24,419	87,455	Jan 31, 2013	Jan 31, 2014
Status			Historical Actual	Target Exceeded	Pending	Pending

Increase the percentage of adults receiving homeless support services who report positive functioning at 6 month follow-up (Lead Agency - SAMHSA; Measure ID - 3.4.02)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	53.3 %	66.0 %	62.3 %	67.4 %	63.1 %[42]	63.1 %
Result	66.0 %[43]	62.3 %[44]	67.4 %[45]	66.7 %	Dec 31, 2013	Dec 31, 2014
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Not Met	Pending	Pending

Increase the number of calls answered by the suicide hotline (Lead Agency - SAMHSA; Measure ID - 2.3.61)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	538,963	555,132	555,132	555,132	555,132[46]	765,638[47]
Result	619,813	664,932	765,638	884,536	Dec 31, 2013	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

[41] The primary data source for setting and reporting targets is the Youth Risk Behavior Surveillance System (YRBSS), which monitors priority health–risk behaviors and is conducted every other year (odd years). Beginning in FY 2011, the National Youth Tobacco Survey (NYTS) was added as an additional data source, which tracks closely with YRBSS. To obtain data on an annual basis, CDC will conduct the NYTS in the intervening years.

[42] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

[43] Previously reported as 54.8%. Correction to running data report which now accounts for all follow–up interviews.

[44] Previously reported as 63.9%. Correction to running data report which now accounts for all follow–up interviews.

[45] Previously reported as 63.1%. Correction to running data report which now accounts for all follow–up interviews.

[46] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

[47] Target adjusted to reflect 2011 actual.

Decrease underage drinking as measured by an increase in the percent of SPF SIG states that show a decrease in 30-day use of alcohol for individuals 12 - 20 years old (Lead Agency - SAMHSA; Measure ID - 2.3.21)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	50.4 %	50.4 %	50.4 %[48]	55.9 %	50.0 %[49]	50.0 %
Result	68.1 %[50]	58.0 %[51]	85.0 %[52]	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Reduce motor vehicle deaths per 100 million vehicle miles traveled (Lead Agency - CDC; Measure ID - 7.2.4)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Set Baseline	1.09	1.06	1.03	1	0.97
Result	1.13	1.11	1.1	Oct 31, 2013	Oct 31, 2014	Oct 31, 2015
Status	Baseline	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

American Indian and Alaska Native patients, 22 and older, with Coronary Heart Disease are assessed for five cardiovascular disease (CVD) risk factors. (Lead Agency - IHS; Measure ID - 30)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		N/A	N/A	N/A	32.3%	36.6%
Result		29%	32.8%	37.5%	Oct 31, 2013	Oct 31, 2014
Status		Historical Actual	Historical Actual	Historical Actual	Pending	Pending

Increase the number of adult volunteer potential donors of blood stem cells from minority race or ethnic groups. (Lead Agency - HRSA; Measure ID - 24.II.A.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	2.06 Million	2.35 Million	2.48 Million	2.66 Million	2.85 Million	3.05 Million
Result	2.22 Million	2.46 Million	2.67 Million	2.88 Million	Dec 31, 2013	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

[48] Includes Cohorts 3 & 4. Cohort 4 began the SPF process in July 2009.

[49] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

[50] Due to NSDUH State Estimate corrections, the actual has been revised from previously reported.

[51] Due to NSDUH State Estimate corrections, the actual has been revised from previously reported.

[52] Based on pooled 2009/2010– 2010/2011 NSDUH state estimates

Analysis of Results

Smoking, and second hand smoke, kills an estimated 443,000 people in the U.S. each year. For every smoker who dies from a smoking-attributable disease, another 20 live with a serious smoking-related disease. As a result, smoking costs the U.S. $96 billion in medical costs and $97 billion in lost productivity each year. For these reasons, HHS is leading the way to reduce tobacco consumption through the Tobacco Control Implementation Committee co-chaired by OASH, CDC, FDA, and NIH, with participation from the HHS agencies integral to tobacco control (CMS, SAMHSA, HRSA, and IHS). This committee, which also serves as the Priority Goal team, has taken a comprehensive, broad-based approach to reducing tobacco use that involves preventing people from initiating smoking, eliminating exposure to secondhand smoke, promoting quitting, and identifying and eliminating disparities in tobacco use among population groups. HHS's Priority Goal on per capita cigarette consumption has so far been making steady progress towards achieving its FY 2013 target of a 17.1 percent decrease from the 2010 baseline (1,281 cigarettes per capita) to 1,062 cigarettes per capita. Success in these efforts is evident as the 2011 target of 1,232 cigarettes per capita was reached exactly. Final FY 2012 results will not be available until June 2013. To stay on course in FY 2012, the CDC awarded $20 million for states to handle expected increases in call volume to the quit-line—1-800-QUITNOW. NIH is also supporting the expected increase in utilization of 1-800-QUITNOW. The launch of CDC's Tips from Former Smokers campaign in March 2012 has generated 207,519 additional calls (a 132 percent increase) to 1-800-QUIT NOW compared to corresponding weeks in 2011, achieving a total of more than 365,000 calls to the Quitlines between March and June 2012. In September 2012, the Assistant Secretary for Health launched the Tobacco-free College Campus Initiative at an event at the University of Michigan, Ann Arbor.

Although the Priority Goal team is confident it can achieve the 2013 goal of reducing adult per capita cigarette consumption by 17.1 percent, serious obstacles do exist. Delays in several FDA milestones, including limitations on FDA's recommended labeling of cigarettes, and education campaigns may make it more difficult to achieve the goal and put more emphasis on the success of other milestones, such as CDC's media campaign. Even so, the supporting measure that tracks smoking cessation (percentage of adult smokers aged 18 years and older who last smoked 6 months to 1 year ago) has been trending up slightly since 2008 and will likely hit the 2012 target of 6.8 percent. The CDC media campaign and investments in state quit-lines are expected to further increase smoking cessation. In addition, there has been steady progress reducing the proportion of smokers among youth (12-17) and young adults (18-25).

The National Center for Health Statistics (CDC) reported in 2009 there were 36,891 suicides, ranking as the 10th leading cause of underage death nationally. To address this serious problem, SAMHSA supports the suicide prevention hotline, which increased the number of calls answered between 2011 and 2012 by 118,898—nearly a 16 percent improvement.

A potential contributor to suicide risk is underage alcohol consumption. SAMHSA and the CDC worked to sustain the ongoing decline in underage drinking. Another consequence of underage drinking is alcohol-related car crashes and other unintentional injuries. HHS promotes the proven traffic safety interventions, such as ignition interlocks for prevention of impaired driving and Graduated Drivers Licensing programs for new teen drivers. In line with these strategies, underage drinking declined by more than 27 percent in FY 2012, as measured by an increase in the percent of SPF SIG states that show a decrease in 30-day use of alcohol for individuals 12-20 years old. More good news is that traffic fatalities have been declining for several years now. Between 2007 and 2008, the rate of traffic fatalities per 100 million vehicle miles traveled declined by more than 7 percent (from 1.36 to 1.26). This same

rate decreased by more than 10 percent between 2008 and 2009 (from 1.26. to 1.13) and by almost 2 additional percent between 2009 and 2011 (from 1.13 to 1.11).

As part of HHS's broad approach to reducing health disparities for minorities, including prevention and wellness, HRSA has committed to increase the number of adult volunteer potential donors of minority race and ethnicity. Increasing minority race/ethnicity donors will enable comparable access for minority patients to receive unrelated donor transplants. IHS has instituted a number of preventive approaches that include increased screenings focusing on reducing cardiovascular disease in the American Indian/Alaska Native population.

Plans for the Future

Because the tobacco industry spends about $8.05 billion each year, or $22 million every day, on cigarette advertising and promotion, mass marketing is a key challenge to achieving the Priority Goal of reducing cigarette consumption. Nevertheless, the CDC and FDA will continue to develop their evidence-based public education campaigns and first-ever government interventions for paid advertising against tobacco use. In this area, one important FDA strategy (requiring all cigarette packs to carry graphic warning labels that include 1-800 QUIT NOW) has been delayed due to litigation. The Administration is vigorously defending FDA's authority and is confident that the industry's efforts to stop these important warnings from going forward will ultimately fail. Regardless of the outcome, in FY 2013 the FDA will launch an education campaign to inform the public about regulation and the danger of tobacco use, while conducting over 40,000 tobacco compliance check inspections of retail establishments by the 2nd Quarter. Also in FY 2013, the CDC will launch phase II of its national media campaign, and the NIH Smokefree.gov Project team will promote Mobile Health (mHealth) tools, such as smart phone apps, among women, teens, military personnel, and other groups.

Goal 3. Objective E: Reduce the occurrence of infectious disease

Infectious diseases continue to be a significant health threat in the U.S. and around the world because of increased and rapid global travel, increased importation of foods, and increased resistance to available drugs. Infectious diseases include vaccine-preventable diseases, foodborne illnesses; HIV and AIDS; and tuberculosis. They also include infections acquired in healthcare settings and infections transmitted by animals and insects.

HHS coordinates and encourages collaboration among the many Federal agencies involved in vaccine and immunization activities. CDC has primary responsibility for reducing the occurrence and spread of infectious diseases in the U.S. population. CDC provides significant support to state and local governments; strengthens infectious disease surveillance, diagnosis, and treatment; and collaborates with Federal and international partners to reduce the burden of infectious diseases throughout the world. FDA and CDC work together to prevent and control foodborne illness outbreaks, and FDA works with international drug regulatory authorities to expedite the review of drugs used to combat infectious diseases.

Infectious diseases exact a significant toll on human life. The prevention and reduction of infectious diseases is a priority for HHS which is being achieved though the coordinated efforts of AHRQ, CDC, CMS, OASH, and other HHS experts.

Within HHS, components such as CDC, FDA, and NIH have primary responsibility for reducing the occurrence of infectious diseases. Other HHS components and offices that contribute to efforts to combat infectious diseases include HRSA, IHS, OASH, and SAMHSA. HHS will use a variety of approaches to reduce the occurrence of infectious diseases.

Objective 3.E Table of Related Performance Measures

Reducing foodborne illness in the population. By December 31, 2013, decrease the rate of Salmonella Enteritidis (SE) illness in the population from 2.6 cases per 100,000 (2007-2009 baseline) to 2.1 cases per 100,000. (Lead Agency - FDA; Measure ID - 212409)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	N/A	2.3 cases/100,000	2.2 cases/100,000	2.1 cases/100,000[53]	2.0 cases/100,000
Result	2.6 cases/100,000	3.5 cases/100,000	3.0 cases/100,000	Jul 31, 2013	Jul 31, 2014	Jul 31, 2015
Status	Historical Actual	Historical Actual	Target Not Met but Improved	Pending	Pending	Pending

[53] CDC's FoodNet system reports pathogen–specific illness data based on the calendar year, not the fiscal year. Therefore, achievement of the annual targets reported here is evaluated based on the calendar year data, not fiscal year data.

American Indian and Alaska Native patients, aged 19-35 months, receive childhood immunizations. (Lead Agency - IHS; Measure ID - 24)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	78%	80%	74.6%	77.8%	Set Baseline	TBD
Result	79%	79%[54]	75.9%[55]	76.8%	Oct 31, 2013[56]	N/A
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Not Met but Improved	Pending	Target Not In Place

Decrease the rate of cases of tuberculosis among U.S.-born persons (per 100,000 population). (Lead Agency - CDC; Measure ID - 2.8.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	1.8	1.9	1.8	1.7	1.7	1.5
Result	1.7	1.6	1.5	Sep 30, 2013	Sep 30, 2014	N/A
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Not Collected

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 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			N/A	Set Baseline	47 %	50 %
Result			40.5 %	38.8 %	Sep 30, 2014	Sep 30, 2015
Status			Historical Actual	Baseline	Pending	Pending

Reduce the incidence (per 100,000 population) of healthcare associated invasive Methicillin-resistant Staphylococcus aureus (MRSA) infections (Lead Agency - CDC; Measure ID - 3.3.2a)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	N/A	N/A	N/A	13.53	12.18
Result	23.75	21.76	20.06	Nov 30, 2013	Nov 30, 2014	Nov 30, 2015
Status	Historical Actual	Historical Actual	Historical Actual	Pending	Pending	Pending

[54] Varicella vaccination added to the series of childhood immunizations the agency reports on in FY 2010.

[55] Pneumococcal conjugate vaccine was added to the series of childhood immunizations the agency reports on in FY 2011.

[56] Beginnng in FY 2013 this measure will match the CDC Immunization Schedule and Healthy People 2020; therefore, results will differeniate the use of the 3 or 4 dose Hib vaccine for individual patients. CDC will identify the new measure as 4313*314 with the *3 representing the Hib vaccine. In previous years, CDC did not make a distinction between the 3 or 4 dose vaccine

Increase the percentage of children under five years old who slept under an insecticide treated bednet the previous night in PMI target countries. (Lead Agency - CDC; Measure ID - 10.C.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			85% (median) in 2006 countries	85% (median) in 2007 countries	85% (median) in 2008 countries	
Result			42.8%	Apr 30, 2013	Apr 30, 2014	
Status			Target Not Met	In Progress	In Progress	

Reduce the proportion of persons with an HIV diagnosis at later stages of disease within three months of diagnosis (Lead Agency - CDC; Measure ID - 2.1.8)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		Set Baseline[57]	27.4 %	26.3 %	24.9 %	22.9 %
Result		27.7 %	Jun 30, 2013	Jun 30, 2014	Jun 30, 2015	Jun 30, 2016
Status		Baseline	Pending	Pending	Pending	Pending

Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served. (Lead Agency - HRSA; Measure ID - 16.I.A.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data
Result	73% (CDC = 66.4%)	72% (CDC = 66.5%)	72.2% (CDC data not available for comparison yet.)	Oct 31, 2013	Oct 31, 2014	Oct 31, 2015
Status	Target Exceeded	Target Exceeded	In Progress	In Progress	In Progress	In Progress

Analysis of Results

Salmonella is the leading known cause of bacterial foodborne illness and death in the United States. Each year, food contaminated with Salmonella causes an estimated 1.3 million illnesses and between 400 and 500 deaths. Salmonella Enteritidis (SE), a subtype of Salmonella, is the second most common type of Salmonella and accounts for approximately 17 percent of all Salmonella cases in humans. The most significant sources of foodborne SE infections are shell eggs (FDA-regulated) and broiler chickens (USDA-regulated). To significantly reduce foodborne illness and death, the FDA and CDC have joined forces and made the reduction of SE infections attributable to shell eggs a Priority Goal for FY 2012.

Through the FDA's egg rule (which requires egg producers to implement controls to prevent SE infections) the FDA conducted inspections of all registered large egg producers during FY 2012. As of August, 43 percent of those firms who had been issued a warning letter had received re-inspections within 6 months of the warning letter's issuance. In all, 93 percent of those firms have now been re-inspected. More importantly, the actual rate of SE infections decreased to 3 cases per 100,000 in FY 2011, down from 3.5 in FY 2010. Although final data for FY 2012 is not available until the summer of FY 2013, preliminary indicators suggest the trend in SE infections continues to decrease.

[57] Per the HHS Secretary's memo (4/11/12) on implementing a common set of core indicators, to be implemented across federal agencies CDC has revised this indicator definition to conform with the cross–agency definition.

In other areas related to decreasing infectious diseases, IHS is measuring a combined series of immunizations consistent with the CDC's Advisory Committee on Immunization Practices standards and schedule that includes coverage for diphtheria, tetanus, whooping cough, polio, measles, mumps and rubella, Hepatitis B, influenza, chicken pox and pneumonia. In 2008, 78 percent of children served by IHS received the combined series. In FY 2012 this immunization rate still increased but did not meet its target due to the addition of four pneumococcal conjugate vaccines to the childhood immunization series.

Other conditions the CDC is actively addressing in a collaborative manner include tuberculosis (TB), HIV infection, MRSA, and influenza. Due to the effectiveness of TB prevention and control programs, the U.S. consistently has one of the lowest TB incidence rates in the world. In fact, effective control efforts by the CDC and its 68 state and local partners have led to the lowest number of overall U.S. TB cases since national reporting began in 1953. CDC monitors key aspects of TB control including completion of treatment within one year, timely laboratory reporting, and testing.

Influenza is another major public health problem in the United States and globally. In the United States, on average 5-20 percent of the population contracts the flu, more than 200,000 people are hospitalized, and approximately 36,000 people die from seasonal flu-related causes. In 2010, CDC's Advisory Committee on Immunization Practices (ACIP) recommended the seasonal influenza vaccine for everyone 6 months of age and older. In FY 2012 CDC revised its flu measure to reflect the CDC's priorities to meet the new standards of vaccinations for everyone 6 months and older. Baseline results for FY 2012 show nearly 39 percent of adults received a flu vaccination.

In alignment with HHS Action Plan to Prevent Healthcare Associated Infections, CDC has developed guidelines and plans to reduce infections associated with healthcare settings, including but not limited to invasive Methicillin-resistant Staphylococcus Aureayus (MRSA) infections. The national incidence of healthcare-associated invasive MRSA infections continued to decline from CY 2008 baseline, decreasing from 21.76 infections per 100,000 population in CY 2010 to 20.06 in CY 2011.

Meanwhile, through the President's Malaria Initiative (PMI), CDC procured more than 17 million long-lasting, insecticide-treated mosquito nets, protected more than 27 million residents by spraying their houses with residual insecticides, and procured more than 41 million artemisinin-based combination therapies in 2010. Scale-up of these interventions through PMI and other program efforts have already led to reductions in all case mortality in children less than five years of age by up to 50 percent in PMI countries surveyed. These efforts have contributed to saving more than 200,000 lives over the past ten years.

Regarding HIV, the CDC and HRSA are both striving to improve results. Previously, CDC tracked the percentage of people diagnosed with HIV infection at earlier stages of disease (not CDC stage 3: AIDS). Consequently, from 2007-2010, the percentage of people identified at earlier stages of disease steadily improved to almost 56 percent. Per the HHS Secretary's memo (April 2012) on implementing a common set of core indicators across federal agencies, CDC has revised this indicator definition to conform to a new cross–agency definition. Baseline results for this measure were calculated by the CDC and show 27.7 percent of individuals in 2010 were diagnosed at later stages of HIV infection. For its part, the HRSA exceeded its target of reducing healthcare disparities and focusing Ryan White HIV funded services on racial/ethnic minorities. In FY 2010, 72 percent of Ryan White program clients were racial/ethnic minorities, compared to 66.5 percent of CDC-reported AIDS cases, serving as an important indicator of access to treatment for populations disproportionately impacted by HIV/AIDS.

Plans for the Future

Because the current Priority Goal measure for reducing SE infections includes all SE infections, determining which SE infections are attributable to shell eggs (as opposed to broiler chickens) makes it difficult to determine whether the FDA's egg rule is having the desired effect of reducing the likelihood that SE contaminated shell eggs are the cause for a particular SE infection. To bridge this gap, the Interagency Food Safety Analytic Collaboration (IFSAC), made up of scientific experts from CDC, FDA, and USDA-Food Safety Inspection Services (FSIS), chose a method for attribution of SE illnesses to shell eggs, and another method to evaluate the variability in the range of estimates produced by different methods in the percentage of SE attributable to shell eggs. The first baseline estimate of egg-associated SE illness should be available by the 3rd Quarter of FY 2013. The FDA will have begun inspections of small producers, while continuing to refine its egg rule enforcement policies with straightforward inspection, re-inspection, and warning strategies.

The IHS, beginning in FY 2013, is changing its childhood immunizations measure to match the CDC Immunization Schedule and *Healthy People 2020*. CDC will continue to scale-up of effective interventions through the President's Malaria Initiative and work to address the procurement delays in national distribution systems that have historically challenged effective scale-up. To combat influenza in FY 2013, the CDC has set an ambitious target of increasing the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza to 47 percent—an 8 percent increase from the current level of 39 percent. For MRSA, CDC targeted an ambitious 32.6 percent decline in MRSA incidence for FY 2013. Going forward, the CDC will begin a new focus on monitoring the effectiveness of efforts to decrease the number of HIV infections diagnosed at later stages of disease. This is important because it leads to a better understanding of how many HIV+ persons are able to access life saving medical care and antiretroviral therapy, while simultaneously reducing the likelihood of HIV transmission to others. Meanwhile, HRSA plans to continue its focus on improving access to treatment for populations disproportionately impacted by HIV/AIDS.

Goal 3. Objective F: Protect Americans' health and safety during emergencies and foster resilience in response to emergencies

Over the past decade, our Nation has renewed its efforts to address large-scale incidents that have threatened human health, such as natural disasters, disease outbreaks, and terrorism. Working with its Federal, state, local, tribal, and international partners, as well as industry in public-private partnerships, HHS has improved and exercised response capabilities and developed plans for medical countermeasures.

Over the next few years, HHS will work with its Federal, state, local, tribal, and international partners to build community resilience and strengthen health and emergency response systems. In alignment with Presidential Policy Directive 8 (PPD-8)—the first-ever National Preparedness Goal — robust systems are essential to a secure and resilient Nation with required capabilities to prevent, protect against, mitigate, respond to, and recover from the threats and hazards that pose the greatest risk. This includes strengthening the Federal medical and public health response capability.

Within HHS, improving health security is a shared responsibility. The Assistant Secretary for Preparedness and Response (ASPR) serves as the Secretary's principal advisor on matters related to bioterrorism, public health emergencies, and also coordinates interagency activities between HHS, other Federal partners, state, local, and tribal officials responsible for emergency preparedness and protection of the civilian population. OASH leads the U.S. Public Health Service Commissioned Corps (Corps), which maintains a system of Corps Officer response teams that rapidly respond to emerging public health emergencies. Other components and offices supporting emergency preparedness include ACF, CDC, and FDA. The table below includes performance measures that are indicative of HHS activities to improve the health and safety of Americans during emergencies.

Objective 3.F Table of Related Performance Measures

Influenza vaccine production (Lead Agency - FDA; Measure ID – 234101

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Started a pilot program to develop and evaluate new methods to detect possible adverse effects, both pre-specified and non-pre-specified, of newly licensed vaccines, including pandemic influenza vaccines, in large population databases. Participated in at least one international workshop or conference.	Complete and evaluate the pilot vaccine adverse-effects program and participate in at least one international workshop or conference.	Apply novel technologies, including mass spectrometry, to quantify the absolute amount of hemagglutinin in the reference standards that are used to determine influenza vaccine potency.	Evaluate and compare new methods to determine the potency of influenza vaccines.	Develop and evaluate new methods to produce high-yield influenza vaccine reference strains	Continue evaluation of new methods to produce high-yield influenza vaccine reference strains

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Result	Nov 30, 2009	Nov 30, 2010	The studies were delayed in FY 2011 awaiting the delivery of required equipment. In FY 2011, CBER did complete preliminary studies to evaluate the use of mass spectrometry to determine the absolute amount of hemagglutinin in reference standards and define initial sample conditions. (Target not met but improved)	In FY 2012 CBER met the goal by evaluating three new methods for the determination of influenza vaccine potency. These methods (ELISA using monoclonal antibodies to capture antigen, Surface Plasmon Resonance, and label-free, antibody-free mass spectrometry) were used to measure the potency of inactivated influenza vaccines from several manufacturers. In each case, the results demonstrated the potential of each method and indicated that further development and evaluation was warranted.	N/A	N/A
Status	Target Met	Target Met	Target Not Met but Improved	Target Met		

Increase the percentage of public health agencies that directly receive CDC Public Health Emergency Preparedness funding that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners. (Lead Agency - CDC; Measure ID - 13.5.3)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Set Baseline[58]	75 %	83 %	91 %	94 %	95 %
Result	68 %	89 %[59]	87 %	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[58] This measure was enhanced as of 2009, which resulted in a re–baselining of the data

[59] In order to account for varying data lags, this measure was adjusted in FY2014 to more accurately reflect outcomes for the corresponding funding period. This adjustment resulted in an update of 2010 results from 92% to 89%.

Enhance the Department's capability to rapidly and appropriately respond to medical emergencies and urgent public health needs, through maintaining operational response teams. (Lead Agency - OASH; Measure ID - 6.1.5)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	36	46	46	41	46	41
Result	41	41	41	41	Sep 30, 2013	Sep 30, 2014
Status	Target Exceeded	Target Not Met	Target Not Met	Target Met	Pending	Pending

Increase the number of new Chemical, Biological, Radiological, and Nuclear threats (CBRN) and Emerging Infectious Disease (EID) medical countermeasures (MCM) under Emergency Use Authority (EUA) or licensed (Lead Agency - ASPR; Measure ID - 2.4.13)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		N/A	Awards contracts for advanced development of recombinant-based influenza vaccines. Initiate clinical study to determine the safety of an anthrax vaccine. Issue RFP to establish Centers of Innovation for Advanced Development and Manufacturing Issue RFP to establish a network of domestic vaccine and biologics manufacturers	CBRN Licensed= 0; EUA= +1; Pan Flu/EID Licensed= +1; EUA= 0	CBRN Licensed= +0; EUA= +3; Pan Flu/EID Licensed= +3; EUA= +0	CBRN Licensed= +2; EUA= +2; Pan Flu/EID Licensed= +2; EUA= +0

Result		Baseline	Awarded contract for Recombinant-based flu vaccines. Started large clinical studies to evaluate safety H5N1 vaccines. Issued RFP to establish Centers of Innovation for Advanced Development and Manufacturing. Proposals received and are under evaluation. Issued RFI to discern the capabilities of US vaccines and biologics manufacturing, which will inform the subsequent RFP.	**Target: EUAs= +1;** CBRN EUA= 1 anti-neutropenia cytokine drug for acute radiation treatment (Neupogen) Flu EUA = 4 Pre-EUA packages submitted to FDA by BARDA on H5N1 vaccines BLA Submissions= 3: (cell-based seasonal and H5N1 influenza vaccines – 2 and botulinum antitoxin - 1) **Pan Flu/EID Licensed= +1;** Licensures = 1: Influenza point-of-care diagnostic device (Simplexa) Awarded 3 contracts establishing the Centers for Innovation in Advanced Development and Manufacturing (CIADM) Issued RFP to establish domestic network of fill finish manufacturers for pandemic influenza and drug shortages.	In Progress	N/A
Status		Target Met	Target Met	Target Met		

Increase laboratory surge capacity in the event of terrorist attack on the food supply. (Radiological and chemical samples/week). (Lead Agency - FDA; Measure ID - 214305)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	2,500 rad & 1,650 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem
Result	2,500 rad & 1,650 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	Dec 31, 2013	Dec 31, 2014
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

Analysis of Results

HHS is expanding diagnostic, preparation, response, and treatment options to deal with both natural and man-made disasters. To do this, both the FDA and ASPR are striving to have more options available to handle a crisis. For example, through the Office of Biomedical Advanced Research and Development Authority (BARDA), ASPR is working to increase the development of medical countermeasures for chemical, biological, radiological, and nuclear agents through public-private partnerships. The intent is to develop countermeasures, facilitate licensure of these producers and build domestic countermeasure manufacturing capacity to address these threats. With the establishment of three Centers for Innovation in Advanced Development and Manufacturing in the U.S. in 2012, nearly 90 percent of the U.S. pandemic influenza vaccine supply will be produced domestically as compared to less than 50 percent in 2009. One of the Centers has already shown its emergency capabilities by responding to the swine H3N2 outbreaks in 2012 with the manufacturing of a cell-based flu vaccine candidate in 2012 for clinical evaluation. These efforts have met or exceeded targets for the past two years.

For its part, the FDA is diversifying flu vaccine production and increasing laboratory surge capacity for testing potentially contaminated foods. To ensure continued progress in preparation for new influenza strains, the FDA continually strengthens vaccine safety monitoring, while advancing the detection of possible adverse events of new licensed vaccines through the use of large population databases. As a result, the FDA achieved its 2012 goal of evaluating three new methods of determining influenza vaccine potency. In the event of a terrorist attack on the food supply, the FDA seeks to increase its ability to rapidly test large numbers of samples of potentially contaminated foods, achieving its target every year since 2009.

Meanwhile, the CDC is helping public health agencies rapidly convene key management staff (within 60 minutes of being notified of an emergency) so that they can integrate information, prioritize resources, and effectively coordinate with key response partners. Since FY 2009, the CDC's 62 grantees (which include states, territories and four major metropolitan U.S. cities) that successfully convened key staff within 60 minutes of notification increased from 68 percent to 87 percent, exceeding FY2011's target by 4 percentage points.

Plans for the Future

The FDA is planning to maintain laboratory surge capacity for potentially contaminated foods in FY 2013 to better perform analysis on 2,500 radiological samples and 2,100 chemical samples per week. This effort will have public health value even in non-deliberate food contamination situations because contaminated food products will be identified and removed from the marketplace more quickly. The FDA will also continue to examine new ways to maximize the evaluation flu vaccine potency.

For FY 2013, ASPR plans to increase the number of better and enhanced medical countermeasures available as licensed products. In addition ASPR plans to fortify further domestic medical countermeasures manufacturing and enhance clinical studies networks while continuing to initiate, monitor, and evaluate programs using effective HHS procurement and program management procedures. The CDC will be increasing the percentage of public health agencies that can assemble, make key decisions and quickly respond during an emergency. Because many emergencies provide little to no notice but still require a rapid response, the CDC will continue focusing on improving the percentage of grantees who can convene key staff within 60 minutes of notification.

Goal 4. Objective A: Ensure program integrity and responsible stewardship of resources

Stewardship of nearly $900 billion in Federal funds involves more than ensuring that resources are allocated and expended responsibly. Managing Federal healthcare related investments with integrity and vigilance will safeguard taxpayer dollars as well as benefit the public through improved health and enhanced well-being. Responsible stewardship involves allocating these resources effectively—and for activities that generate the highest benefits. HHS has placed a strong emphasis on protecting program integrity and the well-being of program beneficiaries by identifying opportunities to improve program efficiency and effectiveness. HHS is making every effort to ensure that the right recipient is receiving the right payment for the right reason at the right time. Internal controls and risk assessment activities are evolving and being strengthened across programs, including Medicare, Medicaid, CHIP, Head Start, TANF, Low Income Home Energy Assistance Program (LIHEAP), foster care, and child care, to strengthen the integrity and accountability of payments.

All agencies and offices in HHS, including ACF, ACL, CMS, OMHA and OIG are focused on ensuring the efficiency and integrity of HHS programs. In the table below are performance measures which focus on HHS plans for responsible stewardship.

Objective 4.A Table of Related Performance Measures

Decrease under-enrollment in Head Start programs, thereby increasing the number of children served per dollar. (Lead Agency - ACF; Measure ID - 3F)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	1.4%	0.8%	0.6%	0.7%	0.6%	Prior Result - 0.1PP
Result	0.9%	0.7%	0.8%	0.7%	Jan 31, 2014	Jan 30, 2015
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending

Reduce total amount of sub-grantee Community Services Block Grant (CSBG) administrative funds expended each year per total sub-grantee CSBG funds expended per year. (Lead Agency - ACF; Measure ID - 12B)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	19%	19%	19%	17%	16%	16%
Result	16.96%	16.04%	16.23%	Oct 31, 2013	Oct 30, 2014	Oct 30, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Improve the average survey results from appellants reporting good customer service on a scale of 1 - 5 at the Administrative Law Judge Medicare Appeals level (Lead Agency - OMHA; Measure ID - 1.1.5)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	3.2	3.2	3.4	3.6	3.6	3.6
Result	4.3	4.3	4.2	4.1	Nov 15, 2013	Nov 7, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

For Home and Community-based Services including Nutrition and Caregiver services increase the number of clients served per million dollars of Title III OAA funding. (Lead Agency - ACL; Measure ID - 1.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	8,422	7,742	8,350	8,600	8,700	8,600
Result	8,544	8,438	8,881	Oct 31, 2013	Oct 31, 2014	Oct 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Analysis of Results

HHS seeks to maximize the efficient and effective use of every tax dollar. Consequently, the Department strives to be a responsible steward of the resources employed to carry out its programs. The following performance measures are examples of this stewardship. Head Start is a federal program that promotes the school readiness of children ages birth to five from low-income families by enhancing their cognitive, social, and emotional development. ACF works to decrease national under-enrollment in Head Start to ensure that the maximum number of children are served and that federal funds are used appropriately and efficiently. During the 2011-2012 program year, Head Start grantees had, on average, not enrolled 0.7 percent of the children they were funded to serve, meeting the FY 2012 target of 0.7 percent.

The Community Services Block Grant program provides funds to alleviate the causes and conditions of poverty in communities. ACF works to refine the program network's ability to provide services to low income individuals and families through an efficient and cost effective delivery system. This measure is calculated by dividing the total amount of sub-grantee CSBG administrative funds per year (numerator) by the total amount of sub-grantee CSBG funds expended per year (denominator). The goal of this measure is to ensure that the majority of CSBG funds are being spent on direct services to support low income individuals and families. In FY 2011, ACF maintained the percentage of administrative costs at 16.23 percent, exceeding the target of 19 percent. The percentage has remained in the 16-17 percent range for the past 3 years due to the agency’s persistent work with contractors to control costs.

Customer satisfaction can serve as an indicator of efficient and effective program operation. The Office of Medicare Hearings and Appeals is evaluating its customer service through an independent assessment that captures the scope of the Level III appeal experience. Medicare has a five level appeals process for adverse decisions regarding claims. Level III represents a hearing before an OMHA administrative law judge (ALJ). OMHA seeks to assure that appellants and related parties are satisfied with their Level III appeals experience, especially with regard to understanding of the process and result. Measurement is on a scale of 1 - 5, 1 represents the lowest score (very dissatisfied) and 5 represents the best score (very satisfied). In FY 2012, OMHA achieved a 4.1 level of appellant satisfaction nationwide, exceeding the 3.6 performance target level.

Access to home and community-based services is foundational to the success of AoA’s programs. Consequently, AoA seeks to increase the number of home and community-based services clients served per million of OAA (Older Americans Act) dollars. The purpose of this measure is to demonstrate the success of the Aging Network in employing available tools to enhance the use of OAA funds. Performance has largely trended upward and performance targets (calculated as percentage increases over the FY 2002 baseline of 6,103 clients served per million dollars of OAA funding) have been

consistently achieved. In FY 2011, 8,881 clients were served. Between FY 2002 and FY 2011 performance has improved by 2,778 or 45 percent.

Plans for the Future

By FY 2014, ACF expects under-enrollment in Head Start programs to be 0.1 percentage point less than the FY 2013 actual result through continued program support and technical assistance. Additionally, ACF plans to meet a target level of 16 percent of sub-grantee funds used for administrative costs in the Community Services Block Grant program for fiscal years 2013 and 2014. OMHA will continue to strive to meet customer expectations and maintain the high customer satisfaction at current levels. And to maintain performance in home and community-based services program, ACL will continue to maintain current actual levels of clients served, as shown by increased targets for FY 2012 - 2014.

Goal 4. Objective B: Fight fraud and work to eliminate improper payments

HHS strives to allocate resources in the most efficient manner possible by preventing inappropriate payments, targeting emerging fraud schemes by provider and by type of service, and establishing safeguards to correct programmatic vulnerabilities. Reducing fraud, waste, and abuse in HHS program spending for health care, social services, and scientific research is a top priority for the Department. These activities are not one-time efforts to reduce fraud and improper payments; rather, the activities reflect our long-term commitment to continuously reduce system waste and inefficiencies.

HHS is strengthening efforts to identify and eliminate improper payments. Internal controls and other risk assessment activities are focused on identifying and eliminating systemic weaknesses that lead to erroneous payments. HHS investments in cutting-edge and data mining technologies, such as predictive modeling, allows for the identification of potential fraud with unprecedented speed and efficiency. HHS data tools have substantially reduced the amount of time it takes to identify fraudulent claims activity to a matter of days rather than analyses that previously took months or years. HHS efforts to combat healthcare fraud, waste, and abuse include provider and beneficiary education, data analysis, audits, investigations, and enforcement. In addition, CMS, and OIG are working in collaboration with the Department of Justice in concentrated investigations in selected cities that have high fraud indicators.

HHS is monitoring and assisting the efforts of states, territories, and tribes to prevent and control error and improper payments in Head Start, Temporary Assistance to Needy Families (TANF), Low Income Heating and Energy Assistance Program (LIHEAP), Foster Care, Child Care, other programs. For example, TANF agencies use employment data from the National Directory of New Hires (maintained by ACF's Office of Child Support Enforcement) to identify unreported and underreported income, thereby reducing improper assistance payments. In addition, ACF uses Title IV-E Foster Care Eligibility Reviews to ensure that children for whom Federal foster care payments are claimed are placed with eligible foster care providers. In addition to CMS and ACF, every agency and office in the Department is focused on improving efficiency, fighting fraud and eliminating improper payments. Below is a sample of performance measures that are used to manage HHS progress toward eliminating improper payments.

Objective 4.B Table of Related Performance Measures

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

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		Set Baseline[60]	8.4%[61]	7.4%[62]	6.4%[63]	6%
Result		9.4%	8.1%	7.1%	Nov 15, 2013	Nov 15, 2014
Status		Baseline	Target Exceeded	Target Exceeded	Pending	Pending

[60] Previously as MCD1.1 in the FY 2013 HHS OPA as "Set Baseline." Target/reporting schedule revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

[61] Previously MCD1.1 in the FY 2013 HHS OPA as 7.4%. Target/reporting schedule revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

[62] Previously as MCD1.1 in the FY 2013 HHS OPA as 6.4%. Target/reporting schedule revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

[63] Previously as MCD1.1 in the FY 2013 HHS OPA as TBD. Target/reporting schedule revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

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

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target				Report national error rates in the 2012 Agency Financial Report based on 17 CHIP States	Report rolling average error rate in the 2013 Agency Financial Report based on States reported in 2012-2013	Report rolling average error rate in the 2014 Agency Financial Report
Result				8.2%	Nov 15, 2013	Nov 15, 2014
Status				Target Met	In Progress	In Progress

Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (Lead Agency - CMS; Measure ID - MIP1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	3.5%	9.5%	8.5%	5.4%	8.3%	8%
Result	10.8%[64]	9.1%	8.6%[65]	8.5%[66]	Nov 15, 2013	Nov 15, 2014
Status	Target Not Met	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending

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

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Set Baseline	14.3%	13.7%	10.4%	10.9%	10.4%
Result	15.4%	14.1%	11%	11.4%	Nov 15, 2013	Nov 15, 2014
Status	Baseline	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

[64] The HHS FY 2009 Agency Financial Report (AFR) reported the Medicare FFS error rate as 7.8%, or $24.1 billion in improper payments. This rate reflected a combination of two different review methodologies to determine errors: 1) the old review process, accounting for the majority of the FY 2009 reviews and 2) the new review process that implemented a more stringent review methodology. Since the new review process was to be used going forward, HHS estimated an adjustment to the FY 2009 error rate for comparison purposes. The adjusted FY 2009 rate was 12.4%. Based on the refined estimation methodology outlined in FY 2011 AFR, HHS further calculated and adjusted the FY 2009 error rate from 12.4% to 10.8% and FY 2010 error rate from 10.5% to 9.1%.

[65] In the FY 2011 Agency Financial Report (AFR), HHS refined its error rate estimation methodology to reflect activity related to the receipt of additional documentation and the outcome of appeals decisions that routinely occur after the cut–off date for the published AFR. The error rate and target for FY 2011 has been adjusted to reflect this revised methodology.

[66] Beginning with the FY 2012 report period, HHS modified the report period by moving it back six months. As a result, the FY 2012 reporting period considers claims from July 1, 2010 through June 30, 2011. In addition, HHS refined the improper payment methodology to account for the impact of rebilling of denied Part A inpatient claims for allowable Part B services. Additional information on these changes can by found in the FY 2012 AFR, available at www.hhs.gov/afr.

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

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		Further develop component measures of payment error for the Part D program	Report Composite Error Rate for the Part D program.	3.2%	3.1%	3.0%
Result		Additional component measure reported. (Target met)	Baseline 3.2%	3.1% Target Exceeded	Nov 15, 2013	Nov 15, 2014
Status		Target Met	Target Met	Target Exceeded	In Progress	In Progress

Increase the Percentage of Medicare Providers and Suppliers Identified as High Risk that Receive an Administrative Action (Lead Agency - CMS; Measure ID - MIP8)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target				N/A	31%	36%
Result				27%[67]	Nov 30, 2013	Nov 30, 2014
Status				Target Not In Place	Pending	Pending

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

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	6%	4.5%	4.7%	4.5%	6%[68]	5.8%
Result	4.7%	4.9%	5.25%	6.2%	Oct 30, 2013	Oct 31, 2014
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Pending	Pending

Analysis of Results

In pursuit of the objective to fight fraud and reduce improper payments, HHS employs a number of measures to track performance. Potential improper payments in the fee-for-service, managed care, and eligibility components of both Medicaid and the Children's Health Insurance Program are rigorously examined. The Medicaid three-year weighted average national error rate reported in the FY 2012 AFR was based on error rate data reported in FY 2010, 2011, and 2012. The current reported three-year rolling error rate is 7.1 percent, a decline of a full percentage point from the FY 2011 three-year average

[67] The previously established FY 2012 target of 15% is no longer relevent. It was set in 2010 when the HHS Strategic Plan was being developed. It has been changed to more accurately reflect the changes in statutorily directed work of CMS in fraud prevention and detection. This also applies to the FY 2015 target of 25% set when the HHS Strategic Plan was being developed in 2010. 27% is the FY 2012 baseline for this goal calculated based on the result of leads at the end of the first year of the Fraud Prevention System (FPS) (July 2012). The targets for 2013 and 2014 are calculated by increasing the baseline by 15% each year.

[68] This target has been revised in light of the recent data trend.

and 2.3 percent lower than the FY 2010 result. As a result of various legislative requirements, CMS did not report a national improper payment rate for the Children's Health Insurance Program in the FY 2009 through 2011 AFRs. CMS resumed the Children's Health Insurance Program (CHIP) measurement and published a single-year national CHIP error rate in the FY 2012 AFR. The current reported the Children's Health Insurance Program error rate (as reported in the FY 2012 AFR) is 8.2 percent.

One of CMS' key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. Paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. The Medicare Fee-for-Service improper payment estimate is calculated under the Comprehensive Error Rate Testing Program. CMS has made progress on its efforts to reduce the Medicare Fee-for-Service error rate over the years; however, at a rate of 8.5 percent, it did not meet the FY 2012 target.

Instead of receiving services under traditional Fee-for-Service arrangements, Medicare beneficiaries have the option to enroll in Part C/Medicare Advantage (Part C) prepaid managed care plans that cover Medicare related services paid on a per capita basis. CMS measures and seeks to reduce the Part C error rate by ensuring that CMS has made correct payments to contracting private health plans that cover Medicare benefits. The error rate measures payment errors in the transfer and interpretation of source data, payment calculation errors, and an estimate that measures the extent to which plan-submitted diagnoses for a sample of enrollees are supported by medical records. CMS has substantially lowered the error rate from the FY 2009 baseline of 15.4 percent.

The Medicare Part D Prescription Drug Benefit Program was established in 2006 as an optional prescription drug benefit. The program also provides financial assistance with premiums and cost sharing for individuals who are eligible for both Medicare and Medicaid (dual eligibles) and other qualified low-income beneficiaries. CMS has developed and implemented a method to measure improper payments in the Part D program to ensure that correct payments are made to the private health plans that provide Medicare prescription drug benefits. CMS exceeded its FY 2012 target of 3.2 percent with an actual rate of 3.1 percent.

To protect the integrity of the Medicare Trust Fund and have the ability to effectively target high risk fraud providers , CMS has developed the Fraud Prevention System (FPS) which allows for better tracking of administrative actions against high risk providers and suppliers. This predictive analytics work will focus on activities in the areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk-based approach increases contractors' efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud.

Our goal is to increase the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action. Our FY 2012 baseline is from the first year of the FPS (July 2012) at a rate of 27 percent of Medicare providers and suppliers (identified through predictive analytics) as high risk that received an administrative action. We have set our FY 2013 and FY 2014 targets at a rate of 31 percent and 36 percent, respectively. CMS is partnering with HHS' Office of General Counsel and the Office of Inspector General, the Department of Justice, and the Federal Bureau of Investigation to implement the full spectrum of administrative actions, which includes referrals to law enforcement. Instances of potential fraud identified through predictive analytics are referred to law enforcement for additional civil and criminal remedies which are powerful tools to assist CMS to protect the integrity of the Medicare Trust Fund.

ACF focuses on reducing erroneous payments in the Title IV-E Foster Care program. The Children's Bureau estimates the national payment error rate and develops an improvement plan to strategically reduce, or eliminate where possible, improper payments under the program. State-level data generated from the Title IV-E eligibility reviews are used to develop a national error rate estimate for the program. The national error rate estimate is determined using the data collected in the most recent foster care eligibility review conducted for each state and extrapolating case-level data on errors and improper payments from each state review sample for a specified period under review to each state as a whole and then to the overall program. Fiscal year 2012's error rate of 6.2 percent (with a 90 percent confidence interval of 5.7 percent to 6.7 percent) represents a modest increase compared to the FY 2011 error rate of 5.3 percent; however, current performance still represents a decrease of nearly 40 percent from the baseline rate of 10.3 percent. The increase in the error rate is primarily attributable to one state, with many other states performing extremely well with error rates below 4 percent.

Plans for the Future

CMS plans to continue implementing effective corrective actions across states to decrease improper payments associated with eligibility errors related to Medicaid and the Children's Health Insurance Program. CMS will also enhance its efforts to reduce improper payments for Medicare Fee-for-Service and Medicare Parts C & D and continue to use predictive analytics to focus on areas where incidence or opportunity for improper payments and/or fraud is greatest. In light of recent performance falling short of targets, ACF has adjusted out-year targets and will continue to work with states to strengthen oversight of Title IV-E eligibility and address payment errors in order to move toward the target of 5.8 percent for 2014.

Goal 4. Objective C: Use HHS data to improve the health and well-being of the American people

Transparency and data sharing are of fundamental importance to HHS and its ability to achieve its mission. HHS data and information are used to increase awareness of health and human service issues and to set priorities for improving health and well-being. By making data and information more transparent and more available, HHS promotes public and private sector innovation and action and provides the basis for new products and services that can benefit Americans.

Several core principles guide HHS's plan for leveraging its data, including publishing more government information online in ways that are easily accessible and usable; developing and disseminating accurate, high-quality, and timely information; fostering the public's use of the information HHS provides; and advancing a culture of data sharing at HHS.

HHS is strongly committed to data security and the protection of personal privacy and confidentiality as a fundamental principle governing the collection and use of data. HHS protects the confidentiality of individually identifiable information in all public data releases, including publication of datasets on the Web. By employing state-of-the-art processes for data prioritization, release, and monitoring HHS increases the value derived from information in several ways. Consumers are able to access information and benefit directly from using it personally. Public administrators can use these information resources to inform service delivery and improve customer satisfaction.

Expanded information resources also will bring new transparency to health care to help spark action to improve performance. For example, expanded health care information can help those discovering and applying scientific knowledge to locate, combine, and share potentially relevant information across disciplines to accelerate progress. It can enhance entrepreneurial value, catalyzing the development of innovative products and services that benefit the public and, in the process of doing so can fuel economic growth through the private sector.

The HHS Data Council coordinates health and human services data collection and includes the following HHS components: ACF, AHRQ, ACL, ASPE, CDC, CMS, FDA, HRSA, IHS, NIH, ONC, OASH, and SAMHSA. Below are performance measures related to use of data to improve health outcomes and well-being.

Objective 4.C Table of Related Performance Measures

Decrease the number of months required to produce MEPS data files (i.e. point-in-time, utilization and expenditure files) for public dissemination following data collection (MEPS-HC) (Lead Agency - AHRQ; Measure ID - 1.3.21)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	11 months	10.8 months	10 months	10 months	10 months	9.5 months
Result	11 months	10.8 months	10 months	10 months	Oct 31, 2013	Oct 30, 2014
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

Increase the electronic media reach of CDC Vital Signs through use of mechanisms such as the CDC website and social media outlets, as measured by page views at http://www.cdc.gov/vitalsigns, social media followers, and texting and email subscribers (Lead Agency - CDC; Measure ID - 8.B.2.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	Set Baseline	350,000	1,169,208	1,215,976	1,959,343
Result	0	256,243	1,113,531	1,829,111	Oct 31, 2013	Oct 31, 2014
Status	Historical Actual	Baseline	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

HHS is committed to making high-quality and useful health-related data easily accessible in a timely manner. The Medical Expenditure Panel Survey Household Component fields questionnaires to individual household members to collect nationally representative data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. Through their efforts from 2006 (baseline) to 2012, AHRQ has reduced the number of months to public release of data. It achieved the accelerated data release schedule for all the targeted MEPS public release files scheduled for release during FY 2012.

The CDC created the Vital Signs Program late in 2009 to provide the latest data and information on key health indicators concerning major public health problems in the United States. The first issue was published on July 6, 2010 and since then Vital Signs has reached its broad audience through a variety of communication channels that comprise this measure. They include page views at CDC.gov, social media followers (Facebook, Twitter), and subscribers to email and texting services. Three issues of CDC Vital Signs were released in Fiscal Year (FY) 2010, which yielded an electronic media reach of over 250,000. Significant increases were achieved in FY 2011, with 12 issues transmitted through over 1 million communication channels. This momentum continued in FY 2012, with 10 issues transmitted through over 1.9 million communication channels.

Plans for the Future

Moving forward, AHRQ is targeting a two week reduction for FY 2014 for the point-in-time file relative to the time for data release accomplished in FY 2012. Further acceleration is targeted for the current MEPS Household Component solicitation, with data delivery taking place in FY 2014 through FY 2018.

Since 2010, exposure to CDC Vital Signs in any form has expanded tremendously due to growing print, broadcast, cable media, and social media interests that have far outpaced expectations; however, media market saturation is likely at some point in time. As a result, the CDC expects more level but sustainable growth in the future.

Goal 4. Objective D: Improve HHS environmental, energy, and economic performance to promote sustainability

Conducting our activities in a sustainable manner will benefit Americans today as well as secure the health and well-being of future generations of Americans. In carrying out this objective, HHS will be a leader in promoting the co-benefits of sustainability to health and well-being. By conserving resources through sustainable purchasing operations, management of real property and recapitalization of building infrastructure and waste management positions, HHS can meet its mission while managing costs. Operational efficiencies, such as reductions in paper, water, and energy use, allow more resources to be devoted to mission-specific purposes.

HHS efforts to reduce greenhouse gas emissions will protect our environment and the public's health. Our operations produce greenhouse gases that are associated with negative health impacts resulting from alterations of our climate, ecosystems, food and water supplies, and other aspects of the physical environment. These gases and other air, water, and land contaminants are generated from energy production and use, employee travel and commuting, facility construction and maintenance, and mission activities, such as patient care and laboratory research.

The Senior Sustainability Officer in the Office of the Secretary helps ensure that HHS operations promote sustainability and comply with Executive Order 13514. However, meeting sustainability goals is a shared responsibility, underpinning the functions offices throughout HHS. It is also the responsibility of the individuals directly employed by HHS as well as its grantees and contractors. To integrate sustainability into the HHS mission HHS agencies and offices are using a variety of techniques, the following measures illustrate some of the ways the HHS will be tracking progress to support sustainability.

Objective 4.D Table of Related Performance Measures

Increase the percent employees on telework or on Alternative Work Schedule (Lead Agency - ASA; Measure ID - 1.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target			12.0%	14.0%	16.0%	18.0%
Result			13.0%	22.0%	Dec 2, 2013	Dec 3, 2014
Status			Target Exceeded	Target Exceeded	Pending	Pending

Ensure Power Management is enabled in 100% of HHS computers, laptops and monitors (Lead Agency - ASA; Measure ID - 1.3)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		N/A	100.0%	100.0%	100.0%	100.0%
Result		32.0%	85.0%	94.0%	Dec 2, 2013	Dec 3, 2014
Status		Historical Actual	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending

Reduce HHS fleet emissions. (Lead Agency - ASA; Measure ID - 1.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	13,232 MTCO2e	12,968 MTCO2e	12,708 MTCO2e	12,454 MTCO2e	12,205 MTCO2e
Result	12,549 MTCO2e	11,750 MTCO2e	13,404 MTCO2e[69]	13,448 MTCO2e	Dec 2, 2013	Dec 2, 2014
Status	Historical Actual	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

Analysis of Results

The President's Executive Order 13514 mandates the reduction of the federal government's carbon footprint by 28 percent in the next decade. HHS's Strategic Sustainability Performance Plan uses a variety of approaches with related performance measures to manage toward achieving that goal. ASA is instituting a number of initiatives to enhance energy efficiency. Teleworking and alternative work schedules reduce the number of vehicle miles traveled by federal employees. ASA tracks progress towards the 20 percent target of employees who use one of these to avoid commuting at least 4 days per pay period. Results for FY 2012 exceeded the target by 8 percent.

Simple changes to electronic equipment configurations can produce significant power savings. HHS is measuring the percentage of eligible computers, laptops and monitors with power management, including power-saving protocols in the standard configuration for employee workstations. Consistent application of power management will decrease the electricity use of HHS facilities. HHS has set aggressive goals to move from the 2010 level of 32 percent of devices with power management enabled to 100 percent of devices with power management by 2013 and to maintain that level continuing through 2015. In 2012, 94 percent of eligible devices were reported in compliance across the Department.

HHS is committed to replacing gasoline-powered vehicles with alternative fuel vehicles (AFV) in accordance with GSA acquisition guidelines and in alignment with HHS Sustainability Plan and the Presidential Order to reduce greenhouse gases. HHS is aiming to reduce fleet emissions by 2 percent annually. This measure uses Million Tons of Carbon Dioxide equivalents, or MTCO2e, a standard measure of greenhouse gas emissions. In 2010, HHS used Recovery Act funds to replace conventionally (petroleum based) powered vehicles with alternative fuel vehicles, substantially reducing HHS's greenhouse gas emissions. In 2011 and 2012, HHS added vehicles to its fleet, resulting in a net gain of CO2e emissions. However, HHS remains committed to reducing the greenhouse gas emissions of its fleet.

Plans for the Future

HHS will continue to support initiatives toward the achievement of the goals in the Executive Order and the Sustainability Performance Plan. Subsequent years' targets have increased to meet the 2015 goal of 20 percent of employees reducing commute time through telework or Alternative Work Schedule. HHS has set aggressive goals to move from the 2010 level of 32 percent of devices with power management enabled to 100 percent of devices with power management by 2013 and to maintain that level continuing through 2015. CO2e emission reduction targets for subsequent periods are expected to stabilize and improve going forward.

[69] Due to an error in calculation, HHS initially reported a result of 9,375 MTCO2e for FY2011. However, after correcting this significant error, the accurate number has been calculated at 13,404 MTCO2e. Measures are now in place to prevent similar miscalculations in the future.

Goal 5. Objective A: Invest in the HHS workforce to help meet America's health and human service needs today and tomorrow

Goal 5. Objective B: Ensure that the Nation's healthcare workforce can meet increased demands

Goal 5. Objective C: Enhance the ability of the public health workforce to improve public health at home and abroad

Goal 5. Objective D: Strengthen the Nation's human service workforce

Goal 5. Objective E: Improve national, state, local and tribal surveillance and epidemiology capacity

HHS is engaging in a variety of activities to strengthen its human capital and infrastructure needs, and to address challenges in recruitment, retention, workforce diversity, and succession planning. HHS is focusing on human capital development to inspire innovative approaches to training, recruitment, retention, and ongoing development of Federal workers. Combined with a focus on opportunities to align multiple training programs supported by HHS and expand surveillance and treatment capacities, the Department will enhance its ability to address current and emerging challenges.

The Nation's human service workforce serves some of the most vulnerable populations in the United States. These workers can be found in early childhood and afterschool programs; domestic violence and child protection services; teen pregnancy prevention programs; care for older adults; and programs addressing mental illness and substance abuse. Human service workers promote economic and social self-sufficiency and the healthy development of children and youth. In addition to the difficulty of addressing these complex issues, the human service workforce faces challenges of high staff turnover, poorly developed or undefined core competencies, unclear compensation expectations, and career trajectories. As our Nation's population ages, the percentage of people ages 18 to 64 is expected to decline, shrinking the potential supply of human service workers. In addition, the population is growing more racially and ethnically diverse, reinforcing the need to equip the human service workforce with the necessary cultural and linguistic skills to be responsive to all Americans' needs.

Improvements in health practices rely on three critical elements: surveillance, epidemiology, and laboratory services. The skill set required to detect emerging threats, monitor ongoing health issues and their risk factors, and identify and evaluate the impact of strategies to prevent disease is specialized and technical.

These challenges play out against a backdrop of persisting problems. Our health professions workforce is not well-distributed geographically, racially or ethnically. Rural areas face the difficulties of low population density and long distances to care, which are especially problematic in Indian Country. Despite the need for greater primary care capacity, physicians are apt to choose other specialties—in part, because educational debt levels have grown and primary care practitioners have lower incomes compared with most specialists.

HHS supports health workforce training efforts across the educational spectrum. CMS makes substantial financial investment in the health professions workforce by supporting the graduate medical education of physicians. CMS also uses various payment incentives to help encourage providers to practice in

underserved areas. NIH is committed to meeting the Nation's needs for biomedical, behavioral, and clinical investigators by providing research training for pre- and post-doctoral trainees and fellows. HRSA and IHS offer programs that provide scholarships and loan repayment in exchange for service in underserved areas. IHS provides loan repayment support for a broad range of health professionals who provide health care services in the Indian health care system of health care settings. HRSA provides support to medical, nursing, and other health professional schools in an effort to improve the supply, diversity, quality, and specialty and geographic distribution of health care providers. IHS supports programs to increase the numbers of AI/AN health professionals through scholarship program and grants to educational institutions. CDC ensures a prepared, diverse, sustainable public health workforce through experiential fellowships and high-quality training programs, which fill critical gaps in key areas such as epidemiology, informatics, prevention effectiveness (health economics and decision sciences), preventive medicine, program management, and policy analysis. Routine placement of fellows in the field also strengthens the ability of state and local health departments to respond to public health problems and emergencies. IHS provides loan repayment support for a broad range of health and allied health professionals required to provide health care services in the Indian health care system of hospitals, clinics, health centers and stations.

HHS components are committed to investing and strengthening the health and human service workforce and improving the quality of training and technical assistance; strategic use of data, monitoring, and evaluation efforts; collaboration with other agencies; and the promotion of evidence-based practices. Below are examples of performance measures from selected components designed to meet the demands for a well-trained health and human service workforce.

Objective 5 Table of Related Performance Measures

Provide research training for postdoctoral fellows that promotes greater retention and long-term success in research careers. (Lead Agency - NIH; Measure ID - CBRR-1.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 10%	N ≥ 10%
Result	Award rate to comparison group reached 14% and exceeded the target by at least 2%.	Award rate to comparison group reached 14% and exceeded the target by at least 2%.	Award rate to comparison group reached 13% and exceeded the target by 1%.	Award rate to comparison group reached 13% and exceeded the target by 1%.	Dec 31, 2013	Dec 31, 2014
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

Number of primary care physicians who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding. (Lead Agency - HRSA; Measure ID - 6.I.C.3.a)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target					172	332[70]
Result					Dec 31, 2014	Dec 31, 2015
Status					Pending	Pending

Number of physician assistants who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding. (Lead Agency - HRSA; Measure ID - 6.I.C.3.b)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target				140	280[71]	420[72]
Result				Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status				Pending	Pending	Pending

Number of nurse practitioners who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding. (Lead Agency - HRSA; Measure ID - 6.I.C.3.c)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target				110	260[73]	430[74]
Result				Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status				Pending	Pending	Pending

Field strength of the NHSC through scholarship and loan repayment agreements. (Lead Agency - HRSA; Measure ID - 4.I.C.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	4,674	7,358	9,203	9,193	8,068[75]	7,607
Result	4,808	7,530	10,279	9,908	Dec 31, 2013	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

[70] Cumulative

[71] Cumulative

[72] Cumulative

[73] Includes nurse midwives; cumulative

[74] Includes nurse midwives; cumulative

[75] Target differs from what is reflected in the FY 2013 Congressional Justification, as target is based on the most recent NHSC FY 2013 budget.

Percentage of health professionals supported by Bureau of Health Professions programs who enter practice in underserved areas. (Lead Agency - HRSA; Measure ID - 6.I.C.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	35%	35%	43%	43%[76]	43%	33%
Result	43%	31%[77]	33%	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending	Pending

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

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	75%	85%	100%[78]	100%[79]	100%	100%
Result	83.2%	85%	88.2%[80]	93.2%	Jan 30, 2014	Jan 30, 2015
Status	Target Exceeded	Target Met	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending

Reduce the average number of days to hire (Lead Agency - ASA; Measure ID - 2.1)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		N/A	80 Average Number of Days	61 Average Number of Days	60 Average Number of Days	60 Average Number of Days
Result		65 Average Number of Days	61 Average Number of Days	65 Average Number of Days	Dec 2, 2013	Dec 2, 2014
Status		Historical Actual	Target Exceeded	Target Not Met	Pending	Pending

[76] This figure differs from the FY 2012 Congressional Justification to better reflect realistic projections based on trend data.

[77] FY 2010 Actuals reported for this measure in the FY2013 Congressional Justification were misreported as 43%. Based on available performance data, the proportion of graduates and program completers entering practice in a MUC or HPSA for FY 2010 was 31%.

[78] The FY 2011 target for this measure reflects the requirement of the 2007 Reauthorization of Head Start that, by October 1, 2011, all Head Start teachers must have at least an AA degree in early childhood education or a related field with pre–school teaching experience or have a BA degree and been admitted into the Teach for America program.

[79] The FY 2012 target for this measure reflects the requirement of the 2007 Reauthorization of Head Start that, by October 1, 2011, all Head Start teachers must have at least an AA degree in early childhood education or a related field with pre–school teaching experience or have a BA degree and been admitted into the Teach for America program.

[80] The data reported for FY 2011 reflects teachers in the 2010–2011 program year, before the statutory mandate was in place.

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 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 10%	N ≥ 10%
Result	Award rate to comparison group reached 13% and exceeded the target by at least 1%.	Award rate to comparison group reached 12%.	Award rate to comparison group reached 12%.	Award rate to comparison group reached 11%.	Dec 31, 2013	Dec 31, 2014
Status	Target Met	Target Met	Target Met	Target Not Met	In Progress	In Progress

Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies. (Lead Agency - CDC; Measure ID - 8.B.4.2)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	Set Baseline	198	237	248	298
Result	119	182	309	335	Dec 31, 2013	Dec 31, 2014
Status	Historical Actual	Baseline	Target Exceeded	Target Exceeded	Pending	Pending

Increase the number of states that report all CD4 and viral load values for HIV surveillance purposes (Lead Agency - CDC; Measure ID - 2.2.4)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target		Set Baseline	26	31	33	33
Result		25	26[81]	32	Feb 1, 2014	Feb 1, 2015
Status		Baseline	Target Met	Target Exceeded	Pending	Pending

Increase the number of new CDC trainees who join public health fellowship programs in epidemiology, preventive medicine, public health leadership and management, informatics, or prevention effectiveness, and participate in training at Federal, state, tribal, local, and territorial public health agencies. (Lead Agency - CDC; Measure ID - 8.B.4.3)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	Set Baseline	185	176	176	212
Result	134	212[82]	197	243	Dec 31, 2013	Dec 31, 2014
Status	Historical Actual	Baseline	Target Exceeded	Target Exceeded	Pending	Pending

[81] Washington D.C. plus 26 states; in 4 additional states, specific CD4/VL reporting values are not specified; however, local interpretation of state law results in reporting of all values.

[82] Inagural year for trainees to be included for CDC's newest fellowship program (65 PHAP trainees).

Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology Training Program (FETP). New Residents (Lead Agency - CDC; Measure ID - 10.F.1a)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Set Baseline	149	164	179	255	430
Result	134	192	351	Jun 30, 2013	Jun 30, 2014	Jun 30, 2015
Status	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase epidemiology and laboratory capacity within global health ministries through the Field Epidemiology Training Program (FETP). Total Graduates (Lead Agency - CDC; Measure ID - 10.F.1b)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	Set Baseline	2,316	2,486	2,660	2,846	3,101
Result	2,166	2,351	2,658	Jun 30, 2013	Jun 30, 2014	Jun 30, 2015
Status	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the number of individuals trained by SAMHSA's Science and Services Program (Lead Agency - SAMHSA; Measure ID - 1.4.09)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Target	N/A	N/A	N/A	37,896	110,000[83]	110,000
Result	45,462	51,415[84]	104,416[85]	108,494	Dec 31, 2013	Dec 31, 2014
Status	Historical Actual	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending

Analysis of Results

HHS recognizes that a high-quality workforce is crucial to the effective delivery of health and human services. The Department has a number of activities that focus on addressing current workforce issues and the strategic development of workforce capacity. HHS also seeks to ensure that our country not only maintains, but enhances its capacity for innovative health-related research. A critical part of the NIH mission is the education and training of the next generation of biomedical, behavioral, and clinical scientists. Success of NIH pre- and post-doctoral 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 support; subsequent support is an indicator of 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. In FY 2012, NIH pre-doctoral trainees and fellows were 11 percent more likely to remain active in biomedical research than non-NIH trainees and fellows; this result exceeded the baseline of 10 percent, but fell short of the annual target of 12 percent. To assess its performance, NIH also routinely monitors the career outcomes of former postdoctoral fellows. In FY 2012, NIH

[83] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels.

[84] All component programs have now reported; therefore, data are revised from previously reported.

[85] These data were submitted in the aggregate by the following service and science contractors: CAPT, NACE, FASD, Border and Prevention Fellows.

postdoctoral fellows were 13 percent more likely to remain active in biomedical research than non-NIH fellows; this exceeded the annual target of 12 percent.

The Nation's healthcare workforce is facing a number of significant challenges that are increasing demands, including shortages of healthcare providers. HRSA's Bureau of Health Professions Programs are designed to improve the health of the Nation's communities, especially vulnerable populations, by supporting programs to augment the supply of health care providers who enter practice in underserved areas and increase access to quality health care. HHS made initial Prevention and Public Health Fund-supported grants for education of primary care physicians, physician assistants, and nurse practitioners in late September 2010. Consequently, the first groups will not complete the programs until FY 2012 and 2013. The National Health Service Corps addresses the nationwide shortage of health care providers in health professional shortage areas by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. The Corps field strength indicates the number of providers fulfilling active service obligations in underserved areas in exchange for scholarship or loan repayment support. In FY 2012, the Corps field strength was 9,908, exceeding the target but somewhat below the FY 2011 level.

Head Start is a federal program that promotes the school readiness of children ages birth to five from low-income families by enhancing their cognitive, social, and emotional development. Head Start grantees are required to develop plans to improve the qualifications of staff. 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 fiscal years 2011 through2014 is to reach 100 percent. In FY 2012, 93.2 percent of Head Start teachers had an AA degree or higher, missing the target of 100 percent, but improving significantly over the FY 2011 result.

Prompt turnaround for recruitment requests are not only necessary for hiring highly qualified candidates in today's competitive market, but are also required under several OPM directives that oblige agencies to streamline processes and decrease timelines. The Assistant Secretary for Administration has set aggressive Agency-wide goals that significantly exceed the OPM federal targets for hiring timelines. To optimize performance, the Office of Human Resources has implemented a number of process and systems improvements to support hiring managers in their recruitment efforts. In FY 2012, the average days to hire was 65 days, missing the target of 61 days, but remaining close the longer term goal of reaching 60 days in FY 2015.

The detection and monitoring of escalating health issues is a key component of HHS's strategic plan to enhance public health. State health departments report shortages of critical disciplines such as epidemiologists, public health nurses, managers, disease investigation specialists, laboratorians, environmental scientists, sanitarians, and informaticians. CDC's fellowship programs promote service while learning; fellows fill critical workforce needs at CDC and in the field while they are in-training for careers in the field of public health. Targets are set based on the typical, annual class size for each of the fellowship programs included in the measure. In 2012, 84 percent of CDC's fellowship program graduates pursued careers in public health practice, while less than 25 percent of graduates of schools of public health did so. Over the past two years, CDC exceeded its targets for training the next generation of the public health workforce, including 243 new trainees in FY 2012. As of September 30, 2012 , CDC supported 546 fellows, 339 (62%) of whom were in state, tribal, local and territorial field assignments in 45 states, the District of Columbia, American Samoa, Puerto Rico, and five tribal locations.

CD4 and viral load reporting provide the fundamental data for four of the National HIV/AIDS Strategy Goals. These goals are to increase the proportion of newly diagnosed persons linked to clinical care, and reduce the proportion of three populations diagnosed with HIV who have undetectable viral loads. CDC data from 14 state and local jurisdictions with laboratory reporting of CD4 and viral load test results demonstrate progress on increasing linkage to care compared to an earlier national estimate. Routine reporting of CD4 and Viral Load data to surveillance programs facilitates case finding and follow-up on new cases. These data help to ensure the timeliness, accuracy, and completeness of the national HIV surveillance system. As of March2013, 32 states reported all CD4 and viral load values for surveillance purposes, exceeding CDC's target of 31 states. The current ease and frequency of long-range travel can make previously regional diseases and infections local risks. Therefore, HHS supports a number of initiatives to develop local and international workforce to improve public health both at home and abroad. Since 1980, CDC developed 46 international Field Epidemiology Training Programs (FETP) serving 64 countries and graduated over 2,600 epidemiologists. FETP and Sustainable Management Development Program graduates go on to serve in key public health positions within Ministries of Health in their respective countries. Their presence enhances sustainable public health capacity in these countries, which is critical in transitioning U.S. government global health investments to long-term host-country ownership. In FY 2011, CDC substantially increased the number of new residents and total graduates.

Not only is the healthcare workforce facing challenges, but so is the human services workforce. HHS works to strengthen this crucial group that addresses some of society's most basic needs. SAMHSA is seeking to increase the total number of individuals trained as a result of its Science and Service programs. This measure reflects the total number of participants who attended a SAMHSA-funded training, meeting, or received technical assistance from the Center for Substance Abuse Treatment, the Center for Mental Health Services, and the Center for Substance Abuse Prevention. Data and trend analysis reflects an increase in the total number of participants who attended a SAMHSA-funded training event related to Science and Service programs. SAMHSA reported FY 2012 results with increases in the number of individuals trained as a result of Science and Service training, exceeding its target.

Plans for the Future

HHS plans to continue to address workforce objectives through activities such as those described above and others. It will seek to reduce internal hiring time to 60 days on average. NIH will maintain its support of researcher training to enhance the country's health-related research capacity through its fellows program. Through various programs, HRSA will promote health professional education and encourage service in underserved areas. CDC plans to continue strengthening capacity to detect and respond to emerging health threats and outbreaks, including HIV and increase the number of public health trainees to fill public health workforce gaps. SAMHSA plans to maintain current capacities for training and education of the mental health workforce. And ACF will push to ensure that all Head Start center-based teachers will have at least an AA degree or higher with relevant experience in early childhood education.

Summary of Evaluations Completed During the Fiscal Year

HHS administers the largest number of assistance programs of any Federal department. Evaluating the effectiveness and benefits of services are an integral part of improving health and human services.

HHS maintains online electronic report libraries and distributes information on evaluation results as an important component of HHS evaluation management. The Department's information and reports on major evaluations are available through the HHS Policy Information Center web site, located at: http://aspe.hhs.gov/pic/performance. This web site offers users an opportunity to search – by key word, selected program, or policy topics.

The results of HHS evaluations are also disseminated on agency and office websites through targeted distribution of printed reports and research briefs, as well as presentations at professional meetings and conferences. HHS evaluators participate in the broader research community through articles in specialist publications and refereed journals.

To search the list of more than 8,000 evaluation products from HHS evaluations go to http://aspe.hhs.gov/evaluation/performance/index.cfm

To review the most recent Performance Improvement reports go to http://aspe.hhs.gov/pic/perfimp/index.html

GAO High Risk Items

The Government Accountability Office (GAO) has placed four HHS programs (listed below) on its "High Risk List," which lists programs that may have greater vulnerabilities to fraud, waste, abuse and mismanagement. As a responsible steward to taxpayer resources, HHS is committed to making improvements related to these challenges and high risk areas.

The programs identified by GAO are:

CMS - Medicare Program

CMS - Medicaid Program

FDA - Revamping Federal Oversight of Food Safety

FDA - Protecting Public Health through Enhanced Oversight of Medical Products

A copy of the CMS plan for addressing risk within Medicare and Medicaid programs is available at: http://www.cms.gov/apps/files/CMS_GAO_High_Risk_Program_Report.pdf

A copy of the FDA plan for addressing risk within these programs is available at: http://www.fda.gov/AboutFDA/ReportsManualsForms/Reports/BudgetReports/ucm290769.htm

Changes in Performance Measures

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
ACF	7P1	Revise	Of all children who exit foster care in less than 24 months, the percentage who exit to permanency (reunification, living with relative, guardianship or adoption).	Of all children who exit foster care in less than 24 months, maintain the percentage who exit to permanency (reunification, living with relative, guardianship, or adoption).	Added verb "maintain" to demonstrate direction of progress
ACF	7P2	Revise	Of all children who exit foster care after 24 or more months, the percentage who exit to permanency (reunification, living with relative, guardianship or adoption).	Of all children who exit foster care after 24 or more months, maintain the percentage who exit to permanency (reunification, living with relative, guardianship, or adoption).	Added verb "maintain" to demonstrate direction of progress
ACF	14D (FVPSA)	Revise FY 2013 Target	Increase the percentage of Family Violence Prevention and Services Act (FVPSA) state subgrant-funded domestic violence program clients who report improved knowledge of safety planning. Target was 89.8%	Increase the percentage of Family Violence Prevention and Services Act (FVPSA) state subgrant-funded domestic violence program clients who report improved knowledge of safety planning. Revise target for FY 2013 to 90%	Round FY 2013 target for simplicity and to better align with strong performance in FY 2011.
ACL	1.1	Revise	For Home and Community-based Services including Nutrition & Caregiver services increase the number of clients served per million dollars of Title III OAA funding FY13 target = 8,600	For Home and Community-based Services including Nutrition & Caregiver services increase the number of clients served per million dollars of Title III OAA funding. FY13 target = 8,700	New data indicate target can be adjusted upwards

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
ACL	3.2	Revise	Increase the number of older persons with severe disabilities who receive home-delivered meals FY13 target = 297,000	Increase the number of older persons with severe disabilities who receive home-delivered meals. FY13 target = 320,000	New data indicate target can be adjusted upwards
CDC	1.3.2a	Retire measure	Increase the rate of influenza vaccination among adults ages 18 to 64.	Replace with New Measure 1.3.3a - Increase the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza	In 2009, the ACIP recommended the seasonal influenza vaccine for everyone six months of age and older. The proposed consolidation of 1.3.1a and 1.3.2a better reflects the universal vaccination recommendation as well as CDC's work to meet national targets and goals
CDC	2.1.4	Retire and replace	Increase the percentage of people diagnosed with HIV infection at earlier stages of disease.	Replace with measure 2.1.8 - Reduce the proportion of persons with HIV diagnosis at later stages of disease within three months of diagnosis.	Measure changed to reflect the common set of core indicators mandated by HHS Secretary memo (4/11/12) for the National HIV/AIDS Strategy.
CDC	3.3.2	Retire and replace	Reduce the estimated number of cases of healthcare associated invasive Methicillin-resistant Staphylococcus aureua (MRSA) infections	Replaced with New Measure 3.3.2a - Reduce the incidence (per 100,000 population) of healthcare associated invasive Methicillin-resistant Staphylococcus aureua (MRSA) infections	CDC is updating the unit of measure to incidence to align with how it reports on other HAI measures. The number of cases will still be included in the narrative.
CMS	CHIP3.1 And CHIP3.2	Combined into CHIP3.3	CHIP3.1 Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP.	CHIP3.3 Improve the availability and accessibility of health insurance coverage by increasing enrolment of eligible children in CHIP and Medicaid	Enrollment in CHIP or Medicaid should be taken in the context of overall children's enrollment in both Medicaid and CHIP. Many factors affect enrollment in CHIP and Medicaid, including states' economic situations,

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
			CHIP3.2 Improve the accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid		programmatic changes, and the accuracy and timeliness of state reporting.
CMS	MCD1.1	Retire and Replace	Estimate the Payment Error Rate in the Medicaid Program	MIP9.1- Estimate the payment error rate in the Medicaid Program	Revised the goal reporting schedule for both Medicaid and CHIP targets to align with the AFR schedule and to make it consistent with the other CMS payment error rate goals (Medicare FFS and Parts C and D). Developed into new goal unique identifier MIP9 to reflect new schedule.
CMS	MCD1.2	Retire and Replace	Estimate the Payment Error Rate in CHIP	MIP9.2 - Estimate the Payment Error Rate in the Children's Health Insurance Program (CHIP)	Revised the goal reporting schedule for both Medicaid and CHIP targets to align with the AFR schedule and to make it consistent with the other CMS payment error rate goals (Medicare FFS and Parts C and D). Developed into new goal unique identifier MIP9 to reflect new schedule.
CMS	MCD6	Revise FY 2013 Target	Work with states to ensure that 90 percent of states report on at least seven quality measures in the CHIPRA core set	Work with states to ensure that 85 percent of states report on at least seven quality measures in the CHIPRA core set	Our Technical Assistance and Analytic Support Program is focused on working with states not only to annually increase the number measures voluntarily reporting to CMS, but also to increase the completeness and accuracy of the data states report. As such, we have modified our target to better reflect the added rigor of working with states to collect complete and accurate data on the Initial Core Measures.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
CMS	MCR22	Revise FY 2013 Target	Improve the accuracy of Medicare Physician Fee Schedule (PFS) payments by identifying, reviewing, and appropriately valuing potentially misvalued codes (including high expenditure or high cost services) under the Medicare PFS through the potentially misvalued code analysis (FY 2013 target = 40%)	Review 40% of potentially misvalued codes identified in 2012; Review 20% of unreviewed potentially misvalued codes identified 2008 to 2011	Through the misvalued code initiative, each year we review previously identified potentially misvalued codes, and we also identify new potentially misvalued codes. The identification and review of misvalued codes is an ongoing process with an expanding baseline, and we believe that should be reflected in the construction of the goal. As such, we have revised the baseline and targets for this goal for 2013 through 2014.
CMS	MCR26	Revise wording of measure and FY 2013 Target	Reduce all-cause hospital readmissions rate	Reduce all-cause hospital readmission rates for Medicare beneficiaries by one percent per year	The target was revised from 5% to 1% to reflect a more realistic target using the Medicare Hospital Readmissions Reduction Program as well as leveraging efforts from the Partnership for Patients, the Quality Improvement Organizations and the Accountable Care Organizations.
CMS	MIP1	Revise FY 2013 Target	Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (FY 2013 target = 5%)	Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (FY 2013 target = 8.3%)	OMB and HHS revise error rate targets after the most recent results are published in the HHS AFR. CMS did not meet its FY 2012 target; therefore, future targets were adjusted downward.
CMS	MIP5	Revise FY 2013 Target	Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program (FY 2013 target = 9.8%)	Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage Program (FY 2013 target = 10.9%)	OMB and HHS revise error rate targets after the most recent results are published in the HHS AFR.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
CMS	MIP8	Change target wording and set FY 2012 baseline and FY 2013 and FY 2014 Targets	Original target wording: Increase the percentage of administrative actions taken against Medicare providers and suppliers identified as high risk. New target wording: Increase the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action. Original FY 2013 and FY 2014 targets: TBD New FY 2013 and FY 2014 targets: 31% and 36%, respectively.	FY 2012 Baseline: 27% FY 2013: 31% FY 2014: 36%	Due to a desire to reflect statutorily mandated changes in CMS fraud prevention work and due to difficulties and anomalies in the reporting systems and data collection used to measure goal performance, the design of this goal has changed. The original goal changed to align with new provisions in the ACA on how to track and target high risk providers through a risk based supplier and provider screening process. The goal changed again with the enactment of the Small Business Jobs Act (SBJA) which added new requirements to use advanced predictive analytics to identify high risk providers.
CMS	PHI2	Revise targets and data source/ data validation	Increase the number of young adults ages 19 to 25 who are covered as a dependent on their parent's employer-sponsored insurance policy (FY 2013 target = 8.8 million) Data Source: Current Population Survey and Medical Expenditure Panel Survey Data	Increase the number of young adults ages 19 to 25 who are covered as a dependent on their parent's employer-sponsored insurance policy (FY 2013 target = 9.7 million) Data source: Current Population Survey Annual Social and Economic Supplement (CPS-ASEC) data Revised data	Targets were revised to be more aggressive.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
				validation: National Health Insurance Survey (NHIS) data	
CMS	PHI4.1	Revise FY 2013 Targets	FY 2013 CJ: 1. Release national Federal risk adjustment model 2. Release 2014 payment notice 3. Data sharing agreements for hub use in place with every state 4. Health plans certified in all Federally-facilitated Exchange states	1. Release 2014 payment notice and payment parameters 2. Data sharing agreements for hub use in place with every state 3. Health plans certified in all Federally-facilitated Exchange states	Delete #1 because the risk adjustment methodology is released in the HHS payment notice.
CMS	PHI4.1	Revise measure wording	Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Affordable Insurance Exchanges and Implementing Medicaid Expansion	Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Health Insurance Marketplaces (Exchanges) and Implementing Medicaid Expansion	Change wording to replace Exchanges with Marketplace
CMS	QIO5 -	FY 2012 Reporting Delay	FY 2012 target 60.5%	FY 2012 Reporting;: TBD	Final reporting is delayed due to systems issues.
FDA	252202	Retire	Voluntary electronic Medical device reporting	Retire measure after FY 2013	Obtained highest level of expected performance. Will develop additional measure around analysis and response to voluntary reports
HRSA	16.II.A.2	Revise FY 2013 Target	Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs; FY 2013 target: 877,525	Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs; FY 2013 target: 1.2 million	Change proposed to be consistent with most recent performance result.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
HRSA	10.I.A.2	Revise wording	Increase the number of children receiving Title V servicers who are enrolled in and have Medicaid and CHIP coverage	Increase the number of children receiving Maternal and Child Health Block Grant services who are enrolled in and have Medicaid and CHIP coverage	Wording changed to provide name for Title V and to agree with how measure is stated in the OPA.
HRSA	10.I.A.1	Revise wording	Increase the number of children served by Title V.	Increase the number of children served by the Maternal and Child Health Block Grant	Wording changed to provide name for Title V and to agree with similarly worded measures
IHS	2	Revise	Diabetes: Ideal Glycemic Control (A1c <7.0)	Retire current measure and replace with this interim measure in 2013: Diabetes: Good Control (A1c <8.0)	New ADA 2012 Clinical Practice Guidelines recommend less stringent goals of <8% for diabetic patients with a history of hypoglycemia, limited life expectancy, advanced micro/macrovascular complications, comorbid conditions, and longstanding diabetes where it is difficult to achieve glucose goal despite diabetes self-management education (DSME), glucose monitoring and effective doses of multiple glucose-lowering medications including insulin. There are risks associated with tight glycemic control of <7% for many diabetic patients. 2012 HEDIS guidelines define A1c good control as <8.0. The joint EASD (European Association for the Study of Diabetes: the European equivalent of the ADA) and the ADA 2012 position statement recommends the answer is to individualize glycemic control targets which IHS proposes for 2014.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
	2	Revise	Diabetes: Ideal Glycemic Control (A1c <7.0)	Retire the above proposed 2013 interim measure of good glycemic control with A1c results that are < 8.0%.	Good glycemic control would be staged over two years with a more complex measure in 2014 replacing the proposed interim measure in 2013. The 2014 measure needs to be developed as an individualized measure with target ranges used by the VA/DoD Diabetes Practice Guidelines Working Group. Target ranges vary from <7%, 7-8%, and 8-9% depending upon a matrix which considers the stage of microvascular complications. Using ranges allows for the flexibility needed for patient safety and limitations of A1c testing accuracy. The complexity of creating such a measure may delay this new measure until FY 2015.
IHS	24	Revise	Combined (4:3:1:3:3:1:4) Childhood Immunization rates: AI/AN patients aged 19-35 months.	Begin reporting as Target = Baseline in FY 2013. Change the Combined Childhood Immunization series from 4:3:1:3:3:1:4 to 4313*314 to match the CDC childhood immunization schedule and *Healthy People 2020.*	CDC will differentiate the use of the 3 or 4 dose Hib vaccine. CDC & *Healthy People 2020* will no longer report on the 4313314 series beginning in 2012. That means that the IHS 2012 results cannot be compared to national US results which are released much later than IHS results. CDC will identify the new series as 4313*314.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
NIH	CBRR-10	Revised Measure	By 2015, make freely available to researchers the results of 300 high-throughput biological assays screened against a library of 300,000 unique compounds, and the detailed information on the molecular probes that are developed through that screening process.	By 2015, make freely available to researchers the results of 400 high-throughput biological assays screened against a library of 300,000 unique compounds, and the detailed information on the molecular probes that are developed through that screening process.	Increased efficiency at the many stages in the pipeline from assay development to probe enables increased productivity.
SAMHSA	3.2.02	Replace with 3.2.02a	Increase the percentage of children receiving trauma informed services showing clinically significant improvement	Increase the percentage of children receiving trauma informed services who report positive functioning at 6 month follow-up	Data source for previous measure no longer available.
SAMHSA	2.3.21	Revise FY 2009 and FY 2010 Actuals	Decrease underage drinking as measured by an increase in the percent of SPF SIG states that show a decrease in 30-day use of alcohol for individuals 12-20 years old	Revision of 2009 and 2010 actuals	Corrections to the 2006-2010 NSDUH state Estimates were made affecting the FY 2009 and FY 2010 actuals.
SAMHSA	2.3.61	Revise FY 2014 Target	Increase the number of calls answered by the suicide hotline		Because the actuals for this measure have exceeded their targets for the past three years, the FY 2014 target should be increased accordingly.
SAMHSA	3.4.02	Replace	Increase the percentage of adults receiving homeless support services who report improved functioning	Increase the percentage of adults receiving homeless support services who report positive functioning at 6 month follow-up	To better align measure description with measure calculation.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2013 REPORT Released 2/2012	MEASURE CHANGE	REASON FOR CHANGE
SAMHSA	3.2.26	Revise	Increase the percentage of children receiving Systems of Care mental health services who report improved functioning	Increase the percentage of children receiving Systems of Care mental health services who report positive functioning at 6 month follow-up	To better align measure description with calculation
SAMHSA	1.4.09	Revise FY 2015 target	Increase the number of individuals trained by SAMHSA's Science and Services Program		Due to more programs having the capability to collect training data, they were added to the Science and Service area in the Center for Mental Health Services. More individuals will be trained than previously predicted; therefore, we increased the target to include a proposed increase in number of people trained.

Administration for Children and Families (ACF)

Measure ID	Data Source	Data Validation
1.1LT and 1A (ACF)	State *LIHEAP Household Report* and Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey	ACF obtains weighted national estimated numbers of LIHEAP income eligible (low income) households from the Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey. The estimates are subject to sampling variability. The Census Bureau validates ASEC data. ACF aggregates data from the states' annual *LIHEAP Household Report* to furnish national counts of LIHEAP households that receive heating assistance (including data on the number of LIHEAP recipient households having at least one member who is 60 years or older and the number of LIHEAP recipient households having at least one member who is five years or younger). The aggregation and editing of state-reported LIHEAP recipiency data for the previous fiscal year are typically completed in September of the following fiscal year. Consequently, the data are not available in time to modify ACF interventions prior to the current fiscal year (i.e. there is at least a one-year data lag). There are no federal quality control or audit requirements for the data obtained from the *LIHEAP Household Report*. However ACF provides to states an electronic version of the *LIHEAP Household Report* that includes formulae that protect against mathematical errors. ACF also cross checks the data against LIHEAP benefit data obtained from the states' submission of the annual *LIHEAP Grantee Survey* on sources and uses of LIHEAP funds.
1.1LT and 1B (ACF)	State *LIHEAP Household Report* and Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey	ACF obtains weighted national estimated numbers of LIHEAP income eligible (low income) households from the Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey. The estimates are subject to sampling variability. The Census Bureau validates ASEC data. ACF aggregates data from the states' annual *LIHEAP Household Report* to furnish national counts of LIHEAP households that receive heating assistance (including data on the number of LIHEAP recipient households having at least one member who is 60 years or older and the number of LIHEAP recipient households having at least one member who is five years or younger). The aggregation and editing of

Measure ID	Data Source	Data Validation
		state-reported LIHEAP recipiency data for the previous fiscal year are typically completed in September of the following fiscal year. Consequently, the data are not available in time to modify ACF interventions prior to the current fiscal year (i.e. there is at least a one-year data lag). There are no federal quality control or audit requirements for the data obtained from the *LIHEAP Household Report*. However ACF provides to states an electronic version of the *LIHEAP Household Report* that includes formulae that protect against mathematical errors. ACF also cross checks the data against LIHEAP benefit data obtained from the states' submission of the annual *LIHEAP Grantee Survey* on sources and uses of LIHEAP funds.
2B (ACF)	Biennial CCDF Report of State Plans	The CCDF State Plan preprint requires states to provide information about their progress in implementing the program components related to professional development and early learning. On a biennial basis, the information for this measure will be available through state plans.
3A (ACF)	Classroom Assessment Scoring System (CLASS: Pre-K)	CLASS: Pre-K is a valid and reliable tool that uses observations to rate the interactions between adults and children in the classroom. Reviewers, who have achieved the standard of reliability, assess classroom quality by rating multiple dimensions of teacher-child interaction on a seven point scale (with scores of one to two being in the low range; three to five in the mid-range; and six to seven in the high range of quality). ACF will implement ongoing training for CLASS: Pre-K reviewers to ensure their continued reliability. Periodic double-coding of reviewers will also be used, a process of using two reviewers during observations to ensure they continue to be reliable in their scoring.
3C (ACF)	Program Information Report (PIR)	The PIR is a survey of all grantees that provides comprehensive data on Head Start, Early Head Start and Migrant Head Start programs nationwide. Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.
3F	Program Information Report (PIR)	The PIR is a survey of all grantees that provides

Measure ID	Data Source	Data Validation
(ACF)		comprehensive data on Head Start, Early Head Start and Migrant Head Start programs nationwide. Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.
4.1LT and 4A (ACF)	The Runaway and Homeless Youth Management Information System (RHYMIS)	RHYMIS incorporates numerous business rules and edit checks, provides a hot-line/help desk and undergoes continuous improvement and upgrading. Extensive cleanup and validation of data take place after each semi-annual transfer of data from grantee systems into the national database. Historically, the reporting response rate of grantees has exceeded 97 percent every year.
7D (ACF)	State Annual Reports	States are required to submit an Annual Report addressing each of the CBCAP performance measures outlined in Title II of CAPTA. One section of the report must "provide evaluation data on the outcomes of funded programs and activities." The 2006 CBCAP Program Instruction adds a requirement that the states must also report on the OMB performance measures reporting requirements and national outcomes for the CBCAP program. States were required to report on this new efficiency measure starting in December 2006. The three percent annual increase represents an ambitious target since this is the first time that the program has required programs 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.
7P1 (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). States' Statewide

Measure ID	Data Source	Data Validation
		Automated Child Welfare Information Systems (SACWIS) are undergoing reviews to determine the status of their operation and the system's capability of reporting accurate AFCARS data. To speed improvement in these data, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.
7P2 (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). States' Statewide Automated Child Welfare Information Systems (SACWIS) are undergoing reviews to determine the status of their operation and the system's capability of reporting accurate AFCARS data. To speed improvement in these data, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.
7Q (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several

Measure ID	Data Source	Data Validation
		AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). States' Statewide Automated Child Welfare Information Systems (SACWIS) are undergoing reviews to determine the status of their operation and the system's capability of reporting accurate AFCARS data. To speed improvement in these data, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.
7S (ACF)	Regulatory Title IV-E Foster Care Eligibility Reviews	Data validation occurs on multiple levels. Information collected during the onsite portion of the review is subject to quality assurance procedures to assure the accuracy of the findings of substantial compliance and reports are carefully examined by the Children's Bureau Central and Regional Office staff for accuracy and completeness before a state report is finalized. Through the error rate contract, data is systematically monitored and extensively checked to make sure the latest available review data on each state is incorporated and updated to reflect rulings by the Departmental Appeals Board and payment adjustments from state quarterly fiscal reports. This ensures the annual program error rate estimates accurately represent each state's fiscal reporting and performance for specified periods. The Children's Bureau also has a database (maintained by the contractor) that tracks all key milestones for the state eligibility reviews.
12B (ACF)	CSBG Information System (CSBG/IS) survey administered by the National Association for State Community Services Programs (NASCSP)	The Office of Community Services (OCS) and NASCSP have worked to ensure that the survey captures the required information. The CSBG Block Grant allows states to have different program years; this can create a substantial time lag in preparing annual reports. States and local agencies are working toward improving their data collection and reporting technology. In order to improve the timeliness and accuracy of these reports, NASCSP and OCS are providing states training, and better survey tools and reporting processes.
14D	SF-PPR, Family Violence Prevention and Services	Submission of this report is a program

Measure ID	Data Source	Data Validation
(ACF)	Program Progress Report Form	requirement. The outcome measures and the means of data collection were developed with extensive input from researchers and the domestic violence field. The forms, instructions, and several types of training have been given to states, tribes and domestic violence coalitions.
16.1LT and 16C (ACF)	Matching Grant Progress Report forms	Data are validated with methods similar to those used with Performance Reports. Data are validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages, and retentions.
18.1LT and 18A (ACF)	Performance Report (Form ORR-6)	Data are validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages, and retentions.
20C (ACF)	Office of Child Support Enforcement (OCSE) Form 157	States currently maintain information on the necessary data elements for the above performance measures. All states were required to have a comprehensive, statewide, automated Child Support Enforcement system in place by October 1, 1997. Fifty-three states and territories were Family Support Act-certified and Personal Responsibility and Work Opportunity Reconciliation Act-certified (PRWORA) as of July 2007. Certification requires states to meet automation systems provisions of the specific act. Continuing implementation of these systems, in conjunction with cleanup of case data, will improve the accuracy and consistency of reporting. As part of OCSE's audit of performance data, OCSE Auditors review each state's and territory's ability to produce valid data. Data reliability audits are conducted annually. Self-evaluation by states and OCSE audits provide an on-going review of the validity of data and the ability of automated systems to produce accurate data. Each year OCSE Auditors review the data that states report for the previous fiscal year. The OCSE Office of Audit has completed the FY 2010 data reliability audits. Since FY 2001, the reliability standard has been 95 percent.
22.2LT and 22B	National Directory of New Hires (NDNH)	Beginning with performance in FY 2001, the above

Measure ID	Data Source	Data Validation
(ACF)		employment measures – job entry, job retention, and earnings gain – are based solely on performance data obtained from the NDNH. Data are updated by states, and data validity is ensured with normal auditing functions for submitted data. Prior to use of the NDNH, states had flexibility in the data source(s) they used to obtain wage information on current and former TANF recipients under high performance bonus (HPB) specifications for performance years FY 1998 through FY 2000. ACF moved to this single source national database (NDNH) to ensure equal access to wage data and uniform application of the performance specifications.

Administration for Community Living (ACL)

Measure ID	Data Source	Data Validation
1.1 (ACL)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.
2.6 (ACL)	National Survey of Older Americans Act Participants.	AoA's national survey uses a range of quality assurance procedures to validate data on OAA participants and services which covers all the steps in the survey process. The surveys have consistently achieved a cooperation rate of over 80% for the sampled Area Agencies on Aging and over 90% for the sample of clients who are currently participating in OAA programs. These high cooperation rates occur because of several important steps in the quality assurance process, including intensive follow-up to contact and interview as many service participants as possible, and calling back at times that are convenient for respondents. After the surveys are complete, range and consistency checks and edits, in conjunction with the CATI software applications, ensure that only correct responses appear in the data files. The data is weighted during three post-survey steps to ensure accuracy. This includes using the inverse of the probability of selection to weight the sample of agencies and clients, adjusting for any non-response patterns and bias that might otherwise occur, and post-

Measure ID	Data Source	Data Validation
		stratification of control totals to ensure consistency with official administrative records.
2.9a (ACL)	National Survey of Older Americans Act Participants	AoA's national survey uses a range of quality assurance procedures to validate data on OAA participants and services which covers all the steps in the survey process. The surveys have consistently achieved a cooperation rate of over 80% for the sampled Area Agencies on Aging and over 90% for the sample of clients who are currently participating in OAA programs. These high cooperation rates occur because of several important steps in the quality assurance process, including intensive follow-up to contact and interview as many service participants as possible, and calling back at times that are convenient for respondents. After the surveys are complete, range and consistency checks and edits, in conjunction with the CATI software applications, ensure that only correct responses appear in the data files. The data is weighted during three post-survey steps to ensure accuracy. This includes using the inverse of the probability of selection to weight the sample of agencies and clients, adjusting for any non-response patterns and bias that might otherwise occur, and post-stratification of control totals to ensure consistency with official administrative records.
2.9b (ACL)	National Survey of Older Americans Act Service Participants	AoA's national survey uses a range of quality assurance procedures to validate data on OAA participants and services which covers all the steps in the survey process. The surveys have consistently achieved a cooperation rate of over 80% for the sampled Area Agencies on Aging and over 90% for the sample of clients who are currently participating in OAA programs. These high cooperation rates occur because of several important steps in the quality assurance process, including intensive follow-up to contact and interview as many service participants as possible, and calling back at times that are convenient for respondents. After the surveys are complete, range and consistency checks and edits, in conjunction with the CATI software applications, ensure that only correct responses appear in the data files. The data is weighted during three post-survey steps to ensure accuracy. This includes using the inverse of the probability of selection to weight the sample of agencies and clients, adjusting for any non-response patterns and

Measure ID	Data Source	Data Validation
		bias that might otherwise occur, and post-stratification of control totals to ensure consistency with official administrative records.
2.9c (ACL)	National Survey of Older Americans Act Participants	AoA's national survey uses a range of quality assurance procedures to validate data on OAA participants and services which covers all the steps in the survey process. The surveys have consistently achieved a cooperation rate of over 80% for the sampled Area Agencies on Aging and over 90% for the sample of clients who are currently participating in OAA programs. These high cooperation rates occur because of several important steps in the quality assurance process, including intensive follow-up to contact and interview as many service participants as possible, and calling back at times that are convenient for respondents. After the surveys are complete, range and consistency checks and edits, in conjunction with the CATI software applications, ensure that only correct responses appear in the data files. The data is weighted during three post-survey steps to ensure accuracy. This includes using the inverse of the probability of selection to weight the sample of agencies and clients, adjusting for any non-response patterns and bias that might otherwise occur, and post-stratification of control totals to ensure consistency with official administrative records.
2.10 (ACL)	State Program Report and National Survey of Older Americans Act Participants.	This is a composite measure that utilizes data from multiple sources. One source is the State Program Report. Another source is the National Survey. State Program Report data is annually submitted by States. The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data. The National Survey draws a sample of Area Agencies on Aging to obtain a random sample of clients receiving selected services. Trained staff administers telephone surveys. Results are analyzed and compared to client population to assure representative sample.
3.1 (ACL)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and State staff. AoA

Measure ID	Data Source	Data Validation
		staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.
3.2 (ACL)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.

Agency for Healthcare Research and Quality – (AHRQ)

Measure ID	Data Source	Data Validation
1.3.21 (AHRQ)	MEPS website	Data published on website A number of steps are taken from the time of sample selection up to data release to ensure the reliability and accuracy of MEPS data including: • Quality control checks are applied to the MEPS sample frame when it is received from NCHS as well as to the subsample selected for MEPS. • Following interviewer training, performance is monitored through interview observations and validation interviews. • A variety of materials and strategies are employed to stimulate and maintain respondent cooperation. • All manual coding and data entry tasks are monitored for quality by verification at 100 percent until an error rate of less than 2 percent is achieved for coding work or less than 1 percent for data entry. • All specifications developed to guide the editing, variable construction and file creation are monitored through data runs that are used to verify that processes are conducted correctly and to identify data anomalies. • Analytic weights are developed in a manner that reduces nonresponse bias and improves national

Measure ID	Data Source	Data Validation
		representativeness of survey estimates. • The precision of survey estimates are reviewed to insure they are achieving precision specifications for the survey. • Prior to data release, survey estimates on health care utilization, expenditures, insurance coverage, priority conditions and income are compared to previous year MEPS data and other studies. Significant changes in values of constructed variables are investigated to determine whether differences are attributable to data collection or variable construction problems that require correction. • Expenditure data obtained from the MEPS medical provider survey are used to improve the accuracy of household reported data.
1.3.38 (AHRQ)	Surveys/case studies	AHRQ staff (OCKT) and evaluation contractor (TBD) to develop methods to validate survey data and conduct case studies
4.4.5 (AHRQ)	All AHRQ systematic reviews are entered into a database, which is used to populate the AHRQ Effective Health Care Program Web site, http://effectivehealthcare.ahrq.gov /.	Effective Health Care Program staff will develop and document a methodology that will be used annually to check data

Assistant Secretary for Administration (ASA)

Measure ID	Data Source	Data Validation
1.1 (ASA)	Manual data calls for telework information through the use of spreadsheets.	Office of Human Resources Telework Liaisons
1.2 (ASA)	HHS data for fleet statistics comes from analysis and output via a resource called the Federal Automotive Statistical Tool (FAST). The input for the HHS data comes from an internal HHS data resource called the HHS Motor vehicle Management Information System (MVMIS). Per the intent of the metric, HHS's measure reflects actual fleet performance	Both the FAST and MVMIS have internal validation processes

Measure ID	Data Source	Data Validation
	values when excluding all fuel products used by HHS law enforcement, protective, emergency response or military tactical vehicles (if any).	
1.3 (ASA)	OCIO HHS administrative data.	
2.1 (ASA)	HHS personnel records	

Assistant Secretary for Preparedness and Response (ASPR)

Measure ID	Data Source	Data Validation
2.4.13 (ASPR)	Program files and contract documents	Contracts awarded and draft Request for Proposal for industry comment are negotiated and issued, respectively, in accordance with Federal Acquisition Regulations (FAR) and the HHS Acquisition Regulations (HHSAR). Interagency Agreements are developed with federal laboratories to address specific advanced research questions.

Centers for Disease Control and Prevention (CDC)

Measure ID	Data Source	Data Validation
1.2.1c (CDC)	Childhood data are collected through the National Immunization Survey (NIS) and reflect calendar years.	The NIS uses a nationally representative sample and provides estimates of vaccination coverage rates that are weighted to represent the entire population, nationally, and by region, state, and selected large metropolitan areas. The NIS, a telephone-based survey, is administered by random-digit-dialing to find households with children aged 19 to 35 months. Parents or guardians are asked about the vaccines, with dates, that appear on the child's "shot card" kept in the home; demographic and socioeconomic information is also collected. At the end of the interview with parents or guardians, survey administrators request permission to contact the child's vaccination providers. Providers are then contacted by mail to provide a record of all immunizations given to the child. Examples of quality control procedures include 100% verification of all entered data with a sub-sample of records independently entered. The biannual data files are reviewed for consistency and completeness by CDC's

Measure ID	Data Source	Data Validation
		National Center for Immunization and Respiratory Diseases, Immunization Services Division - Assessment Branch and CDC's National Center for Health Statistics' Office of Research and Methodology. Random monitoring by supervisors of interviewers' questionnaire administration styles and data entry accuracy occurs daily. Annual methodology reports and public use data files are available to the public for review and analysis.
1.3.3a (CDC)	Behavioral Risk Factor Surveillance System (BRFSS) Behavioral Risk Factor Surveillance System (BRFSS), interviews conducted September-June for an influenza season (e.g., September 2011-June 2012 for the 2011-12 influenza season) and provided to ISD from OSELS by August (e.g. August 2012 for the 2011-12 influenza season). Final results usually available by September (e.g. September 2012 for the 2011-12 influenza season). BRFSS is an on-going state-based monthly telephone survey which collects information on health conditions and risk behaviors from ~400,000 randomly selected persons ≥18 years among the non-institutionalized, U.S. civilian population. Numerator: BRFSS respondents were asked if they had received a 'flu' vaccine in the past 12 months, and if so, in which month and year. Persons reporting influenza vaccination from August through May (e.g., August 2011-May 2012 for the 2011-12 flu season) were considered vaccinated for the season. Persons reporting influenza vaccination in the past 12 months but with missing month or year of vaccination had month and year imputed from donor pools matched for week of interview, age group, state of residence and race/ethnicity. The cumulative proportion of persons receiving influenza vaccination coverage during August through May is estimated via Kaplan-Meier analysis in SUDAAN using monthly interview data collected September through June. Denominator: Respondents age ≥18 years responding to the BRFSS in the 50 states and the District of Columbia	Data validation methodology: Estimates from BRFSS are subject to the following limitations. First, influenza vaccination status is based on self or parental report, was not validated with medical records, and thus is subject to respondent recall bias. Second, BRFSS is a telephone-based survey and does not include households without telephone service (about 2% of U.S. households) and estimates prior to the 2011-12 influenza season did not include households with cellular telephone service only, which may affect some geographic areas and racial/ethnic groups more than others. Third, the median state CASRO BRFSS response rate was 54.4% in 2010, and nonresponse bias may remain after weighting adjustments. Fourth, the estimated number of persons vaccinated might be overestimated, as previous estimates resulted in higher numbers vaccinated than doses distributed.

Measure ID	Data Source	Data Validation
	with interviews conducted September-June for an influenza season (e.g., September 2011-June 2012 for the 2011-12 influenza season) and provided to ISD from OSELS by August (e.g. August 2012 for the 2011-12 influenza season). Persons with unknown, refused or missing status for flu vaccination in the past 12 months are excluded.	
2.1.8 (CDC)	National HIV surveillance system	CDC conducts validation and evaluation studies of the data systems which monitor HIV to determine the quality of data generated by them. HIV data for 2010 are reported data from all 50 states. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". CDC requires a minimum of 12 months after the end of a calendar year to provide accurate trend data.
2.2.4 (CDC)	Legal Assessment Project -The Legal Assessment Project is a legal research and policy analysis project led by CDC's Division of HIV/AIDS Prevention, Office of the Director. The project is conducting a series of 50 state legal surveys (including both statutory and regulatory law) across a number of legal domains, using standard legal research methods. The laws are described as characteristics of policy environments that may facilitate or hinder effective HIV prevention.	CDC conducts legal research to assess policy, statutory and regulatory changes that affect the states' ability to conduct effective HIV prevention.
2.8.1 (CDC)	The National TB Surveillance System	TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.
3.2.1 (CDC)	National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; and National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC,	A 10% quality control sample of survey records was independently keyed and coded.

Measure ID	Data Source	Data Validation
	NCHS	
3.3.2a (CDC)	Emerging Infections Program / Active Bacterial Core Surveillance/Emerging Infections Program Surveillance for Invasive MRSA Infections	Surveillance Site personnel trained in methodology, updates annually; laboratory audits performed by Site staff
3.3.4 (CDC)	National Healthcare Safety Network (NHSN)	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings. CDC developed a validation protocol to provide healthcare facilities and states standard approaches for validating data.
4.6.3 (CDC)	National Health Interview Survey, NCHS	NCHS validates the data
4.6.5 (CDC)	The primary data source for setting and reporting targets is the Youth Risk Behavior Surveillance System (YRBSS), which monitors priority health-risk behaviors and is conducted every other year (odd years). Beginning in FY 2011, the National Youth Tobacco Survey (NYTS) was added as an additional data source, which tracks closely with YRBSS. To obtain data on an annual basis, CDC will conduct the NYTS in the intervening years.	Validity and reliability studies of YRBSS and NYTS attest to the quality of the data. CDC conducts quality control and logical edit checks on each record
4.11.9 (CDC)	National Health Interview Survey (NHIS), CDC, NCHS	Data are reported from a national surveillance system and follows predetermined quality control standards.
7.2.4 (CDC)	National Highway Traffic Safety Administration Fatal Analysis Reporting System (FARS)	Data are from police accident reports for any crash on a public road that resulted in a fatality within 30 days of the crash. Each police accident report of an eligible crash is then entered into the national "Fatal Analysis Reporting System" database (FARS). The quality of the data is reviewed by state FARS data coordinator.
8.B.2.2 (CDC)	Electronic media reach of CDC Vital Signs is measured by CDC.gov web traffic and actual followers and subscribers of CDC's social media, e-mail updates and texting service The data source for this measure is Omniture® web analytics, which is a software product that provides consolidated and accurate statistics about interactions with CDC.gov and social media outlets as individuals seek and access information about *CDC Vital Signs.*	Monthly review of Omniture data by CDC Office of the Associate Director for Communication (OADC) and Vital Signs staff.
8.B.2.5 (CDC)	The data source for this measure is Omniture® web analytics, which is a software product that	Ongoing review of Omniture reports by Community Guide staff.

Measure ID	Data Source	Data Validation
	provides consolidated and accurate statistics about interactions with CDC.gov	
8.B.4.2 (CDC)	Data are compiled annually at the end of the fiscal year to count the total number of trainees in field assignments in state, tribal, local, and territorial public health agencies. Data for each fiscal year represent the number of CDC directly-funded fellows in place at the end of the fiscal year and the fellows funded with contracts using funds from that fiscal year. In 2009, this measure included the Epidemic Intelligence Service (EIS), Preventive Medicine Residency/Fellowship (PMR/F), Public Health Prevention Service (PHPS), and the Public Health Associate Program (PHAP), formerly known as the Public Health Apprentice Program; the Public Health Informatics Fellowship Program (PHIFP) was added in 2010; the CDC-supported Emerging Infectious Diseases (EID) Laboratory Fellowships, CDC/Council of State and Territorial Epidemiologists' (CSTE) Applied Epidemiology Fellowship, Post-EIS Practicum (now known as the Health Systems Integration Program), PHPS Residency, and Applied Public Health Informatics Fellowship were added to the measure in FY 2011. The PHPS Residency pilot program ended in FY 2012. Trainees funded by other federal agencies are excluded.	Staff reviews and validates data through the fellowship programs' personnel systems.
8.B.4.3 (CDC)	Data are compiled annually at the end of the fiscal year to count the number of new trainees entering classes in the Epidemic Intelligence Service (EIS), Preventive Medicine Residency/Fellowship (PMR/F), Public Health Prevention Service (PHPS), Public Health Informatics Fellowship (PHIF), Prevention Effectiveness (PE) Fellowship, and Presidential Management Fellows (PMF) programs. As of 2010, Public Health Associate Program (PHAP) trainees are included. Trainees funded by other federal agencies are excluded.	Staff reviews and validates data through the fellowship programs' personnel systems.
10.C.1 (CDC)	Demographic and Health Surveys (DHS), Multiple Indicator Surveys (MICS), and Malaria Indicator Surveys (MIS).	In sub-Saharan Africa, nationally representative household surveys, like the UNICEF Multiple Indicator Cluster Surveys (MICS) or the MEASURE Demographic and Health Surveys (DHS) conducted by MACRO/Measure Evaluation measure mortality of children less than five as a complement to decadal censuses. These surveys give robust estimates of mortality that can be used to track improvements in

Measure ID	Data Source	Data Validation
		survival in populations without strong systems of vital registration. In PMI countries, malaria indicator surveys at baseline, midpoint and after four full years of implementation will be used to obtain nationally representative estimates of coverage with ITNs, ACTS, and IPTp. In addition, a nationally representative mortality survey will provide baseline mortality data and a similar survey will provide follow-up data after at least three years of implementation. These surveys will most often be scheduled independently of PMI but may be supported by PMI funding. A fifty percent drop in malaria mortality would be evident through these surveys even if deaths together for children under five were considered together from all causes. The Demographic and Health Surveys are conducted and funded largely by USAID. They cover multiple programs such as HIV, Reproductive Health, etc. Each program module has a set of questions and in some cases laboratory tests. Countries decide what program modules they would like to add to the survey. The sample sizes are dependent on the population of the country. The surveys are designed to be representative of the country and vary by country. The methodologies are sound and widely accepted; the results are used by the MOHs and the global public health community for planning and evaluating. These surveys are designed to be repeated over time for consistency. More information is available at http://www.measuredhs.com/
10.F.1a (CDC)	FETP Annual Program Reports	Reports from Countries are submitted to CDC annually. These reports are confirmed by program directors in each Country.
10.F.1b (CDC)	FETP Annual Program Reports	Reports from Countries are submitted to CDC annually. These reports are confirmed by program directors in each Country.
13.5.3 (CDC)	Self-reported data from 62 PHEP grantees.	Quality assurance reviews with follow-up with grantees

Centers for Medicare & Medicaid Services (CMS)

Measure ID	Data Source	Data Validation
CHIP 3.3 (CMS)	Statistical Enrollment Data System	Each State must assure that the information is accurate and correct when the information is submitted to SEDS by certifying that the information

Measure ID	Data Source	Data Validation
		shown on the CHIP forms is correct and in accordance with the State's child health plan as approved by the Secretary. CMS staff populates the data into various SEDS reports and verifies each of the enrollment measures. Each form has the following seven measures that are reported by service delivery system: 1: Unduplicated Number Ever Enrolled During the Quarter. 2: Unduplicated Number of New Enrollees in the Quarter. 3: Unduplicated Number of Disenrollees in the Quarter. 4: Number of Member-Months of Enrollment in the Quarter. 5: Average Number of Months of Enrollment (item 4 divided by item 1). 6: Number Enrolled At Quarter's End (point in time). 7: Unduplicated Number Ever Enrolled in the Year" (4th Quarter Only). CMS compares these enrollment measures to past quarters and trends over the life of each program to ensure that there aren't any anomalies in the data, and if apparent errors are detected, CMS corresponds with the State staff who are responsible for reporting enrollment statistics. If there are major increases or decreases, CMS investigates the causes of the changes in enrollment patterns.
MCD6 (CMS)	Developmental. The core set of measures required under CHIPRA was published in December 2009. CMS will initially use the automated web-based system - CHIP Annual Reporting Template System (CARTS) for the reporting of quality measures developed by the new program. This is the same system that was used for the CHIP Quality GPRA goal that was discontinued after FY 2010 (MCD2).	Developmental. CMS will monitor performance measurement data related to the core set of measures through CARTS.
MCD8 (CMS)	Developmental. For FY 2011 and FY 2012, the data source will be the links to the Federal Register. The link to the recommended core set is: http://federalregister.gov/a/2010-32978. The link to the published core set is http://federalregister.gov/a/2011-33756. By January 1, 2013, CMS will provide States with technical specifications for reporting information on the adult quality core measures set, coupled with technical assistance to increase the feasibility of reporting. Information voluntarily reported to CMS by early 2014, will serve as the data source for	Developmental. For FY 2011 and FY 2012, the data validation will be the link to the core set in the Federal Register. The link to the recommended core set is: http://federalregister.gov/a/2010-32978. The link to the published core set is http://federalregister.gov/a/2011-33756

Measure ID	Data Source	Data Validation
	assessing States' progress in reporting standardized adult quality measurement data to CMS.	
MCR1.1a (CMS)	The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in all Medicare Advantage plans and in the original Medicare fee-for-service plan.	The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 4.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.
MCR1.1b (CMS)	The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in the original Medicare fee-for-service plan and in all Medicare Advantage plans.	The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 4.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.
MCR22 (CMS)	The PFS rules and regulations; the Relative Value Scale Update Committee (RUC) database; relevant PFS utilization data available at the time of analysis.	In progress. We conduct a series of clinical review meetings to check the appropriate valuation of the codes identified as potentially misvalued.
MCR23 (CMS)	The Prescription Drug Event (PDE) data	CMS has a rigorous data quality program for ensuring the accuracy and reliability of the PDE data. The first phase in this process is on-line PDE editing. The purpose of on-line editing is to apply format rules, check for legal values, compare data in individual fields to other known information (such as beneficiary, plan, or drug characteristics) and evaluate logical consistency between multiple fields

Measure ID	Data Source	Data Validation
		reported on the same PDE. On-line editing also enforces business order logic which ensures only one PDE is active for each prescription drug event. The second phase of our data quality program occurs after PDE data has passed all initial on-line edits and is saved in our data repository. We conduct a variety of routine and ad hoc data analysis of saved PDEs to ensure data quality and payment accuracy.
MCR25 (CMS)	The Common Working File (CWF) will be the primary data source for this analysis; the claims will undergo final-action to be consistent with the data available in the Integrated Data Repository (IDR) database. The claims will be used to identify Annual Wellness Exams for Original Medicare beneficiaries, using HCPCS code G0438 for Part B FFS initial AWV claims as well as the HCPCS code G0439 for subsequent AWVs. The baseline will consist of the total number of beneficiaries receiving any AWV claim in 2011 (the first year of the benefit), and will help inform future target estimates. CMS will base future annual utilization goals on the number of unique beneficiaries receiving any AWV service as estimated in total by the end of the most recent calendar year.	The CWF contains claims that are submitted by providers to Medicare and are from Systems of Record or other authoritative data sources. AWV utilization rates for Part B beneficiaries will be calculated and compared to previous months' or years' data to check for any unusual changes in data values.
MCR26 (CMS)	Medicare claims data. The data used to calculate the performance measures are administrative claims data submitted by hospitals and Medicare Advantage plans. Administrative claims data is a validated data source and is the data source for public reporting of hospital readmission rates on the Hospital Compare website (www.hospitalcompare.hhs.gov). ; As stated on the Hospital Compare website, research conducted when the measures were being developed demonstrated that the administrative claims-based model performs well in predicting readmissions compared with models based on chart reviews.	The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. CMS uses national administrative inpatient hospital claims data to calculate the readmission rate measure. The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. Inpatient hospital claims information is assumed to be accurate and reliable as presented in the database.
MCR28.1 (CMS)	The CDC National Healthcare Safety Network	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
MCR28.2 (CMS)	The CDC National Healthcare Safety Network	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of

Measure ID	Data Source	Data Validation
		report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
MIP1 (CMS)	Comprehensive Error Rate Testing (CERT) Program.	The CERT program is monitored for compliance by CMS through monthly reports from the contractors. In addition, the OIG periodically conducts reviews of CERT and its contractors.
MIP5 (CMS)	The Part C Composite Error Rate is made up of two components: Medicare Advantage Prescription Drug (MARx) payment system error (MPE): The MPE measures errors in the system which issues payments to Medicare Advantage Plans. Source data come from CMS' monthly Beneficiary Payment Validation (BPV) analyses, which are employed by CMS to ensure the accuracy of the monthly Part C payments calculated by MARx. Risk Adjustment Payment Error (RAE) Estimate: The RAE measures errors in diagnostic data submitted by plans to Medicare. The diagnostic data is used to determine risk adjusted payments made to plans.	Data used to determine the Part C composite payment error rate is validated by several contractors. The Part C MPE estimate is based on data from CMS' monthly payment validation process, beneficiary payment validation (BPV), and is confirmed and analyzed by multiple contractors. The Part C RAE estimate is based on data obtained from a rigorous Risk Adjustment Data Validation process in which medical records are reviewed by two independent coding entities in the process of confirming discrepancies for a national random sample of beneficiaries.
MIP6 (CMS)	The components of payment error measurement in the Part D program are: A rate that measures payment errors in the system that issues payments to Part D plan sponsors. A rate(s) that measures payment errors related to low income subsidy (LIS) payments for beneficiaries dually-eligible for Medicare and Medicaid and non-duals also eligible for LIS status. A rate that measures payment errors due to errors in Prescription Drug Event (PDE) records. A rate that measures payment errors due to incorrect assignment of Medicaid status to beneficiaries who are not dually eligible for Medicare and Medicaid. A rate that measures payment errors due to errors in Direct and Indirect Remuneration (DIR) amounts reported by Part D sponsors to CMS.	For the Part D component payment error rates, the data to validate payments comes from multiple internal and external sources, including CMS' enrollment and payment files. Data are validated by several contractors. Data for the payment system error measure come from CMS' monthly Beneficiary Payment Validation (BPV) process, which is employed by CMS to ensure the accuracy of the monthly Part D payments calculated by the payment system; this data is confirmed and analyzed by several contractors. Data for the LIS payment error measure come from CMS' internal payment and enrollment files for all Part D plan beneficiaries. Data for the PDE error measure come from CMS' PDE Data Validation process, which validates PDE data through contractor review of supporting documentation submitted to CMS by a national sample of Part D plans. The data element for incorrect Medicaid status is

Measure ID	Data Source	Data Validation
		the PERM eligibility error rate, which is validated by the Medicaid program for the entire Medicaid population and is used by the Part D program as a proxy for incorrect Medicaid status. From the population of Part D beneficiaries who are eligible for Medicare and Medicaid, we randomly assign a subset, equal to the PERM rate, to be ineligible for Medicaid, resulting in payment error. Data for the DIR error measure come from audit findings for a national sample of Part D plans; the audits are conducted by contractors as part of the CMS Financial Audit process.
MIP8 (CMS)	Our predictive analytics work, using FPS, will focus on activities in the areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk-based approach increases contractors' efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud	FPS captures the link between each individual ASR and each subsequent administrative action. The FPS Dashboard and supporting systems will enable a seamless reporting of all data necessary to develop the baseline and to measure performance against any future targets.
MIP9.1 (CMS)	As part of a national contracting strategy, adjudicated claims data and medical policies are gathered from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS and our contractors are working with the 17 States to ensure that the Medicaid and CHIP universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews.
MIP9.2 (CMS)	As part of a national contracting strategy, adjudicated claims data and medical policies are gathered from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS and our contractors are working with the 17 States to ensure that the Medicaid and CHIP universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews.
MSC1 (CMS)	Nursing homes submit this information to the State Minimum Data Set database, which is linked to the national Minimum Data Set database.	The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self-reported by the nursing home. MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. Beginning in FY 2011, the data source is changed from MDS version 2.0 to MDS version 3.0. Beginning with the FY 2012 reporting

Measure ID	Data Source	Data Validation
		period, we are reporting the prevalence of pressure ulcers, stage 2 and greater, in high-risk long stay residents. The previous measure included pressure ulcers, stage 1 through stage 4 for all long stay nursing home residents.
PHI2 (CMS)	Current Population Survey Annual Social and Economic Supplement (CPS-ASEC) data	National Health Insurance Survey (NHIS) data
PHI4 (CMS)	Exchange IT System Metrics	Operational standard operating procedures will include audit and verification of system metric output.
QIO4 (CMS)	Baseline State-level performance rates calculated using self-reported and validated data abstracted from hospitals participating in the CMS Hospital Inpatient Quality Reporting (IQR) program.	The accuracy and reliability of data from the QIO Clinical Warehouse are monitored constantly through reabstraction of a sample of approximately 48 medical records per year by the CMS Data Abstraction Center (CDAC) for a random sample of 800 hospitals per year.
QIO5 (CMS)	Data is self reported by the dialysis facilities. Dialysis facilities submit directly to the 18 ESRD Networks who then submit directly to CMS through a file transfer.	Prior to monthly ESRD Network dashboard publishing, edit checks are programmed to ensure that only eligible facilities are reporting. A further check is conducted using a trend report comparing over 70% of all reported data with historical trends to ensure that missing case rates and case counts are in line with monthly annual trends.

Food and Drug Administration (FDA)

Measure ID	Data Source	Data Validation
212409 (FDA)	CDC/FoodNet	FoodNet Annual Reports are summaries of information collected through active surveillance of nine pathogens. A preliminary version of this report becomes available in the spring of each year and forms the basis of each year's Morbidity and Mortality Weekly Report (MMWR) FoodNet Surveillance. The FoodNet Final Report becomes available later in the year when current census information becomes available. The illness rates calculated for this Priority Goal use the same data and same methodology as the illness rates in the MMWR. CDC's FoodNet system reports pathogen-specific illness data based on the calendar year, not the fiscal year. Therefore, achievement of the annual targets reported here is evaluated based on the calendar year data, not fiscal year data.

Measure ID	Data Source	Data Validation
214305 (FDA)	Field Data Systems	These maximum capacities are extrapolated to estimate for times of emergency with the laboratory operating under abnormal conditions that are variable and uncertain. FDA and FERN work to maximize capabilities by continually improving methods and training along with increasing automated functionality and available cache of supplies. Through using these laboratories, with known instrumentation and methods, after examining the sample throughput during emergencies, and after consultation with the laboratories and FDA subject matter experts, the listed sample totals are the estimates reached. The surge capacity estimates provided in the performance measures for these laboratories have been examined under the stress of emergencies and outbreaks such as the melamine contamination, Deepwater Horizon oil spill, and the Japan nuclear event.
214306 (FDA)	BioPlex and ibis Biosensor systems	CFSAN scientists have developed the means to evaluate and adapt commercially available instruments to develop and validate more rapid, accurate, and transportable tests to stop the spread of foodborne illness and cases of chemical contamination. Using one such system, known as Bioplex, CFSAN scientists are using the device to rapidly serotype pathogens such Salmonella. The Bioplex system can serotype 48 different samples in 3 to 4 hours, which vastly improves response time in foodborne illness outbreaks. CFSAN scientists also are using the ibis Biosensor system to speed the identification of Salmonella, E. coli, and other pathogens, toxins, and chemical contaminants.
223205 (FDA)	Review performance monitoring is being done in terms of cohorts, e.g., FY 2009 cohort includes applications received from October 1, 2008, through September 30, 2009. CDER uses the Document Archiving, Reporting, and Regulatory Tracking System (DARRTS). FDA has a quality control process in place to ensure the reliability of the performance data in DARRTS.	The Document Archiving, Reporting, and Regulatory Tracking System (DARRTS) is CDER's enterprise-wide system for supporting premarket and postmarket regulatory activities. DARRTS is the core database upon which most mission-critical applications are dependent. The type of information tracked in DARRTS includes status, type of document, review assignments, status for all assigned reviewers, and other pertinent comments. CDER has in place a quality control process for ensuring the reliability of the performance data in DARRTS. Document room task leaders conduct one hundred percent daily quality control of all incoming data done by their IND and NDA technicians. Senior task leaders then conduct a random quality control check of the entered data in DARRTS. The task leader then validates that all data entered into DARRTS are

Measure ID	Data Source	Data Validation
		correct and crosschecks the information with the original document.
234101 (FDA)	CBER's Office of Vaccines Research and Review; and CBER's Emerging and Pandemic Threat Preparedness Office	The data are validated by the appropriate CBER offices and officials.
252202 (FDA)	CDRH Adverse Events Reports	FDA's adverse event reporting system's newest component is the Medical Device Surveillance Network (MedSun) program. MedSun is an initiative designed both to educate all health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events, medical errors and other problems to FDA and/or the manufacturer, and to ensure that new safety information is rapidly communicated to the medical community thereby improving patient care.
262401 (FDA)	NCTR Project Management System; peer-review through FDA/NCTR Science Advisory Board (SAB) and the NTP Scientific Board of Counselors; presentations at national and international scientific meetings; use of the predictive and knowledge-based systems by the FDA reviewers and other government regulators; and manuscripts prepared for publication in peer-reviewed journals.	NCTR provides peer-reviewed research that supports FDA's regulatory function. To accomplish this mission, it is incumbent upon NCTR to solicit feedback from its stakeholders and partners, which include FDA product centers, other government agencies, industry, and academia. The NCTR SAB —composed of non-government scientists from industry, academia, and consumer organizations, and subject matter experts representing all of the FDA product centers—is guided by a charter that requires an intensive review of each of the Center's scientific programs at least once every five years to ensure high quality programs and overall applicability to FDA's regulatory needs. Scientific and monetary collaborations include Interagency Agreements with other government agencies, Cooperative Research and Development Agreements that facilitate technology transfer with industry, and informal agreements with academic institutions. NCTR also uses an in-house strategy to ensure the high quality of its research and the accuracy of data collected. Research protocols are often developed collaboratively by principal investigators and scientists at FDA product centers and are developed according to a standardized process outlined in the "NCTR Protocol Handbook." NCTR's Project Management System tracks all planned and actual expenditures on each research project. The Quality Assurance Staff monitors experiments that fall within the Good Laboratory Practices (GLP) guidelines. NCTR's annual report of research accomplishments, goals, and publications is published and available on FDA.gov. Research findings

Measure ID	Data Source	Data Validation
		are published in peer-reviewed journals and presented at national and international scientific conferences.
280005 (FDA)	CTP's Tobacco Inspection Management System (TIMS) is a database that contains the tobacco retail inspection data submitted by state and territorial inspectors commissioned by FDA.	CTP/OCE has in place a process for ensuring the quality of the data in TIMS. OCE staff conduct random quality control checks of inspection data submitted for tobacco retail inspections where no violations were found. OCE staff conduct quality control checks for all tobacco retail inspections where potential violations were found.
293206 (FDA)	FDA Nanotechnology Task Force; National Nanotechnology Initiative (NNI); Science Board to the FDA; FDA staff presentations at public meetings; and manuscripts and other written materials for publication in peer-reviewed journals and other communication forums.	FDA will validate its efforts in promoting innovation and predictability in the development of safe and effective nanotechnology-based products by assessing outcomes and other progress in five areas related to nanotechnology including science, research, policy, communication, and planning. Information from several data sources and relevant FDA activities will provide measures in the five areas related to nanotechnology. Information will be gathered and documented from multiple data sources, which may include agency source data, agency guidance and other written materials, the NNI, cooperation and coordination with other regulatory agencies, public meetings, publications, and other areas.

Health Resources and Services Administration (HRSA)

Measure ID	Data Source	Data Validation
1.I.A.1 (HRSA)	HRSA Bureau of Primary Health Care's Uniform Data System	Validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norm.
1.I.A.3 (HRSA)	HRSA/Bureau of Primary Health Care contractors that perform PCMH surveys.	Data validated by Health Center program staff.
3.III.A.1 (HRSA)	Program research records	Validated by program staff and research presentations.
4.I.C.2 (HRSA)	HRSA Bureau of Clinician Recruitment Service's Management Information Support System (BMISS)	BMISS is internally managed with support from the NIH which provides: Data Management Services, Data Requests and Dissemination, Analytics, Data Governance and Quality, Project Planning and Requirements Development, Training, and Process Improvement.

Measure ID	Data Source	Data Validation
6.I.C.2 (HRSA)	Annual grantee data submitted through the Bureau of Health Profession's Performance Management System.	Data are entered through a web-based system that incorporates extensive validation checks. Once approved by the project officer (1st level of review), data are cleaned, validated, and analyzed by scientists within BHPr's Office of Performance Measurement (2nd level of review). Inconsistencies in data reported identified throughout the 2nd level of review are flagged and sent to the project officer for follow-up and correction.
6.I.C.3.a (HRSA)	Annual performance reports submitted by BHPr grantees through the BHPr Performance Management System.	Data are entered through a web-based system that incorporates extensive validation checks. Once approved by the project officer (1st level of review), data are cleaned, validated, and analyzed by scientists within BHPr's Office of Performance Measurement (2nd level of review). Inconsistencies in data reported identified throughout the 2nd level of review are flagged and sent to the project officer for follow-up and correction. Validated by project officers.
6.I.C.3.b (HRSA)	Annual performance reports submitted by BHPr grantees through the BHPr Performance Management System.	Data are entered through a web-based system that incorporates extensive validation checks. Once approved by the project officer (1st level of review), data are cleaned, validated, and analyzed by scientists within BHPr's Office of Performance Measurement (2nd level of review). Inconsistencies in data reported identified throughout the 2nd level of review are flagged and sent to the project officer for follow-up and correction.
6.I.C.3.c (HRSA)	Grantee reports submitted through HRSA's Electronic Hand Book.	Validated by project officers.
10.I.A.1 (HRSA)	The Title V Information System (TVIS) collects data on grantee performance from grantee annual reports.	TVIS allows each State to enter data on performance. TVIS provides preformatted and interactive data entry. Calculations are done automatically and the system performs immediate checks for errors. Data are validated by project officers and program staff.
10.I.A.2 (HRSA)	The Title V Information System (TVIS) collects data on grantee performance from grantee annual reports.	TVIS allows each State to enter data on performance. TVIS provides preformatted and interactive data entry. Calculations are done automatically and the system performs immediate checks for errors. Data are validated by project officers and program staff.
10.III.A.3 (HRSA)	Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and	Data are validated by CDC.

Measure ID	Data Source	Data Validation
	Prevention (CDC).	
16.E (HRSA)	ADAP Quarterly Report data provided by State ADAPs.	Web-based data checked through a series of internal consistency/validity checks. Also HIV/AIDS program staff review submitted Quarterly reports, and provide technical assistance on data-related issues.
16.I.A.1 (HRSA)	HRSA HIV/AIDS Bureau's Ryan White HIV/AIDS Program Services Report	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all CADR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.
16.II.A.2 (HRSA)	The Ryan White CARE Act Data Report (CADR) [now called The Ryan White HIV/AIDS Program Annual Data Report (RDR) and beginning January 2009 it will be called The Ryan White HIV/AIDS Program Services Report (RSR)] is completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers.	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all CADR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.
24.II.A.2 (HRSA)	Data are captured within the National Marrow Donor Program's computerized system, containing information pertaining to registered volunteer adult donors willing to donate blood stem cells to patients in need. Monthly reports generated from the computerized system to indicate the number of registered donors (broken down by self-reported race and ethnicity).	Validated by project officers analyzing comprehensive monthly reports broken down by recruitment organization. To decrease the likelihood of data entry errors, the program contractor utilizes value protected screens and optical scanning forms.
29.IV.A.3 (HRSA)	Reported by grantees through the Program's Performance Improvement Measurement System	Validated by project officers
36.II.B.1 (HRSA)	Family Planning Annual Report (FPAR). The FPAR consists of 14 tables in which grantees report data on user demographic characteristics, user social and economic characteristics, primary contraceptive use, utilization of family planning and related health services, utilization of health personnel, and the composition of project revenues. For this measure, FPAR Table 11: "Unduplicated number of Users Tested for Chlamydia by Age and Gender," is the data source.	The responsibility for the collection and tabulation of annual service data from Title X grantees rests with the Office of Population Affairs (OPA), which is responsible for the administration of the program. Reports are submitted annually on a calendar year basis (January 1 - December 31) to the regional offices. Grantee reports are tabulated and an annual report is prepared summarizing the regional and national data. The annual report describes the methodology used both in collection and tabulation of grantee reports, as well as the definitions provided by OPA to the grantees for use in completing data requests. Also included in the report are lengthy notes that provide detailed

Measure ID	Data Source	Data Validation
		information regarding any discrepancies between the OPA requested data and what individual grantees were able to provide. Data inconsistencies are first identified by the Regional Office and then submitted back to the grantee for correction. Additionally, discrepancies found by the contractor compiling the FPAR data submits these to the Office of Family Planning (OFP) FPAR data coordinator who works with the Regional Office to make corrections. All data inconsistencies and their resolution are noted in an appendix to the report. These are included for two reasons: (1) to explain how adjustments were made to the data, and how discrepancies affect the analysis, and (2) to identify the problems grantees have in collecting and reporting data, with the goal of improving the process.

Indian Health Service (IHS)

Measure ID	Data Source	Data Validation
2 (IHS)	Clinical Reporting System (CRS); yearly Diabetes care and outcome audit	Comparison of CRS and audit results; CRS software testing; quality assurance review of site submissions
18 (IHS)	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
20 (IHS)	IHS operated hospitals and clinics report the accrediting body, the length of accreditation, and other significant information about their accreditation status to the IHS Headquarters, Office of Resource Access and Partnerships, which maintains a List of Federal Facilities - Status of Accreditation.	The Joint Commission and AAAHC, non-governmental organization, maintain lists of certified and accredited facilities at their public websites. Visit the Joint Commission ;website at http://www.qualitycheck.org/CertificationList.aspx. Visit the Accreditation Association for Ambulatory Health Care at http://www.aaahc.org/eweb/dynamicpage.aspx?site=aaahc_site&webcode=find_orgs.
24 (IHS)	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions; Immunization program reviews
30 (IHS)	Clinical Reporting System(CRS)	CRS software testing; quality assurance review of site submissions
TOHP-SP (IHS)	Routine IHS Tribal consultation documentation for HHS consultation report and IHS Director's Activities database	Routine IHS Tribal consultation documentation for HHS consultation report and IHS Director's Activities database

Immediate Office of the Secretary (IOS)

Measure ID	Data Source	Data Validation
1.1 (IOS)	"Get Involved" website http://www.hhs.gov/open/getinvolved/index.html and HHS-sponsored challenges listed on the Challenge.Gov website at http://challenge.gov/HHS	Collection on annual basis and updates on Open.Gov; quarterly updates requests through HHS Innovation Council
1.2 (IOS)	www.healthdata.gov	Quarterly reports on data on Data.Gov submissions posted on HHS.Gov/Open
1.3 (IOS)	HHS Innovation Council Administrative records	Community of Practice Website (www.hhs.gov/open/opengovernmentplan/participation/strategic.html)

National Institutes of Health (NIH)

Measure ID	Data Source	Data Validation
CBRR-1.1 (NIH)	Doctorate Records File and the NIH IMPAC II database	"Analyses of career outcomes for predoctoral and postdoctoral NRSA participants, compared to individuals that did not receive NRSA support," using the Doctorate Records File and the NIH IMPAC II administrative database. Contact: Jennifer Sutton Program Policy and Evaluation Officer Office of Extramural Programs (301) 435-2686
CBRR-1.2 (NIH)	NIH IMPAC II database	"Analyses of career outcomes for postdoctoral NRSA participants, compared to individuals that did not receive NRSA support," using the NIH IMPAC II administrative database. Contact: Jennifer Sutton Program Policy and Evaluation Officer Office of Extramural Programs (301) 435-2686
CBRR-10 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an

Measure ID	Data Source	Data Validation
		article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Further information on Probe Reports from the NIH Molecular Libraries Program can be found here: http://www.ncbi.nlm.nih.gov/books/NBK47352/ Further information on the Molecular Libraries Program can be found here: http://commonfund.nih.gov/molecularlibraries/ Further information on the S1P1 compound in clinical development can be found here: http://www.receptos.com/clinical-development-RPC1063.php; http://www.receptos.com/pdfs/Receptos-102212.pdf Hanson MA, Roth CB, Jo E, Griffith MT, Scott FL, Reinhart G, Desale H, Clemons B, Cahalan SM,Schuerer SC, Sanna MG, Han GW, Kuhn P, Rosen H, Stevens RC. Crystal structure of a lipid G protein coupled receptor. Science. 2012 Feb 17;335 (6070):851-855. http://www.sciencemag.org/content/335/6070/851.full Calamini B, Silva MC, Madoux F, Hutt DM, Khanna S, Chalfant MA, Saldanha SA, Hodder P, Tait BD, Garza D, Balch WE, Morimoto RI. Small molecule proteostasis regulators for protein conformational diseases. Nature Chem Biol. 2011 Dec 25;8(2):185-196. http://www.nature.com/nchembio/journal/v8/n2/pdf/nchembio.763.pdf Luo T, Masson K, Jaffe JD, Silkworth W, Ross NT, Scherer CA, Scholl C, Fröhling S, Carr SA, Stern AM, Schreiber SL, Golub TR. STK33 kinase inhibitor BRD-8899 has no effect on KRAS-dependent cancer cell viability. Clinical Invest. 2012 Mar 1; 122(3):935-947. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3286931/?tool=pubmed
SRO-3.9 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are

Measure ID	Data Source	Data Validation
		articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. Data provided directly by intramural primary investigators. Contact NHGRI, Policy & Program Analysis Branch, Jonathan M Gitlin, Ph.D., 301-594-6593, gitlinjm@mail.nih.gov for more information.
SRO-5.13 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. Lock EF, Abdo N, Huang R, Xia M, Kosyk O, O'Shea SH, Zhou Y-H, Sedykh A, Tropsha A, Austin CP, Tice RR, Wright FA, Rusyn I. Quantitative high-throughput screening for chemical toxicity in a population-based in vitro model. Toxicological Sciences 2012; 126(2): 578-588. Sakamuru S, Li X, Attene-Ramos MS, Huang R, Lu J, Shou L, Shen M, Tice RR, Austin CP, Xia M. Application of a homogenous membrane potential assay to assess mitochondrial function. Physiol Genomics 2012; 44: 495-503. doi:10.1152/physiolgenomics.00161.2 011. Fox JT, Sakamuru S, Huang R, Teneva N, Simmons SO, Xia M,

Measure ID	Data Source	Data Validation
		Tice RR, Austin CP, Myung K. High-throughput genotoxicity assay identifies antioxidants as inducers of DNA damage response and cell death. Proc Natl Acad Sci 2012; 109: 5423-5428. doi/10.1073/pnas.1114278109. Shukla SJ, Huang R, Simmons SO, Tice RR, Witt KL, VanLeer D, Ramabhadran R, Austin CP, Xia M. Profiling environmental chemicals for activity in the antioxidant response element signaling pathway using a high-throughput screening approach. Environ Health Perspect 2012; 120: 1150-1156. dx.doi.org/10.1289/ehp.1104709.
SRO-6.4 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. Yurtsever, et. al. Journal of Biological Chemistry epub 2012. http://www.jbc.org/content/early/2012/10/30/jbc.M112.410282.full.pdf+html?sid=90f3ae6b-cda5-4313-aa8b-032dd216320c Huang, et al. PNAS, 109 (40) ,16354–16359. 2012 http://www.pnas.org/content/109/40/16354.full.pdf+html
SRO-8.7 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected.

Measure ID	Data Source	Data Validation
		Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. Saldana L and Chamberlain P. Supporting Implementation: The Role of Community Development Teams to Build Infrastructure. Am J Community Psychol. 2012 Mar 20. [Epub ahead of print] http://www.ncbi.nlm.nih.gov/pubmed/22430709 Epstein JN, et al. Use of an Internet Portal to Improve Community-Based Pediatric ADHD Care: A Cluster Randomized Trial. Pediatrics. 2011 Nov;128(5):e1201-8. doi: 10.1542/peds.2011-0872. Epub 2011 Oct 17. Fourtney J, et al. Implementation outcomes of evidence-based quality improvement for depression in VA community based outpatient clinics. Implement Sci. 2012 Apr 11;7:30.

Office of the Assistant Secretary for Health (OASH)

Measure ID	Data Source	Data Validation
1.4 (OASH)	The data sources are the Department of Treasury's Alcohol and Tobacco Tax and Trade Bureau (TTB), and the U.S. Census Bureau.	The goal is calculated using publicly available data from the Department of Treasury and the U.S. Census Bureau by the scientific and policy staff at CDC's Office of Smoking and Health.
6.1.5 (OASH)	OFRD web-based database	Project officer oversight and validation

Office of Medicare Hearings and Appeals (OMHA)

Measure ID	Data Source	Data Validation
1.1.1 (OMHA)	The Medicare Appeals System (MAS) is the sole appeals tracking and reporting system supporting Medicare Parts A, B, C, and D, Entitlement, and Income Related Monthly Adjustment Amount (IRMAA) appeals across Levels 2 and 3 of the appeals process. MAS allows users to track the processing of appeals electronically and facilitates the transfer of appeal data records throughout the various levels.	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included direction for development of a plan transitioning work from SSA to HHS. An element specifically included was "CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the Medicare program."[§931(a)(2)(E)]

Measure ID	Data Source	Data Validation
		The Medicare Appeals System (MAS) was developed in response to this and implemented with the opening of the new Office of Medicare Hearings and Appeals on July 1, 2005. MAS is the sole appeals tracking and reporting system supporting Medicare Parts A, B, C, and D, Entitlement, and Income Related Monthly Adjustment Amount (IRMAA) appeals across Levels 2 and 3 of the appeals process. MAS allows users to track the processing of appeals electronically and facilitates the transfer of appeal data records throughout the various levels. MAS is able to import scanned documents, produce reports for analysis, reporting, and workflow management, and ensure consistency of information across the levels of Medicare Appeal. Throughout the adjudication process, MAS provides workflow management through team-specific task sharing – allowing all adjudicatory team members access to information on tasks that have been completed and those yet to be accomplished. The entire adjudicatory process, from the initial request for hearing to the decision, is tracked in MAS. The system's data collection includes appeal request information, case file location, claims information, parties to the appeal, and appeal dispositions. Processing appeals using MAS improves timeliness, assists in meeting required processing deadlines, and minimizes paper utilization. In addition to supporting case processing and workload balancing, data derived from MAS has been used for replies to Congressional queries, the OIG audit of the OMHA program, appellant satisfaction surveys, and tracking performance measures.
1.1.5 (OMHA)	Appellate Climate Survey	The most recent version of the survey was administered by a third party contractor using a stratified random sample of appellants whose cases were closed within fiscal year 2012. The survey was designed to collect appellant: demographic information, overall satisfaction, satisfaction with hearing format, satisfaction with other aspects (e.g., scheduling, clarity of case processing documents, interaction with the ALJ team after the scheduling and prior to the hearing, and use of the OMHA website) and possible predictors of satisfaction (e.g., case fully heard and considered, ALJ behavior, etc).

Office of the National Coordinator for Health Information Technology (ONC)

Measure ID	Data Source	Data Validation
1.A.2 (ONC)	Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey, Electronic Medical Record Supplement	The NAMCS is nationally representative of office-based physicians. Historically, the response rate is approximately 68%. Beginning with survey year 2010, the survey allows ONC to evaluate trends in electronic health record adoption by region, provider specialty, and state. Estimates for FYs 2008-11 for this measure derive from the mail supplement to the NAMCS.
1.B.4 (ONC)	Centers for Medicare & Medicaid Services	CMS is making incentive payments to eligible providers based on information that providers input into a National Level Repository (NLR). Information from the NLR is also populated from other CMS systems, including the Provider Enrollment, Chain, and Ownership System (PECOS) and the National Plan and Provider Enumeration System (NPPES). CMS has put procedures in place to ensure the integrity of the Medicare and Medicaid EHR Incentive Programs payments and the quality of data in the NLR. The numerator for this measure is the total number of eligible professionals and hospitals that received incentive payments from either of the CMS EHR Incentive Programs during the fiscal year. The denominator is the total number of eligible health care professionals and hospitals that have successfully met program milestones. The numerator and denominator estimates are both provided in the impact analysis of the EHR Incentive Program stage I meaningful use rule that is available here: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

Substance Abuse & Mental Health Services Administration (SAMHSA)

Measure ID	Data Source	Data Validation
1.2.33 (SAMHSA)	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.4.09 (SAMHSA)	For CSAP, training contractors that contributed data include Border, CAPT, FASD, Prevention Fellows, NACE. Data are entered into the Performance Management Reporting and	All data are automatically checked as they are input to SAIS, TRAC, and PMARTS. Validation and verification checks are run on the data as they are being entered. The systems will not allow any data that are out of range or

Measure ID	Data Source	Data Validation
	Training System (PMRTS). For CSAT, Services Accountability and Improvement System (SAIS). For CMHS, TRAC on-line data reporting and collection system.	violate skip patterns to be saved into the database. Each of these science and service activities uses a quality control protocol for collecting and submitting its data and is overseen by SAMHSA staff. The data are then submitted to SAMHSA after automated cleaning software that processes initial types of errors, such as missing data and outliers. The data then go to the data management team who clean the data using established Uniform Coding Convention cleaning rules. Problems are communicated to and resolved a COTR and/or contractor, as needed, via the transmittal of "cleaning sheets". These data were then submitted to the analytic team for analysis and reporting.
2.3.21 (SAMHSA)	National Survey on Drug Use and Health State estimates	Performance results are based on state-level estimates obtained via the National Survey on Drug Use and Health (NSDUH). State estimates are entered by each SPF SIG grantee into the Prevention Management and Reporting Tool (PMRTS). Validation and verification checks are run on the data as they are being entered. Automated programs identify typical data errors such as missing data and outliers. Additionally, the data management team analyzes data to calculate annual performance results. Data are carefully cleaned using the pre-established Uniform Coding Conventions. Data abnormalities are communicated to the GPOs and grantees via cleaning sheets for explanation or correction. The data management team responsible for this data assures that required fields are complete and that all edits are made. The SPFSIG cross site evaluation team performs analyses and generates reports annually and on an ad hoc basis as needed. Information about methodology for the NSDUH is available at http://www.samhsa.gov/data/Methodological_Reports.aspx
2.3.61 (SAMHSA)	The number of calls answered is reported in the National Suicide Prevention LifeLine Monthly Report	Specialists in information technology at the National Suicide Prevention LifeLine evaluation center validate phone records received from Sprint to determine the number of calls received and answered at 1-800-273-TALK.
3.2.02a (SAMHSA)	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into the TRAC system. Validation and verification checks are run as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the TRAC database.
3.2.26	TRAC on-line data reporting and collection	All TRAC data are automatically checked as they are input

Measure ID	Data Source	Data Validation
(SAMHSA)	system.	into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.2.30 (SAMHSA)	Data on children's outcomes were reported in the grantees' ED524 Bi-Annual Report submitted to their GPO every six months. The methods for collecting these measures varied by grantee, but were generally student self-report for the violence and substance use measures and school records for attendance and mental health services.	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things.
3.4.02 (SAMHSA)	Data are collected through standard instruments and submitted through the TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.4.20 (SAMHSA)	Data are submitted annually to SAMHSA by States, which obtain the information from local human service agencies that provide services.	SAMHSA's CMHS has developed additional error checks to screen data and contacts States and local providers concerning accuracy when data is reported outside expected ranges. CMHS has also issued guidance to all States and localities on data collection and monitors compliance with data collection through increased site visits to local PATH-funded agencies.
3.4.21 (SAMHSA)	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation).	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews.
3.4.25 (SAMHSA)	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.