# U.S. Department of Health and Human Services
# FY 2022 Annual Performance Plan and Report

## Message from the HHS Performance Improvement Officer

The U.S. Department of Health and Human Services (HHS) supports and implements programs that enhance the health, safety, and well-being of the American people. The scope of HHS's work to ensure the health and safety of our nation has never been more evident than in the central role HHS has played in the government-wide response to the COVID-19 pandemic. HHS has mobilized resources across the Department to address the full scope of this once in a century event.

In accordance with the Government Performance and Results Act (GPRA) of 1993, as amended in the GPRA Modernization Act (GPRAMA) of 2010, I am pleased to present the Fiscal Year 2022 Annual Performance Plan and Report, documenting the Department's performance during the past year. Further information detailing HHS performance is available at Performance.gov.

The previous administration established the HHS Strategic Plan FY 2018–2022 with a set of strategic priorities that began in FY 2018. HHS is currently developing the HHS Strategic Plan FY 2022-2026. In FY 2020, HHS monitored over 900 performance measures to manage departmental programs and activities and improve the efficiency and effectiveness of these programs. As required by GPRAMA, this report includes a representative set of performance measures to illustrate progress toward achieving the Department's strategic goals in the HHS Strategic Plan FY 2018-2022 established by the previous administration. The information in this report spans the Department's 11 operating divisions and 14 staff divisions and includes work done across the country and throughout the world. Each HHS division has reviewed its submission and I confirm, based on certifications from the divisions, that the data are reliable and complete. When results are not available because of delays in data collection, the report notes the date when the results will be available. Where known, impacts of the COVID-19 pandemic on HHS performance results are also identified in this report. As additional data becomes available, HHS will continue to update the information on those impacts in future reports. The results presented here demonstrate that HHS is performing well across a wide range of activities.

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U.S. Department of Health and Human Services

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## Overview

The U.S. Department of Health and Human Services (HHS) is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services. Operating Divisions (OpDivs), including agencies in the U.S. Public Health Service and human service agencies, administer HHS programs. Staff Divisions (StaffDivs) provide leadership, direction, and policy and management guidance to the Department.

The scope of HHS's work to ensure the health and safety of our nation has never been more evident than in the central role HHS has played in the government-wide response to the COVID-19 pandemic. HHS has mobilized resources across the Department to address the full scope of this once-in-a-century event, including deploying medical personnel to staff field hospitals and care for those afflicted with the virus; providing financial support and distributing equipment such as ventilators, respirators, surgical masks, and gloves to our hospitals and health care providers; purchasing and ensuring domestic prioritization of supplies to help states increase testing; investing in research to develop vaccines and therapeutics; and supporting human service needs such as child care and meals for older adults. HHS will continue to work with our partners both inside and outside the Federal government to address this public health emergency and apply lessons learned from the pandemic to ensure readiness for future threats.

Through its programming and other activities, HHS works closely with state, local, and U.S. territorial governments. The Federal Government has a unique legal and political government-to-government relationship with tribal governments and provides health services for American Indians and Alaska Natives consistent with this special relationship. HHS works with tribal governments, urban Indian organizations, and other tribal organizations to facilitate greater consultation and coordination between state and tribal governments on health and human services.

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

## Mission Statement

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

## HHS Organizational Structure

The Department includes 11 OpDivs that administer HHS programs:

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

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

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

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

## Cross-Agency Priority Goals

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

## Agency Priority Goals

The HHS FY 2020-2021 Agency Priority Goals (APGs) were established by the previous administration and supported multiple objectives across the HHS Strategic Plan. For presentation purposes, the

Department has chosen to display these APGs under their most closely aligned strategic objectives. HHS is currently developing the FY 2022-2023 APGs, which will be reported in the FY 2023 Annual Performance Plan and Report.

## Strategic Goals Overview

In the previous administration, the Department developed the HHS Strategic Plan FY 2018-2022. The HHS Strategic Plan FY 2018-2022 identifies 5 strategic goals and 20 strategic objectives. The full HHS Strategic Plan FY 2018-2022 is located at https://www.hhs.gov/about/strategic-plan/index.html. The five strategic goals are:

Goal 1: Reform, Strengthen, and Modernize the Nation's Health Care System.
Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play.
Goal 3: Strengthen the Economic and Social Well-Being of Americans across the Lifespan.
Goal 4: Foster Sound, Sustained Advances in the Sciences.
Goal 5: Promote Effective and Efficient Management and Stewardship.

HHS is currently developing the HHS Strategic Plan FY 2022-2026. The strategic goals and strategic objectives will be included in the FY 2023 Annual Performance Plan and Report.

## Performance Management

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

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

## Strategic Review

GPRAMA aligned agency strategic planning cycles to presidential election cycles and administrative transitions. As a result, the previous administration established HHS's FY 2018–2022 Strategic Plan with a set of strategic priorities that began in FY 2018. As HHS sets its new priorities for FY 2022-2026 and begins the development of a new strategic plan, the objectives contained in the HHS Strategic Plan FY 2018-2022 are all assessed and categorized as Progressing. HHS is using its FY 2020 Strategic Review process to inform goals and plans for the future.

## Annual Performance Plan and Report

The Annual Performance Plan and Report provides information on the Department's progress towards achieving the goals and objectives described in the HHS Strategic Plan. HHS is currently developing the Strategic Plan for FY 2022-2026 that will align with the Administration and the Department's priorities. The measures related to the HHS Strategic Plan FY 2022-2026 will be reported in the FY 2023 Annual Performance Plan and Report. As required by GRPAMA and OMB Circular A-11, the organization of this FY 2022 report instead aligns with the HHS Strategic Plan FY 2018-2022 established by the previous administration and the information in this report reflects results available as of April 2021. The COVID-19 pandemic is impacting HHS programs in a variety of ways, and in some cases those impacts are still evolving given the dynamic nature of the situation. The pandemic may impact the ability of some HHS programs to achieve projected targets, or result in the need to revise targets in future years. Where known, impacts of the COVID-19 pandemic on HHS performance results are identified in the sections below. As additional data becomes available, HHS will continue to update information on those impacts in future reports.

## Goal 1. Objective 1: Promote affordable health care, while balancing spending on premiums, deductibles, and out-of-pocket costs

Affordability is a key component of accessible health care. For individuals and families, high costs of care create economic strain. Americans often have to choose between spending a higher proportion of wages on health care and paying for other household essentials. Without timely access to health care services, Americans risk worsening health care outcomes and higher costs. Yet for many, costs make health care out of reach.

HHS is committed to lowering health care costs for Americans to affordable levels and minimizing the burden of government health care spending. By increasing consumer information, offering lower-cost options and innovation in payment and service delivery models, and promoting preventive care and market competition, HHS is working with its partners to reduce the burden of higher health care costs.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, CMS, and FDA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 1.1 Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 50.0% | 48.0% | 43.0% | 37.0% | 28.0% | 25% | 25% | 25% |
| **Result** | 49.0% | 48.0% | 42.0% | 36.7% | 27% | 4/30/22 | 4/30/23 | 4/30/24 |
| **Status** | Target Exceeded | Target Met | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending | Pending |

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

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit did Medicare coverage recommence. This is known as the coverage gap (or "donut hole"). The Affordable Care Act began closing the coverage gap through a combination of manufacturer discounts and gradually increasing federal subsidies until it closed in 2020. The discount applies at the point of sale, and both the beneficiary cost sharing and the manufacturer discounts count toward the annual out-of-pocket threshold (known as True Out-of-Pocket Costs). This performance measure reflects CMS's effort to reduce the average out-of-pocket costs paid by non-Low Income Subsidy Medicare beneficiaries while in the coverage gap, reached once the combined amount a beneficiary and their drug plan pay for

prescription drugs reaches a certain level. For 2020 and beyond, this means that non-LIS beneficiaries, who reach this phase of Medicare Part D coverage will pay no more than 25 percent of costs for all covered Part D drugs. For 2021, beneficiaries reach this phase when total drug costs amount to $4,130 and stay in this phase until they pay $6,550 in qualified out-of-pocket costs. CMS's tracking of this measure has shown that that in most years non-LIS out-of-pocket costs have decreased beyond the targets required by statute (2019 exceeded the target goal).

***Increase the percentage of Medicare health care dollars tied to Alternate Payment Models incorporating downside risk (Lead Agency CMS; Measure ID - MCR36)[1]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | 30% | 40% | TBD |
| **Result** | N/A | N/A | N/A | N/A | 12/15/20 | 12/15/21 | 12/15/22 | TBD |
| **Status** | N/A | N/A | N/A | N/A | 20.21% | Pending | Pending | Pending |

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

Medicare is leading the way by publicly announcing, tracking, and reporting payments tied to APMs that are taking on a downside risk, while working through the Health Care Payment Learning and Action Network (HCP-LAN or LAN) to ensure that its large group of papers, providers, purchasers, patients, product manufacturers, and policymakers across the United States also adopt aligned goals to move towards downside risk APMs. The final CY 2019 baseline for this new downside risk APM goal is 20.21 percent.

[1] CMS is reporting the FY 2022 target and result availability date as "to be determined" (TBD) due to the unknown impacts of the Coronavirus (COVID-19) pandemic. CMS cannot commit to specific future results date at this time.

## Goal 1. Objective 2: Expand safe, high-quality health care options, and encourage innovation and competition

Strengthening the nation's health care system is not achievable without improving health care quality and safety for all Americans. The immediate consequences of poor quality and safety include health care-associated infections, adverse drug events, and antibiotic resistance.

Health care safety is a national priority. HHS investments in prevention have yielded both human and economic benefits. From 2010 to 2014, efforts to reduce hospital-acquired conditions and infections resulted in a decrease of 17 percent nationally, which translates to 87,000 lives saved, $19.8 billion in unnecessary health costs averted, and 2.1 million instances of harm avoided.[2]

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, AHRQ, CDC, CMS, HRSA, OCR, ONC, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 1.2 Table of Related Performance Measures

***Reduce all-cause hospital readmission rate for Medicare-Medicaid Enrollees (Lead Agency - CMS; Measure ID - MMB2)***

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Prior Result -1.0% | Prior Result -1.0% | Prior Result - 0.5% | Prior Result - 0.25% | Prior Result -0.25% |
| **Result** | 84.0% | 83.7% | 84.5% | 83.7% | 84.6% | 4/30/22 | 4/30/23 | 4/30/24 |
| **Status** | Actual | Actual | Actual | Target Not Met | Target Not Met | Pending | Pending | Pending |

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. Discharge from a hospital is a critical transition point in a patient's care; incomplete handoffs at discharge can lead to adverse events for patients and avoidable readmissions. Hospital readmissions may indicate poor care, missed opportunities to better coordinate care, and result in unnecessary costs.

While many studies have pointed to opportunities for improving hospital readmission rates, the rate of readmissions for individuals who are dually eligible for both Medicare and Medicaid (also referred to as Medicare-Medicaid Enrollees) is often higher than for Medicare beneficiaries overall. In 2019, an estimated 12.3 million beneficiaries were dually eligible for Medicare and Medicaid.

CMS calculates this measure using the number of readmissions per 1,000 eligible beneficiaries. Eligible beneficiaries are dually eligible individuals of any age. CMS found an increase in the readmissions rate from 2018 to 2019 of 1.07 percent. CMS continues to believe the experience from 2015 to 2019

[2] https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2014-final.html

demonstrates a similar "plateauing" of readmissions around 84.0 per 1,000 rate. Therefore, CMS is maintaining the target reduction for CY 2022 of 0.25 percent in the future based on this measure's apparent plateau and national trends (https://www.hcup-us.ahrq.gov/reports/statbriefs/sb248-Hospital-Readmissions-2010-2016.pdf) reflecting a slowing in readmissions reductions for all Medicare beneficiaries (after a number of years of larger declines).

CMS will continue to implement programs and innovations aimed at incentivizing a reduction in Medicare fee-for-service hospital readmissions:

- The Medicare-Medicaid Financial Alignment Initiative managed fee-for-service demonstration in Washington State, which focuses on improving care coordination for high-risk dually eligible beneficiaries and holds the state accountable for readmission and associated costs;
- The Medicare Hospital Readmissions Reduction Program (HRRP) assesses a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits; and
- The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) program rewards incentive payments based on hospital readmissions.
- Accountable care organizations, including the Medicare Shared Savings Program (MSSP).

An array of CMS Innovation Center models with financial incentives to reduce utilization and readmissions, including Bundled Payments Care Improvement (BPCI) initiative, the Next Generation ACO model, and Primary Care First.

***Improve hospital patient safety by reducing preventable patient harms (Lead Agency – CMS; Measure ID – QIO11)[3,,4]***

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | 86 harms | 82 harms | 78 harms | TBD | TBD | Discontinued |
| **Result** | 92 harms | 88 harms | 86 harms | N/A | N/A | N/A | N/A | N/A |
| **Status** | Actual | Actual | Met | Data Unavailable | Data Unavailable | Data Unavailable | Data Unavailable | N/A |

The purpose of this measure is to determine the national impact of patient safety efforts by counting the number of preventable patient harms that take place per 1,000 inpatient discharges. Preventable harms can cause additional pain, stress, and costs to the patient and their family during intended treatment and increase spending on the part of payers. This measure utilizes the AHRQ National Scorecard, which includes abstraction from a nationally representative sample of approximately 20,000 hospital charts per year that yields clinical relevant yet highly standardized national hospital safety metrics. This represents an enormous contribution to the government's ability to measure, monitor, and improve patient safety at a national scale. As a composite of many different harms, the AHRQ

[3] Data are preliminary based on partial data from this calendar year combined with data from prior years to fill gaps. The estimates are subject to change after all data from this calendar year are available and all quality control procedures have been completed.
[4] Examples of some of the preventable patient harms included in this measure are: adverse drug events, catheter-associated urinary tract infections, central line-associated bloodstream infections, falls, pressure ulcers, surgical site infections, ventilator-associated pneumonia/events, venous thromboembolism, and hospital readmissions.

National Score Card also includes data from the CDC's National Healthcare Safety Network and AHRQ's Healthcare Cost and Utilization Project databases.

Beginning in FY 2018, CMS lists the result as "data unavailable" due to analytic issues surrounding the preliminary 2018 all cause harm metrics. Due to the inability to collect, track, and report on data in accordance to the specified methodology as well as inconsistencies in availability of patient charts due to COVID-19, CMS will discontinue reporting on this measure. Ensuring patient safety continues to be a CMS priority.

***Reduce the standardized infection ratio (SIR) central line-associated bloodstream infection (CLABSI) in acute care hospitals (Lead Agency - CDC; Measure ID - 3.3.3)*** [5,6]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | Baseline | 0.90 | 0.80 | 0.70 | 0.63 | .50 | .45 | .40 |
| **Result** | 1.0 | 0.89 | 0.81 | 0.74 | 0.69 | 11/30/21 | 11/30/22 | 11/30/23 |
| **Status** | Actual | Target Exceeded | Target Not Met but Improved | Target Not Met but Improved | Target Not Met but Improved | Pending | Pending | Pending |

Reducing health care-associated Infections (HAIs) across all health care settings supports the HHS mission to prevent infections and their complications as well as reduce excess health care costs in the United States. These efforts also align with the National Action Plan to Prevent Health Care Associated Infections: Roadmap to Elimination (National HAI Action Plan),[7] National Action Plan for Combatting Antibiotic Resistance Bacteria (CARB), and Healthy People 2030 Goals.

CDC did not meet its FY 2019 target for reducing the CLABSI SIR, but the result of 0.69 represents a 31 percent decrease from the 2015 baseline, showing continued progress in reducing the ratio. Similar to previous years, infection decreases were more pronounced in certain areas, like neonatal intensive care units, than in hospital wards and other ICUs. As more infections are prevented, it becomes more difficult to prevent remaining infections using existing technologies and techniques and prevention efforts begin to plateau. For infections that CDC has optimal prevention approaches for, CDC has prevented and continues to prevent many, though not all, of these CLABSIs. A greater proportion of remaining CLABSIs are less likely due to issues with central line insertion as when CDC started preventing CLABSIs on a national scale two decades ago. More CLABSIs are now likely due to catheter maintenance practices. Interventions to prevent these types of CLABSIs are more challenging to implement and have a less definable impact on rates. Additionally, it becomes more difficult to develop and refine performance measures to provide an accurate picture of performance overtime. As previously mentioned, the current performance is based on revised baselines computed in 2015, which followed substantial decreases from 2008.

CDC is on track to meet other 2020 National HAI Action Plan targets. Going forward, CDC will continue to monitor HAIs and to develop strategies to support continued progress on action plan goals.

[5] The baseline for this measure was updated in FY 2015 and will affect future targets and data reporting for FY 2016 onward.
[6] CDC uses a standardized infection ratio (SIR), the ratio of the observed number of infections to the number of predicted infections, to measure progress in reducing HAIs compared to the baseline period (FY 2015). In 2015, CDC developed a new baseline for all HAIs including CLABSI to better assess national and local prevention progress and identify gaps for tailored prevention.
[7] https://health.gov/hcq/prevent-hai-action-plan.asp

***Reduce standardized infection ratio for hospital-onset Clostridioides difficile infections (Lead Agency - CDC; Measure ID - 3.2.4b)*** [8]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | Baseline | 0.84 | 0.76 | 0.75 | 0.70 | .70 | .60 | .50 |
| **Result** | 1.00 | 0.92 | 0.80 | 0.71 | 0.58 | 3/31/21 | 3/31/22 | 3/31/23 |
| **Status** | Actual | Target Not Met but Improved | Target Not Met but Improved | Target Exceeded | Target Exceeded | Pending | Pending | Pending |

Clostridioides difficile infection (CDI)[9] is a preventable, life-threatening bacterial infection that can occur in both inpatient and outpatient health care settings. CDC provides data-driven strategies and tools for targeted intervention to the health care community to help prevent CDI, as well as resources to help the public safeguard its own health. CDI prevention is a national priority, with a 2020 target to reduce CDI by 50 percent in the National Action Plan for CARB and to reduce hospital-onset CDI by 30 percent in the current National HAI Action Plan. In FY 2019, the SIR for hospital-onset CDI was 0.58 (Measure 3.2.4b), exceeding not just the 2019 target, but also surpassing the 2020 HAI Action Plan CDI goal. CDC is also on track to meet the 2020 National Action Plan for CARB target for CDI.

[8] CDC rebaselined measure 3.2.4b in 2015, and subsequent targets were adjusted to align to changes in the current HHS HAI Action Plan.
[9] https://www.nejm.org/doi/full/10.1056/NEJMoa1408913

## Goal 1. Objective 3: Improve Americans' access to health care and expand choices of care and service options

Accessing health services involves gaining entry into the health care system, usually through payment; gaining access to diverse options for receiving treatment, services, and products, including physical locations and online options; and having a trusted relationship with a health care provider. Efforts to improve access to care are not limited to physical health care. Improving access to behavioral and oral health care, including through innovative solutions that use health information technology, also is critical, especially for populations experiencing disparities in access. HHS has removed regulatory barriers, created incentives for increased access to newly developed drugs and devices, expanded patient access and choice through Health Reimbursement Arrangements, and launched the Rural Health Strategy to improve access to care in Medicare and Medicaid. To improve outcomes in this objective, HHS continues to address the high cost of care, lack of availability of services, and lack of culturally competent care.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, CMS, HRSA, IHS, OCR, OGA, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 1.3 Table of Related Performance Measures

***Increase tele-behavioral health encounters nationally among American Indians and Alaska Natives (Lead Agency - IHS; Measure ID - MH-1)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 8,600 | 8,901 | 10,359 | 11,600 | 13,600 | 21,860 | 46,000 | 48,000 |
| **Result** | 9,773 | 10,388 | 12,212 | 13,204 | 17,933 | 60,696 | 12/31/21 | 12/31/22 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending |

Telehealth services have proven effective in providing access to care where there are provider shortages or other barriers to care. The integration of behavioral health services through a telehealth option will increase tele-behavioral health encounters nationally among American Indians and Alaska Natives (AI/AN). Expanding tele-behavioral health service delivery will increase access to specialty care such as child psychiatry and addiction psychiatry. Historical results show the increasing demand for these services as the measure consistently exceeded targets. Due to the COVID-19 pandemic, and flexibilities offered through the emergency act waivers, IHS increased efforts to expand access to telehealth by immediately offering technical assistance support to behavioral health clinics as they transitioned from office-based visits to tele-behavioral health visits. With the expansion of telehealth services during the COVID-19 response, IHS accelerated efforts to increase the number of tele-behavioral health visits and accurately capture visits. The FY 2020 result of 60,696 encounters reflects these efforts and the extraordinary circumstances and response to the COVID-19 pandemic. In FY 2022, the 48,000 tele-behavioral health encounters target is based on an anticipated encounter increase as facilities continue to modify operations to support tele-behavioral health visits in addition to office-based visits. In FY 2021 and FY 2022, IHS will continue to expand access to care for tele-behavioral health services.

## Goal 1. Objective 4: Strengthen and expand the health care workforce to meet America's diverse needs

Whether people access health care in a doctor's office, in a health center, in a pharmacy, at home, or through a mobile device, they depend on a qualified, competent, responsive workforce to deliver high-quality care. HHS regularly produces reports projecting growth or deficits in the supply and demand of various occupations in the health care workforce. At a national level, by 2025, demand is expected to exceed supply for several critical health professions, including primary care practitioners, geriatricians, dentists, and behavioral health providers, including psychiatrists, mental health and substance abuse social workers, mental health and substance use disorder counselors, and marriage and family therapists. At a state level, the picture is more complex, with some states projected to experience greater deficits in certain health care occupations. For example, rural areas experience greater shortages in the oral and behavioral health workforces. HHS works in close partnership with academic institutions, advisory committees, research centers, and primary care offices. These collaborations help HHS make informed decisions on policy and program planning to strengthen and expand the workforce.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: CDC, CMS, HRSA, IHS, OCR, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 1.4 Table of Related Performance Measures

***Support field strength (participants in service) of the National Health Service Corps (NHSC) (Lead Agency - HRSA; Measure ID - 4.I.C.2)[10]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 8,495 | 9,153 | 9,219 | 8,705 | 11,410 | 13,700 | 14,338 | 15,187 |
| **Result** | 9,683 | 10,493 | 10,179 | 10,939 | 13,053 | 16,229 | 12/31/21 | 12/31/22 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending |

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 NHSC field strength indicates the number of providers actively serving with the NHSC in underserved areas in exchange for scholarship or loan repayment support.

As of September 30, 2020, 16,229 primary care medical, dental, and mental and behavioral health practitioners were providing service nationwide through the following programs: NHSC Scholarship Program, NHSC Loan Repayment Program, NHSC Students to Service Loan Repayment Program, and the State Loan Repayment Program. These programs collectively serve the immediate needs of underserved communities and support the development and maintenance of a pipeline of health care

[10] Field disciplines include: allopathic/osteopathic physicians, dentists, dental hygienists, nurse practitioners, physician assistants, nurse midwives, mental and behavioral health professionals, and clinicians

providers capable of meeting the needs of these communities in the future. Despite the effects of COVID-19 in FY 2020, HRSA anticipates an increase in participation in the NHSC due to additional funding through the American Rescue Plan Act (ARP). In FY 2021 and FY 2022, NHSC will continue to assist students through scholarships and loan repayments and professionals through loan repayment awards as incentives to practice in underserved communities.

## Goal 2. Objective 1: Empower people to make informed choices for healthier living

Health promotion and wellness activities involve providing information and education to motivate individuals, families, and communities to adopt healthy behaviors, which ultimately can improve overall public health. However, the lack of access to and understanding of health information can lead people to make uninformed decisions and engage in risky behavior. The Department supports a series of programs and initiatives aimed at improving nutrition; increasing physical activity; reducing environmental hazards; increasing access to preventive services; and reducing the use of tobacco, alcohol, and illicit drugs and prescription drug abuse. HHS achieves these outcomes through culturally competent and linguistically appropriate health education, services, and supports made possible through strategic partnerships.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, ATSDR, CDC, FDA, HRSA, IHS, NIH, OASH, OCR, OGA, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 2.1 Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | 1,145 | 1,128 | 967 | 903 | 838 | 817 | 755 |
| **Result** | 1,211 | 1,164 | 1,114 | 1,061 | 1,004 | 7/31/21 | 7/31/22 | 7/31/23 |
| **Status** | Actual | Target Not Met but Improved | Target Exceeded | Target Not Met but Improved | Target Not Met but Improved | Pending | Pending | Pending |

Although cigarette smoking remains the leading cause of tobacco-related disease, tobacco users are increasingly shifting consumption to other tobacco products and dual use with other combusted tobacco, which include cigars, cigarillos and little cigars, pipe tobacco, roll-your-own tobacco, and hookah. This has resulted in a slowing of the decline in the consumption of all combustible tobacco, and indicates that the use of non-cigarette combustible products has become more common in recent years and that some smokers may be switching to other combustible tobacco products rather than quitting smoking cigarettes completely. Per capita combustible tobacco product consumption continued to decline from 1,061 cigarette equivalents in FY 2018 to 1,004 cigarette equivalents in FY 2019, nearly reaching the FY 2019 target.

To address these challenges and continue improving performance, recipients of CDC's National Tobacco Control Program (NTCP) cooperative agreement will focus on statewide prevention efforts to support the achievement of the four NTCP goals: 1) Prevent initiation of commercial tobacco use among youth and young adults; 2) Eliminate exposure to secondhand smoke (SHS); 3) Promote quitting among adults and youth; and 4) Identify and eliminate tobacco-related disparities. Achievement of these goals will reduce chronic disease morbidity, mortality, and disability related to commercial tobacco use and dependence and SHS exposure in the United States. Additionally, in January 2020, in coordination with

the Office of the Surgeon General, CDC's released *Smoking Cessation: A Report of the Surgeon General* – the 34th tobacco-related Surgeon General's report published since 1964.

The 2020 report is the first Surgeon General's Report to focus on cessation in over 30 years. The 2020 report summarizes the latest science on individual, health system, and population-based interventions proven to help people quit smoking. CDC developed a variety of communication products to promote the findings of the report to a variety of stakeholders, including consumers, health care professionals, and partners. Moreover, the 2020 *Tips from Former Smokers*® (*Tips*®) aired a new round of hard-hitting ads which will run for 28 consecutive weeks. CDC also continued the successful nationwide *Tips*® TV promotion offering free nicotine replacement therapy to eligible 1-800-QUIT-NOW callers. Population-based strategies, including mass-reach public education campaigns like CDC's *Tips*® campaign, are a proven way to promote tobacco cessation treatments and increase utilization. In FY 2021 and FY 2022, CDC will continue to monitor combustible tobacco consumption to inform its strategies on reducing tobacco-related disease.

***Reduce the age-adjusted proportion of adults (age 20 years and older) who are obese (Lead Agency - CDC; Measure ID - 4.11.10a)[11,12]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | 33.2% | N/A | 33% | N/A | 32.3% | N/A | 32.3% |
| **Result** | N/A | 39.6% | N/A | 42.4% | N/A | 5/30/22 | N/A | 5/30/24 |
| **Status** | N/A | Target Not Met | N/A | Target Not Met | N/A | Pending | N/A | Pending |

In adults, National Health and Nutrition Examination Survey (NHANES) data show 42.4 percent of adults were obese in 2017-2018, which is above the target of 33 percent. Some community factors that affect diet and physical activity include the affordability and availability of healthy food options, peer and social supports, marketing and promotion, and policies that determine whether a community is designed to support healthy food access and physical activity.

CDC will continue work to improve overall health and wellbeing of all people, including those most impacted by risk factors for obesity and other chronic disease across the lifespan. This approach begins with preventing and managing obesity risk in children, which has the potential to impact adult obesity in the long term. CDC focuses on increasing breastfeeding support; promoting the introduction and availability of healthy, affordable foods; and creating safe, easily accessible places where children can be physically active. CDC also works with national, state, territorial, tribal, and community partners to increase the availability of healthy, affordable foods in worksite and community retail; create safe, easily accessible places where people can be physically active in urban and rural communities; and ensure that health care settings help adults with obesity and other chronic diseases manage their conditions.

Adult obesity rates have been on the rise since 1999-2000. The proportion of adults (aged 20 years and older) who have obesity increased from 30.5 percent in 1999-2000 to 42.4 percent in 2017-2018. Disparities exist by race/ethnicity, age, sex, education, and income level. Obesity is a complex health issue resulting from a combination of causes including individual and environmental factors. Individual

[11] Data for this measure are collected and reported every other year.
[12] There was a delay in publication of CDC's NHANES data, and FY 2018 results will not be available until spring 2020. CDC anticipates that subsequent NHANES data may also be delayed and has adjusted the reporting dates.

behaviors such as unhealthy diet and lack of physical activity contribute to obesity, and environmental factors can make it easier or harder to make these behaviors changes. Many states and communities do not have supports in place that encourage healthy eating and active living. These supports require societal will to establish healthier standards so all adults have access to healthy foods and opportunities to be physically active where they live, learn, work, and play.

In FY 2021 and FY 2022 CDC will continue to support recipients in implementing evidence-based strategies to help increase healthy eating and active living through partnerships with states, territories, tribes, and communities throughout the United States.

## Goal 2. Objective 2: Prevent, treat, and control communicable diseases and chronic conditions

Communicable diseases and chronic conditions affect the lives of millions of Americans every day. The emergence and spread of infectious diseases—such as HIV/AIDS, hepatitis, tuberculosis, measles, and human papillomavirus—can quickly threaten the stability of public health for communities and place whole populations at risk. The rise of globalization and ease of travel also has made it easier for domestic and international outbreaks—including COVID-19 as well as recent outbreaks of measles, pandemic influenza A, Ebola, Zika, and chikungunya—to create public health challenges. Moreover, the prevalence of chronic conditions—such as diabetes, heart disease, stroke, and cancer—in the United States continues to contribute to the daily struggles of Americans. The occurrence of multiple chronic conditions also exacerbates the adverse health impacts and health care costs associated with chronic conditions and their associated health risks. HHS programs and initiatives focus on promoting partnerships, educating the public, improving vaccine development and uptake, advancing early detection and prevention methods, and enhancing surveillance and response capacity.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, ASPA, ASPR, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, OGA, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 2.2 Table of Related Performance Measures

***Increase the percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test who are virally suppressed (Lead Agency - HRSA; Measure ID - 16.III.A.4)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 83% | 83% | 83% | 83% | 83% |
| **Result** | 83% | 85% | 86% | 87% | 88% | 10/31/22 | 10/31/23 | 10/31/24 |
| **Status** | Actual | Actual | Actual | Target Exceeded | Target Exceeded | Pending | Pending | Pending |

The Ryan White HIV/AIDS Program (RWHAP) works to improve health outcomes by preventing disease transmission or slowing disease progression for disproportionately impacted communities. One way RWHAP accomplishes its mission is through the provision of medications that help patients reach HIV viral suppression. People living with HIV who use medications designed to virally suppress the disease are less infectious, which reduces the risk of their transmitting HIV to others. In FY 2021 and FY 2022, RWHAP will continue to play a central role in ending the HIV epidemic by ensuring that persons living with HIV have access to regular care, receive antiretroviral medications, and adhere to a regular schedule for taking their medications. The percentage of RWHAP clients who are virally suppressed currently exceeds the national average. Because the Ending the HIV Epidemic Initiative will introduce people with low rates of viral suppression into the Ryan White HIV/AIDS Program and because the impact of COVID-19 on viral suppression is not yet known, HRSA is maintaining this target.

***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 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 53% | 56% | 59% | 62% | 66% | 70% | 70% | 70% |
| **Result** | 42% | 43% | 38% | 45.3% | 48% | 9/30/21 | 9/30/22 | 9/30/23 |
| **Status** | Target Not Met | Target Not Met but Improved | Target Not Met | Target Not Met but Improved | Target Not Met but Improved | Pending | Pending | Pending |

In the United States, on average 5 to 20 percent of the population contracts the flu, more than 200,000 people are hospitalized from seasonal flu-related complications, and approximately 36,000 people die from seasonal flu-related causes. This measure reflects the universal influenza vaccination recommendation and aligns with the Advisory Committee on Immunization Practices' updated recommendation (as of 2010) for the seasonal influenza vaccine. Seasonal influenza vaccination rates for adults aged 18 and older increased from 38 percent in FY 2017 to 48 percent in FY 2019. Interpretation of these results should take into account limitations of the survey, which include reliance on self-reporting of vaccination status and a decrease in response rates. Preliminary estimates from claims-based data systems showed no decreases in flu vaccination coverage. Four in ten adults report receiving a flu vaccination. In FY 2021 and FY 2022, CDC will continue to monitor the percentage of adults aged 18 and older who receive annual are vaccination against seasonal influenza to inform its strategies for improving adult vaccination coverage rates.

While the most recent data shows improvement, flu vaccination coverage among adults remains at about 4 in 10 adults reporting receipt of a flu vaccination.

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

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

- Designing and funding investigations into the factors associated with disparities in adult vaccination among racial and ethnic minority populations and projects designed to expand the evidence base for interventions to increase vaccination among adults with chronic medical conditions and underserved populations.
- Engaging 18 subject matter experts with deep expertise in addressing health disparities and representing a broad array of disciplines to provide input on the development of concrete, scalable, and sustainable interventions that may begin to reduce disparities in adult vaccination in the African American community.
- Purchasing 9.3 million additional doses directly from vaccine manufacturers to help uninsured and under-insured adult Americans get their flu vaccines, especially those at higher risk.
- Collaborating with numerous existing and new partners to expand flu vaccine coverage, with specific efforts to address racial and ethnic disparities for the 2020-2021 influenza season. For example, CDC is working with the National Association for Community Health Centers to implement evidence-based strategies to increase adult vaccination coverage among underserved priority populations. CDC has developed new partnerships to promote flu vaccination in high-risk populations (cardiovascular, diabetes, chronic lung conditions, etc.) and those in congregate settings (i.e., long-term care facilities, homeless shelters, and prisons). The work to promote flu vaccination will help pave the way for COVID-19 vaccination in these same at-risk groups.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | Baseline | 2 | 2 | 2 | 2 | 2 |
| **Result** | N/A | N/A | 2 | 7 | 6 | 2 | 12/31/21 | 12/31/22 |
| **Status** | N/A | N/A | Actual | Target Exceeded | Target Exceeded | Target Met | Pending | Pending |

Illness caused by influenza and other pathogens, including SARS-CoV-2 (severe acute respiratory syndrome coronavirus), can evolve, spread geographically, and infect large numbers of people quickly. In addition to the annual toll taken by seasonal influenza, hundreds of thousands of people could be hospitalized with influenza in the US during a severe pandemic. ASPR is improving the Nation's seasonal and pandemic influenza prevention and treatment options by a) expanding and maintaining the number of influenza vaccine options and domestic manufacturing capability of those vaccines; b) developing new vaccines with broader protection and faster production time; and c) supporting development and broadening indications for influenza therapeutics. This has included licensing of the first two non-egg based platforms, as well as the first two pre-pandemic influenza vaccines, and an antiviral to treat influenza infection. However, an average of over 36,000 Americans still die annually from influenza, influenza vaccine efficacy rates still fluctuate seasons to season and are not as high as desired, and there are no treatments for hospitalized patients. Finally, as re-inforced by the COVID-19 experience, vaccine production and availability must be faster than current capabilities. In FY 2020, efforts to address these gaps continued in parallel with funding efforts to maintain current capabilities. Specifically, BARDA made awards to significantly expand domestic production of the recombinant influenza vaccine and adjuvant, and address alternative (non-needle/syringe) administration approaches.

During FY 2021 and FY 2022, key components of ASPR's strategy is to further accelerate vaccine production capability, improve vaccine efficacy, and develop formulations that will enable increased vaccine uptake. To do this, ASPR continues to support improvements on current vaccine platforms, such as development of adjuvanted vaccines, as well as development of new, more rapid platforms that may also have better efficacy. Efforts will also be made to identify new therapeutic targets to treat hospitalized patients.

### *HHS FY 2020-2021 Agency Priority Goals*

The HHS FY 2020-2021 APGs established by the previous administration supported multiple objectives across the HHS Strategic Plan. For presentation purposes, the Department has chosen to display these APGs under their most closely aligned strategic objectives.

**Ending the HIV Epidemic.** Ending the HIV Epidemic. End the HIV epidemic by reducing new HIV infections through 1) linking people to HIV medical care as quickly as possible so that treatment can be initiated; and 2) preventing HIV through prescribing pre-exposure prophylaxis (PrEP) to those who have indications for PrEP. Starting from the baselines for December 31, 2017, by September 30, 2021:

- Reduce by 15 percent new HIV infections among persons aged 13 or older.
- Increase by 15 percent linkage to HIV medical care within one month of diagnosis among persons aged 13 or older.
- Increase by 15 percent the number of persons with indications for PrEP who are prescribed PrEP.

**Kidney Care.** Reduce morbidity and mortality associated with end-stage renal disease and increase patient choice by improving access to alternatives to center-based dialysis. Starting from the baseline for the calendar year ending December 31, 2019, by December 31, 2021:

- Increase by 10 percent the number of new end-stage renal disease patients on home dialysis.
- Increase by 10 percent the number of kidney transplants performed.

## Goal 2. Objective 3: Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support

Mental illness and substance abuse create health risks and place a heavy burden on affected individuals and their families. Substance use disorders arise from the recurring use of alcohol and/or drugs, which lead to clinically and functionally significant impairments. Mental disorders are health conditions that involve significant changes in thinking, emotion, and/or behavior and lead to distress and/or problems functioning in social, work, or family activities. Mental and substance use disorders are illnesses that impact people's ability to go about their daily lives in family, social, and professional settings and place individuals at risk of additional health problems. HHS works closely with federal, state, tribal, local, territorial, and community partners, including faith-based and community organizations, to help identify and address mental health problems and substance use disorders.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, OCR, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

**Objective 2.3 Table of Related Performance Measures**

***Reduce the age-adjusted annual rate of overdose deaths involving synthetic opioids other than methadone (e.g., fentanyl) among states funded through CDC's multi-state surveillance and prevention cooperative agreement (per 100,00 residents) (Lead Agency - CDC; Measure ID - 7.2.7b)*** [13]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | Baseline | 8.7 per 100,000 residents | 8.3per 100,000 residents | 8.0 per 100,000 residents | 7.7 per 100,000 residents | 7.7 per 100,000 residents |
| **Result** | N/A | N/A | 9.0 per 100,000 residents | 11.2 per 100,000 residents | 1/31/21 | 1/30/22 | 1/30/23 | 1/30/24 |
| **Status** | N/A | N/A | Actual | Target Not Met | Pending | Pending | Pending | Pending |

CDC tracks the rise of opioid overdose deaths and uses these data to inform prevention activities. Over 450,000 people have died from overdoses involving opioids in the United States from 1999 through 2018. In response to this growing public health crisis, CDC's Prescription Drug Overdose Prevention for States (PfS) program funded 29 state health departments to advance and evaluate comprehensive state-level interventions for preventing opioid-related overdose, misuse, and abuse.

The age-adjusted annual rate of opioid deaths involving synthetic opioids other than methadone (e.g., fentanyl) in FY 2018 was 11.2 per 100,000 residents among states funded for the PfS program, which did not meet the target of 8.7 per 100,000 residents. The growing issue of polysubstance use means that an opioid-involved overdose often occurs in combination with exposure to other opioids and/or other non-opioid substances. The overdose epidemic has also grown increasingly complex by co-involvement of

[13] CDC has PfS cooperative agreements with 29 states.

prescription and illicit drugs. To address this emerging trend, CDC will continue to strengthen surveillance activities, identify interventions, and implement prevention programs that address the evolving nature of the epidemic. Surveillance components will continue to collect and disseminate timely morbidity and mortality data for all drug overdoses, including emerging threats, such as polysubstance use and stimulants. CDC will also continue to fund innovative surveillance strategies to help drive action and inform more targeted prevention efforts. Prevention activities will strengthen prescription drug monitoring programs, improve consumer awareness around the risks of prescription opioids, establish linkages to care, and improve provider and health system support to increase safer prescribing.

***Reduce the age-adjusted rate of overdose deaths involving natural and semisynthetic opioids (T40.2) or methadone (T40.3) as a contributing cause of death among states funded through CDC's multi-state surveillance and prevention cooperative agreement(per 100,000 residents. (Lead Agency - CDC; Measure ID - 7.2.7c)*** [14]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 4.2 per 100,000 residents | 4.1 per 100,000 residents | 3.9 per 100,000 residents | 3.7 per 100,000 residents | 3.6 per 100,000 residents |
| **Result** | N/A | N/A | 5.7 per 100,000 residents | 4.9 per 100,000 residents | 1/30/21 | 1/30/22 | 1/30/23 | 1/30/24 |
| **Status** | N/A | N/A | Baseline | Target Not Met | Pending | Pending | Pending | Pending |

CDC monitors the reduction of overdose deaths involving all opioids among the states funded specifically for PfS awards made in FY 2016. Since 2016, as the epidemic has evolved, CDC has scaled its programs from an initial cohort of states to a program with a national scope. This performance measure reports outcomes based on the number of funded states and includes overdoses caused by methadone. These data allow CDC to better guide prevention activities related to safer prescribing.

CDC has tailored its response as the epidemic continues to evolve and will continue to take action to further reduce overdose deaths. In FY 2019, CDC released its new Notice of Funding Opportunity, Overdose Data to Action (OD2A). This program funds 47 states, Washington, D.C., 16 localities, and two territories to advance the understanding of the opioid overdose epidemic and to scale-up prevention and response activities which builds on previous surveillance efforts to foster an interdisciplinary, comprehensive and cohesive public health approach to the complex and changing nature of the opioid overdose epidemic. In FY 2022, CDC will continue to support recipients along the trajectory of moving from data to action, building upon work completed through the funding opportunity OD2A.

[14] CDC has PfS cooperative agreements with 29 states.

### *Increase the number of substance use treatment admissions with Medication-Assisted Treatment (MAT) planned as part of Opioid Use Disorder Treatment (Lead Agency - SAMHSA; Measure ID - 2.3.19K)* [15]

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 200,000 | 220,000 | 242,000 | 280,000 | 285,000 |
| **Result** | 196,704 | 191,817 | 241,675 | 255,464 | 8/31/21 | 8/31/22 | 8/31/23 | 8/31/24 |
| **Status** | Actual | Actual | Actual | Target Exceeded | Pending | Pending | Pending | Pending |

SAMHSA expects the number of people receiving MAT and the number of admissions to substance abuse treatment with MAT to increase. States are continuing to develop their systems with increased resources from grant programs, such as the State Opioid Response grants, Tribal Opioid Response grants, and Targeted Capacity Expansion: Medication-Assisted Treatment Prescription-Drug and Opioid Addiction grants. Medicaid systems have increased their focus on opioid-related technical assistance, and outreach efforts from across HHS promote the use of MAT. SAMHSA uses data from the Treatment Episode Dataset (TEDS) to track the provision of substance use treatment for opioid use disorders, which includes tracking the planned use of MAT at admission.[16] In CY 2015, 196,704 treatment admissions had MAT as a planned part of the treatment plan. In CY 2016, 191,817 admissions had MAT planned and 241,675 opioid admissions had MAT planned in CY 2017, and 255,464 opioid admissions had MAT planned in CY 2018. MAT data for CY 2019 will be available in 2021. SAMHSA will continue to monitor the use of MAT in CY 2021 and 2022.

### *Increase the availability of electronic clinical decision support tools related to safe pain management and opioid prescribing (Lead Agency - AHRQ; Measure ID - 2.3.8)*

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2014** | N/A | N/A | N/A |
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | N/A | N/A | N/A |
| **FY 2018** | Develop at least one new electronic clinical decision support tool related to safe pain management and opioid prescribing. | Developed and tested a dashboard that aggregates pain-related information into one consolidated view for clinicians. Information includes data such as pain medications, pain assessments, pain-related diagnoses, and relevant lab test results. | Target Met |

[15] TEDS Annual Report, which is based on calendar year data, can be found at: https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set. CY 2015, CY 2016, and CY 2017 were updated; states are allowed to update and/or correct their data at any given time.

[16] MAT consists of provision of methadone, buprenorphine or extended-release naltrexone, in combination with counseling and behavioral therapies. TEDS is a compilation of client-level data routinely collected by the individual state administrative data systems to monitor their substance use treatment systems. TEDS records do not represent individuals; rather, each record represents a treatment episode. Thus, an individual admitted to treatment twice within a calendar year counts as two admissions. TEDS does not include all substance use treatments. It includes treatment admissions and discharges at facilities licensed or certified by a state substance abuse agency to provide care for people with a substance use disorder (or at facilities that are administratively tracked for other reasons). In general, facilities reporting TEDS data are those that receive state alcohol and/or drug agency funds (including federal block grant funds) for the provision of alcohol and/or drug treatment services.

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2019** | 1) Test, revise, and disseminate at least one new electronic clinical decision tool related to safe pain management and opioid prescribing and<br>2) Partner with stakeholders to identify additional evidence-based electronic clinical decision tools related to safe pain management and opioid prescribing and make them publicly available. | Worked with CDC to test, revise, and disseminate two opioid clinical decision support (CDS) tools using the Connect web platform | Target Met |
| **FY 2020** | Develop, test, and disseminate at least one electronic clinical decision support tool related to opioids or safe chronic pain management. | Through two contracts, began designing, developing, and disseminating new patient-facing and clinician-facing clinical decision support applications for chronic pain management. | Target Met |
| **FY 2021** | Evaluate electronic clinical decision support tools related to chronic pain management and disseminate the results of the evaluation | 9/30/21 | Not Started |

Addressing the nation's opioid epidemic is an ongoing focus of AHRQ's Health Services Research, Data, and Dissemination portfolio. In FY 2017, AHRQ launched a new initiative to ensure that health care professionals have access to evidence supporting safe pain management and opioid prescribing at the point of care through electronic Clinical Decision Support (CDS). CDS Connect is the infrastructure for developing and sharing these CDS tools.[17]

In FY 2020, the two new contracts began designing and developing the CDS for chronic pain management, including meeting with end-users (e.g., patients, clinicians) and planning for integration with their pilot sites' electronic health records. One contract built on the pain management dashboard developed by the AHRQ CDS Connect project in 2018, and the other contract built brand new applications to help with opioid tapering. Each contract has been developing both clinician- and patient-facing CDS applications. Information about the contracts has been disseminated through project profiles at https://digital.ahrq.gov, and abstracts have been submitted for presentation at research conferences. One project's evaluation approach has received OMB approval for compliance with the Paperwork Reduction Act.

In FY 2021, both contracts will complete the design of the CDS applications, followed by testing and deployment at their pilot sites. Each of the contracts will perform a self-evaluation of their CDS and will disseminate resources and lessons learned through AHRQ's CDS Connect platform. This will include implementation guides and other materials for re-use by other health care systems. Each project's self-evaluation is in addition to a separate evaluation of AHRQ's overall CDS initiative, which began in FY2020.

[17] https://cds.ahrq.gov.

The project that is providing safe pain management and opioid prescribing data is ending in FY 2021 and this measure will be retired.

***By 2023, evaluate the efficacy of new or refined interventions to treat opioid use disorders (OUD) (Lead Agency - NIH; Measure ID - SRO-4.9)***

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | N/A | N/A | N/A |
| **FY 2018** | Initiate at least one study to improve identification of OUD or evaluate the comparative effectiveness of available pharmacotherapies for OUD treatment. | A Phase 3 clinical trial to test a non-opioid medication for managing symptoms of opioid withdrawal was completed. | Target Met |
| **FY 2019** | Conduct one preclinical study and one clinical trial to develop non-opioid based medications to treat OUD that may avoid the risks of opioid dependence and overdose. | A pre-clinical study of a novel opiate withdrawal therapy was conducted, and a clinical trial of a therapy for both opioid withdrawal and associated insomnia was also conducted. | Target Met |
| **FY 2020** | Conduct one pre-clinical and one clinical study of a longer acting formulation of a medication for the treatment of opioid use disorders or opioid overdose. | NIH conducted a pre-clinical development study of a novel long-acting formulation of nalmefene for treating OUD, and a clinical study of a novel long-acting implant that delivers naltrexone, an effective treatment for OUD. | Target Met |
| **FY 2021** | Conduct a Phase I clinical trial of an anti-opioid vaccine and a new medication to treat OUD. | 12/31/21 | In Progress |
| **FY 2022** | Conduct a clinical trial of a medication for relapse prevention of OUD or overdose. | 12/31/22 | In Progress |

The misuse of and addiction to opioids such as heroin and prescription pain medicines is a serious national problem. This issue has become a public health epidemic with devastating consequences, which include increases in OUDs and related fatalities from overdoses; rising incidence of newborns who experience neonatal abstinence syndrome because their mothers used these substances during pregnancy; and increases in the spread of infectious diseases, such as HIV and hepatitis C. This measure highlights one facet of NIH-funded research in providing scientific evidence to inform the public health response to the opioid crisis.

In FY 2020, NIH supported the pre-clinical development of a new implant that will deliver nalmefene, a drug that blocks opioid signaling, over a six-month period. The goal is to advance this implant to be tested in humans for the prevention of relapse to opioid addiction in patients following opioid detoxification. In addition, NIH supported a clinical trial to evaluate the safety and efficacy of GM0017, an implant that delivers the OUD medication naltrexone over six months. This implant is being developed for prevention of opioid relapse in individuals with OUD who have been detoxified. Naltrexone is currently delivered as an extended-release injection on a monthly basis. Developing an implant that could deliver naltrexone over six months would allow individuals to stay on the medication

without monthly doctor visits, and help individuals in recovery remain abstinent from opioids.

In FY 2021, NIH is funding clinical trials to study an anti-opioid vaccine and a new medication to treat OUD. In FY 2022, NIH will fund a clinical trial to study a medication for relapse prevention of OUD or overdose.

***Increase the percentage of youth ages 12-17 who experienced major depressive episodes with severe impairment in the past year receiving treatment for depression (Lead Agency - SAMHSA; Measure ID - 2.3.19O)*** [18]

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 48.0% | 48.5% | 50.0% | 55.0% | 56.0% |
| **Result** | N/A | 46.7% | 47.5% | 46.9% | 49.7% | 12/31/21 | 12/31/22 | 12/31/23 |
| **Status** | N/A | Actual | Actual | Target Not Met | Exceeds the target | Pending | Pending | Pending |

With states and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) driving efforts to address the needs of children and youth with serious emotional disturbances, SAMHSA expects to see increases in the percentage of youth with a past year major depressive episode who receive mental health treatment. The National Survey on Drug Use and Health (NSDUH) defines treatment for depression as 1) Seeing or talking to a medical doctor or other professional, or 2) Using prescription medication for depression in the past year. SAMHSA has funded a number of programs to increase access to treatment, which include Healthy Transitions continuation grants and contracts for technical assistance and evaluation.

The prevalence of receiving depression care among youth with major depressive episode and severe impairment in the past year remained stable between 2006 and 2018. In CY 2019, the rate was 49.7 percent, which exceeds the target (48.5 percent) by 1.2 percent. In FY 2018, in addition to supporting contracts for technical assistance and evaluation, SAMHSA continued support for 14 continuation grants and supported 4 new grants. SAMHSA will work to improve this result in CY 2020 and CY 2021 by providing technical assistance to grantees and by continuing to monitor major depressive episodes in youth ages 12-17. The agency anticipates that these efforts made to improve access to services will lead to identifying reductions in the percentage of youth who report major depressive episodes.

***Increase the percentage of adults with Serious Mental Illness (SMI) receiving mental health services (Lead Agency - SAMHSA; Measure ID - 2.3.19L)*** [19]

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 67.0% | 68.0% | 71.0% | 75.0% | 76.0% |
| **Result** | N/A | 64.8% | 66.7% | 64.1% | 65.5% | 12/31/21 | 12/31/22 | 12/31/23 |

NSDUH defines the mental health services as inpatient treatment/counseling, outpatient treatment/counseling, or the use of prescription medication for mental health problems. In CY 2019, 65.5 percent of the adults aged 18 or older received the mental health services, which was less than the target (68.0 percent). In CY 2021 and CY 2022, SAMHSA will continue to provide guidance to agencies

[18] The latest full NSDUH report, the 2019 NSDUH full report, is available at https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases .

[19] The latest full NSDUH report, the 2019 NSDUH full report, is available at https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases. Ibid.

on how to administer mental health services to individuals with SMI. Federal efforts, including ISMICC, discretionary grant programs, and SAMHSA's Clinical Support Services for SMI Technical Assistance Center will enable agencies to provide coordinated efforts and resources to individuals with SMI.

### *HHS FY 2020-2021 Agency Priority Goals*

The HHS FY 2020-2021 APGs established by the previous administration supported multiple objectives across the HHS Strategic Plan. For presentation purposes, the Department has chosen to display these APGs under their most closely aligned strategic objectives.

**Reducing Opioid Morbidity and Mortality.** Reduce opioid-related morbidity and mortality through: 1) improving access to prevention, treatment and recovery support services; 2) targeting the availability and distribution of overdose-reversing drugs; 3) strengthening public health data and reporting; 4) supporting cutting-edge research; and 5) advancing the practice of pain management. Starting from the baseline of September 30, 2019, by September 30, 2021:

1. Treatment—Increase uptake of medications for the treatment of opioid use disorder:
    a. By 15 percent the number of unique patients receiving prescriptions for buprenorphine in U.S. outpatient retail pharmacies (excluding implantable or long-acting injection products).
    b. By 100 percent the number of prescriptions for long-acting injectable or implantable buprenorphine from retail, long-term care, and mail-order pharmacies in the United States.
    c. By 25 percent the number of prescriptions for extended-released naltrexone from retail, long-term care, and mail-order pharmacies in the United States
    d. By 57 percent the number of providers with a DATA 2000 waiver authorizing buprenorphine prescribing for opioid use disorder treatment.
2. Overdose intervention—Increase availability and access to overdose-reversing drugs:
    a. By 50 percent the number of prescriptions dispensed for naloxone in U.S. outpatient retail and mail-order pharmacies.

## Goal 2. Objective 4: Prepare for and respond to public health emergencies

As demonstrated during the COVID-19 pandemic, the health of Americans during public health emergencies and other incidents depends on the effectiveness of preparedness, mitigation, response and recovery efforts. Threats in an increasingly interconnected, complex, and dangerous world include naturally emerging infectious diseases such as COVID-19; frequent and severe weather events; state and non-state actors that have access to chemical, biological, radiological, or nuclear agents; non-state actors who commit acts of mass violence; and cyber-attacks.

HHS is engaged in the research, development, and procurement of medical countermeasures, which include vaccines, drugs, therapies, and diagnostic tools to address COVID-19 as well as other emerging infectious diseases. HHS collaborates with others to ensure that the appropriate number of safe and effective medical countermeasures are developed and stockpiled and can be easily distributed to save lives during an incident. HHS also invests in building the capacity of other countries to detect, prevent, and respond to incidents.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, ASA, ASPA, ASPR, CDC, CMS, FDA, HRSA, IHS, IOS, NIH, OASH, OCR, OGA, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 2.4 Table of Related Performance Measures

***Maintain the percentage of CDC-funded Public Health Emergency Preparedness (PHEP) state and local public health agencies 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)*** [20]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 95% | 96% | 96% | 96% | 96% | 96% | 96% | 96% |
| **Result** | 100% | 95% | 85% | 98% | N/A | 2/28/22 | 2/28/23 | 2/28/23 |
| **Status** | Target Exceeded | Target Not Met | Target Not Met | Target Exceeded | N/A | Pending | Pending | Pending |

Public health agencies must be able to rapidly convene key management staff (within 60 minutes of notification) to appropriately respond to an emergency. This effort includes the integration of information and the prioritization of resources to ensure timely and effective coordination within the public health agency and key response partners. CDC uses the data from this measure to evaluate the ability to assemble a minimum of six key decision-makers who can cover all of the activated incident management lead roles needed to effectively manage a public health agency's response. This measure does not report the ability to assemble large groups of public health staff or to deploy a group of responders.

[20] CDC results are based on jurisdictions (N) that allocated PHEP funding for pulsed-field gel electrophoresis E.coli activities.

In response to the pandemic, CDC allowed PHEP recipients to use FY 2019 PHEP funds to support critical COVID-19 response activities. Specific examples of how recipients planned to use funds include laboratory equipment, reagents and other specialized materials and supplies needed for lab processing and testing of COVID-19 samples; electronic staffing systems; communications and call center equipment; and contact tracing. CDC also modified FY 2019 and FY 2020 PHEP program requirements as a result of the current COVID-19 pandemic response underway in the 62 PHEP jurisdictions. To support this critical work and reduce recipient burden, CDC integrated PHEP planning requirements with COVID-19 pandemic response activities, allowing recipients to use their response to the current public health incident to demonstrate their preparedness capabilities. Among the changes, CDC has waived all drill requirements, including the staff assembly drill (Measure 13.5.3). As a result, data will not be reported for FY 2019 and FY 2020. In FY 2021 and FY 2022 CDC will continue to work with recipients to help identify preparedness gaps based on COVID-19 lessons learned and develop targeted strategies to improve performance.

***Increase the number of new licensed medical countermeasures within Biomedical Advanced Research and Development Authority (BARDA) (Lead Agency - ASPR; Measure ID - 2.4.13a)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **Result** | N/A | 3 | 5 | 9 | 7 | 3 | 12/31/21 | 12/31/22 |
| **Status** | N/A | Target Met | Target Exceeded | Target Exceeded | Target Exceeded | Target Met | Pending | Pending |

Medical countermeasures are federally regulated products used during a public health emergency. Examples of emergencies include chemical, biological, radiological and nuclear (CBRN) agents, pandemic influenza, and emerging (or re-emerging) infectious diseases. Through the BARDA program, ASPR develops and makes available medical countermeasures to prepare for and respond to national emergencies. Each of APSR's products is designed to address a particular gap in our ability to address these emergencies. In addition, ASPR oversees purchases of medical countermeasures for storage in the Strategic National Stockpile.

Within ASPR, BARDA invests in the innovation, advanced research and development, acquisition, and manufacturing of medical countermeasures – the vaccines, drugs, therapeutics, diagnostic tools, and non-pharmaceutical products needed to combat health security threats. To date, BARDA has received 59 FDA approvals, licensures, and clearances for medical countermeasures. For more information about BARDA's medical countermeasures, please see https://www.medicalcountermeasures.gov/barda.

ASPR's approach to advanced research and development has a proven track record of success due to continuous collaboration with NIH, CDC, FDA, and the Departments of Defense, Homeland Security, Veteran Affairs, and Agriculture. HHS sets research and development priorities under a five-year strategy and implementation plan.

An example of the medical countermeasures developed to save lives is progress on multi-drug resistant (MDR) organisms, which are a threat to national security and public health. As rates of antimicrobial resistance (AMR) in pathogens continue to increase new therapeutics and vaccines are essential to combat the growing crisis. Every year, 2.8 million Americans develop a drug resistant infection and 35,000 people die. Globally, MDR infections kill 700,000 each year - current estimates are that MDR organisms will kill more than 10 million a year by 2050 if left unchecked. BARDA supports development and procurement of medical countermeasures to protect Americans against CBRN threats. MDR does

not discriminate, and victims of CBRN events are at risk of suffering fatal complications from drug resistant infections. One of BARDA's top priorities is to develop a vaccine to protect people from these threats.

During FY 2021 and FY 2022, ASPR continues to support the development of critical medical countermeasures to increase national preparedness including:

- New antiviral therapeutic and vaccine candidates against Ebola Sudan and Marburg viruses
- A second antiviral candidate against smallpox
- A next generation botulinum antitoxin
- New antidotes for treatment of chemical agents (for example, mustard gas exposure and chlorine gas)
- Diagnostic devices to confirm infection with biological agents and identify an effective antibiotic sooner
- Innovations for advanced, portable ECMO (extracorporeal membrane oxygenation) devices
- Innovations in early-stage medical countermeasure research and development focusing on sepsis, wearable diagnostics and distributed manufacturing technologies,
- New candidate products for addressing the pathologies resulting from radiological or nuclear events, including thermal burns
- Multi-tissue human microphysiological models ("body-on-a-chip") incorporating immune system models for screening of vaccines and therapeutics
- Novel antibacterial drugs, diagnostics, and vaccines

The U.S. government has undertaken a government-wide response to combat the SARS-CoV-2 virus and limit negative health outcomes. ASPR has received resources from several COVID-19 supplemental appropriations to enhance ongoing efforts and continue a comprehensive and coordinated response.

ASPR continues to work with partners across the Federal government, the states, and the private sector to focus on priorities related to addressing SARS-CoV-2 and other threats. ASPR has expanded agreements with companies to develop medical countermeasures that enhance national health security, and continues to seek insight from partners in the private and public sectors to identify promising technologies. Strengthening health security in the face of the novel coronavirus outbreak involves launching multiple products that address different aspects of COVID-19. For example, to protect the American people from this new coronavirus, health care professionals need medical countermeasures that enable quick and accurate diagnosis, vaccination to prevent the spread of the virus, and treatment for those infected with effective therapeutics or antivirals.

## Goal 3. Objective 1: Encourage self-sufficiency and personal responsibility, and eliminate barriers to economic opportunity

Strong, economically stable individuals, families, and communities are integral components of a strong America. Many Americans currently experience or are at risk for economic and social instability. The social and health impacts of poverty can include reduced access to nutritious food; fewer educational opportunities, and poor educational outcomes; a lack of access to safe and stable housing; increased risk of poor health outcomes including obesity and heart disease; and difficulty obtaining work opportunities. The Department coordinates safety-net programs across the Federal Government; state, local, tribal, and territorial governments; and faith-based and community organizations.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, and CMS. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 3.1 Table of Related Performance Measures

***Increase the percentage of adult Temporary Assistance for Needy Families (TANF) work-eligible individuals who entered employment (Lead Agency - ACF; Measure ID - 22B)*** [21]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | TBD | TBD | TBD |
| **Result** | N/A | N/A | 18.0% | 17.5% | 6/30/21 | 6/30/22 | 6/30/23 | 6/30/24 |
| **Status** | N/A | N/A | Actual | Actual | Pending | Pending | Pending | Pending |

TANF provides states with block grants to design and operate programs that help needy families reach self-sufficiency, with a focus on preparing parents for work. This program measure assesses how effectively recipients transition from cash assistance to employment. Full success requires not only that recipients be employed, but also that they remain employed, increase their earnings, and demonstrate a reduction in dependency on cash assistance.

ACF is committed to helping the states identify innovative and effective employment strategies and offering a range of targeted technical assistance efforts. As one example, ACF provides research on potential areas for employment and skill-building. In FY 2021 and FY 2022, ACF will continue to support state, tribal, and community partners' efforts to design and implement programs that focus simultaneously on adult employment and family well-being.

[21] These data exclude territories but include the District of Columbia.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 76.84% | 83.01% | 85.26% | 84.84% | 82.88% | 81.76% | 76.05% | Prior Result +1% |
| **Result** | 82.19% | 84.42% | 84% | 82.06% | 80.95% | 75.30% | 11/30/21 | 11/30/22 |
| **Status** | Target Exceeded | Target Exceeded | Target Not Met | Target Not Met | Target Not Met | Target Not Met | Pending | Pending |

In FY 2020, 179 locations offered ACF Matching Grant Program services. This is a decrease from 250 locations in FY 2017. Since the program provides $2,750 in funds for each eligible individual served, program funding is directly linked to the number of eligible participants. While providing services, grantees must match federal funds by at least 50 percent. ACF encourages grantees to experiment in the delivery of services at one or more sites to improve efficiencies and outcomes.

ACF attributes the drop in performance for indicator 16C to the impact of the COVID-19 pandemic in the second half of the FY. Indeed, this 180-day measure was on track to greatly exceed the FY target with 83.67 percent of individuals deemed self-sufficient in the first half of the year. Although outcomes remain commendable under the current conditions, ACF expects consistent positive growth to resume as grantees seek new employment opportunities for refugees and pandemic impacts begin to subside later in FY 2021.

ACF expects to complete enhanced on-site or remote monitoring of each grantee's local service provider site at least once every three years. As the number and quality of these monitoring meetings has increased, the analysis of the monitoring data continues to yield information useful to performance improvement efforts. During the pandemic, ACF continues to enforce the Performance Improvement Plan (PIP) requirement that affects each site expecting to serve at least 50 clients in the fiscal year, performing 10 percentage-points or more below the network's self-sufficiency average, and performing at least 5 percentage-points below the annual national program average. Each PIP must include concrete measures such as enhanced monitoring, professional development training, reassignment of personnel, and reductions in funding. Grantees report on the progress of their PIPs every six months.

## Goal 3. Objective 2: Safeguard the public against preventable injuries and violence or their results

Injuries and violence affect all Americans regardless of an individual's age, race, or economic status. Preventable injuries and violence—such as falls, homicide stemming from domestic violence, and gang violence—kill more Americans ages 1 to 44 than any other cause, including cancer, HIV, or the flu.[22] Hospitalizations, emergency room visits, and lost productivity caused by injuries and violence cost Americans billions of dollars annually.

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. The Department supports multiple trauma-informed care initiatives to integrate a trauma-informed approach into health, behavioral health, and related systems to reduce the harmful effects of trauma and violence on individuals, families, and communities.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, CDC, IHS, OASH, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 3.2 Table of Related Performance Measures

***Maintain the percentage of domestic violence program clients who have a safety plan (Lead Agency - ACF; Measure ID - 14D)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| **Result** | 91.9% | 89.6% | 92.8% | 93.4% | 93% | 5/31/21 | 5/31/22 | 5/31/23 |
| **Status** | Target Exceeded | Target Not Met | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending | Pending |

Family Violence Prevention and Services Act grantee data for fiscal years 2017 through 2019 show that more than 90 percent of domestic violence program clients reported improved knowledge of safety planning as a result of grantee efforts. These data correlate with other indices of longer-term client safety and well-being.[23] Since many program participants receive short-term crisis assistance and would not expect to report significant change, consistently achieving a higher than 90 percent benchmark is unrealistic. In FY 2021 and 2022, ACF will continue to implement its improved data quality checks to ensure data accuracy as well as work with the grantees to identify ways to promote domestic violence safety.

[22] https://www.cdc.gov/injury/wisqars/overview/key_data.html

[23] Bybee, D. I., and Sullivan, C. M. (2002). Strengths-based intervention resulted in positive change for battered women over time. American Journal of Community Psychology, 30(1), 103-132.

***Decrease the percentage of children with substantiated or indicated reports of maltreatment that have a repeated substantiated or indicated report of maltreatment within six months (Lead Agency - ACF; Measure ID - 7B)[24]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 6.30% | 6.20% | 6.30% | 6.74% | 6.50% | 6.40% | Prior Result -0.2PP | Prior Result -0.2PP |
| **Result** | 6.40% | 6.50% | 6.90% | 6.70% | 6.60% | 10/31/21 | 10/31/21 | 10/31/22 |
| **Status** | Target Not Met but Improved | Target Not Met | Target Not Met | Target Met | Target Not Met, but Improved | Pending | Pending | Pending |

In FY 2018, the rate of repeat child maltreatment decreased to 6.7 percent, which met the target for that year. In FY 2019, the rate continued to decrease to 6.6 percent, which was an improvement, but fell just short of the target of 6.5 percent. In FY 2021 and FY 2022, ACF will continue to identify and implement ways to support states in their efforts to care for children and families who are experiencing a crisis, while ensuring the safety of children. The renewed emphasis on prevention efforts may also lead to improved performance in this area.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 41.6% | 41.6% | 41.5% | 37.5% | 36.3% |
| **Result** | N/A | N/A | N/A | 38.1% | 36.3% | 33.3%[25] | 1/31/22 | 1/31/23 |
| **Status** | N/A | N/A | N/A | Target Not Met | Target Not Met | Target Not Met | Pending | Pending |

Domestic and intimate partner violence has a disproportionate impact on AI/AN communities. AI/AN women experience intimate partner violence at higher rates than any other single race or ethnicity in the United States. However, intimate partner violence is a preventable public health problem and screening for Intimate Partner (Domestic) Violence provides the ability to identify victims and those at risk for injury. The Intimate Partner (Domestic) Violence screening measure supports improved processes for identification, referral, and treatment for female victims (age 14-46) of domestic violence. In FY 2018, IHS began reporting the Intimate Partner (Domestic) Violence screening measure using the IHS Integrated Data Collection System Data Mart (IDCS DM). FY 2020 represents the third year of IDCS DM reporting; IHS continues to monitor and adjust to reporting system changes and provide training for documentation in the electronic reporting system.

In FY 2019, IHS identified successful strategies among the IHS Areas and sites that met or exceeded the target screening rates for intimate partner violence. Strategies that sites identified as a pathway to success include: frequent data review and communication of data to staff; staff training that targeted the use of specific screening tools; and inclusion of this important measure in facility quality improvement projects. IHS uses this information to increase support and to cultivate knowledge about this measure across sites and to provide technical assistance and training to IHS health care providers

[24] The program updated the FY 2016 actual result for this performance measure based on a technical correction to calculate the data based on the national population, which is consistent with previous results. The program updated the FY 2017 target due to this change.
[25] Interim result.

and sites. In FY 2020, IHS continued to encourage dissemination of these evidence-based strategies across all facilities. IHS continues to provide training on the appropriate screening and injury assessments and documentation in the IHS electronic health record reporting system. IHS provides outreach and assistance to tribal sites upon request including a virtual training made available in FY 2020 regarding a specific Intimate Partner Violence (IPV) lethality risk screening tool. In addition, IHS recorded a two-hour live training webinar provided to Urban health organizations that discussed screening tools and appropriate interventions to offer patients experiencing intimate partner violence. Due to COVID-19 response efforts, opportunities for facilities to participate and complete trainings were limited.

Although several IHS Areas met or exceeded the FY 2020 target, IHS did not meet the national target of 41.5 percent. The IHS COVID-19 pandemic response and the transition from in person primary care to virtual care at several sites, may have impacted screening women for DV/IPV. To avoid potential coronavirus exposure risk, there have been fewer in-person visits and many health care services for prevention and health maintenance were postponed by patients during the pandemic. While patients with acute illness or the need for emergency care were still seen at IHS facilities, the COVID-19 pandemic response limited health care provider – patient interactions and reduced opportunities to screen the general population. Due to the sensitivity of the DV/IPV screening, proper administration requires the health care provider to ensure the patient is comfortable responding without external influence. Therefore, increased telehealth visits that occur within a patient's home would not necessarily meet the safety and security recommendations to be applied during the DV/IPV assessment.

While IHS anticipates similar challenges in FY 2021, increased administration of the DV/IPV screening will occur as in-person patient-provider interactions increase. In addition, IHS is aligning this measure with the agency-wide policy on the care of patients experiencing Intimate partner violence which can be found within the Indian Health Manual, Part 3, Chapter 31. Long-term efforts will include targeted approaches to increase participation and reporting of this measure including technical and training assistance for future grant awardees that address the DV/IPV objectives. IHS will also promote webinars and on-demand trainings that support the agency-wide policy to increase participation among IHS, Tribal, and Urban facilities. Starting in FY 2021, IHS is establishing methods to assist grant recipients in prioritizing the intimate partner violence screening within their community facilities, including data collection tools and resources. These efforts will strengthen facility and service unit quality improvement programs and emphasize the importance of including this measure in such efforts to reduce and address intimate partner violence and improve health care delivery.

## Goal 3. Objective 3: Support strong families and healthy marriage, and prepare children and youth for healthy, productive lives

Families are the cornerstone of America's social fabric. People live longer, have less stress, and are more financially stable in a healthy family environment where both parents are present, share the responsibility of the household, and raise the children. Additionally, in these households, children tend to be healthier, both mentally and physically, and are better able to have their fundamental needs met. The Department supports healthy families and youth development through collaborations across the Federal Government and with states, territories, community partners, tribal governments, and faith-based organizations.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, CDC, HRSA, IHS, OASH, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 3.3 Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 26% | 25% | 24% | 15% | 17% | 15% | 16% | Prior Result -1PP |
| **Result** | 22% | 24% | 16% | 18% | 16% | 17% | 1/31/22 | 1/31/23 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Not Met | Target Exceeded | Target Not Met | Pending | Pending |

The ACF Office of Head Start (OHS) strives to increase the percentage of Head Start children in high-quality classrooms. ACF measures progress by reducing the proportion of Head Start grantees scoring in the low range (below 2.5) in any domain of the Classroom Assessment Scoring System (CLASS: Pre-K). This research-based tool measures teacher-child interaction on a seven-point scale in three broad domains: Emotional Support, Classroom Organization, and Instructional Support. Research findings underscore the importance of teacher-child interactions as a demonstrated measure of classroom quality. OHS assesses each Head Start grantee using the CLASS instrument during onsite monitoring reviews. The most recent data from FY 2020 CLASS reviews indicate that 17 percent of grantees scored in the low range, which fell short of the target of 15 percent.

In FY 2020, ACF unveiled a rule to better improve the quality of Head Start services by refining the Designation Renewal System (DRS), which determines whether Head Start and Early Head Start agencies deliver high-quality and comprehensive services to the children and families. The final rule on the DRS will become effective on October 27, 2020 and promotes increased quality in Head Start classrooms by establishing quality thresholds for each domain of the CLASS®. Any grantee with a score below one or more quality thresholds will be designated for quality improvement. For these grantees, OHS will provide support for quality improvement in teacher-child interactions and teaching practices. Additionally, this rule raises minimum expectations for all grantees regarding quality of the classroom learning environment. Any grantee with a score below one or more of the now higher minimum

thresholds will be designated for competition. The final rule is available at https://www.federalregister.gov/documents/2020/08/28/2020-17746/head-start-designation-renewal-system. In FY 2021 and FY 2022, ACF plans to reduce the proportion of grantees scoring in the low range by at least one percentage-point, year over year.

***Reduce the proportion of children and adolescents ages 2 through 19 who are obese (Lead Agency - CDC; Measure ID - 4.11.10b)[26,27]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | 15.7% | N/A | 15.2% | N/A | 14.7% | N/A | 14.7% |
| **Result** | N/A | 18.5% | N/A | 19.3% | N/A | 5/30/21 | N/A | 5/30/23 |
| **Status** | N/A | Target Not Met | N/A | Target Not Met | N/A | Pending | N/A | Pending |

CDC funds a number of interventions that target obesity as well as related chronic diseases. The percentage of all children and adolescents (ages 2 to 19 years) that have obesity increased from 16.8 percent in FY 2008 to 19.3 percent in FY 2018, exceeding the target of 15.2%. Despite this overall increase, there has been progress among children from lower-income families enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children. Research shows behaviors that influence excess weight gain include early infant weight gain, lack of responsive feeding approaches, eating high-calorie, low-nutrient foods and beverages, not getting enough physical activity, sedentary activities, medication use, and sleep routines. Public health and health care practitioners can educate individuals about healthy lifestyle choices and ways to improve their diet and increase physical activity. However, it can be difficult for many children and parents to make healthy food choices and get enough physical activity due to underlying social determinants of health, which include housing insecurity, food insecurity, education, poverty). Places such as child care centers, schools, or communities can affect diet and activity through the foods and drinks offered and the opportunities provided for physical activity.

In FY 2021 and FY 2022, CDC will continue promoting good nutrition and physical activity in children and adolescents to help prevent childhood obesity. Through initiatives such as the Childhood Obesity Research Demonstration (CORD) project, CDC will continue to study and promote ways to prevent childhood obesity and its consequences. For the first phase of the project, CORD 1.0, CDC examined whether a multi-level, multisector, coordinated strategy involving primary care and evidence-based public health interventions could help low-income children and their families increase healthier behaviors and prevent (primary prevention) and control (secondary prevention) obesity. CORD 2.0 tested a model of quality clinical childhood obesity management for low-income families with an emphasis on assessing unmet social needs as part of the interventions. For CORD 3.0, CDC is further increasing the availability of effective pediatric weight management interventions for children from lower-income families. CORD 3.0 funds five recipients for five years (funding period 2019-2024). During this phase, CDC will provide technical expertise and support to researchers to package their existing effective family-centered programs for use among low-income families through community sites that

[26] The data for this performance goal are collected and reported every other year.
[27] There was a delay in publication of CDC's NHANES data, and FY 2018 results will not be available until spring 2020. CDC anticipates that subsequent NHANES data may also be delayed and has adjusted the reporting dates.

are feasible, convenient, and acceptable to diverse families. This will include testing the packages in additional sites for comparable outcomes. Community sites may include federally qualified health centers, community health centers, and clinics.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 86% | 86% | 87% | 90% | 90% | 90% | 91% | 91% |
| **Result** | 88.2% | 91.6% | 90.7% | 90% | 90% | 6/30/21 | 12/30/21 | 12/30/22 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Met | Target Met | Pending | Pending | Pending |

The Transitional Living Program (TLP) supports community-based, adult-supervised residences for youth ages 16 to under 22 who cannot safely live with their own families, or for whom living with their families provides undue hardships. This long-term shelter program offers otherwise homeless youth housing for up to 18 months and provides the educational, employment, health care and life skills necessary for youth to transition into self-sufficient living. The TLP safe and appropriate exit rate is the percentage of TLP youth discharged during the year who find immediate living situations that are consistent with independent living. During FY 2019, TLPs met the 90 percent target for this measure by attaining a 90 percent safe and appropriate exit rate.

Because safe and stable housing is one of the core outcomes for the TLP program, ACF proposes to keep this performance standard and increase the annual target to 90 percent. In FY 2021 and FY 2022, ACF will continue to work with grantees to ensure that appropriate service delivery and technical assistance systems are in place to provide increased support to at-risk youth.

***(For adult-serving programs) Increase the proportion of participants who, at program exit, express positive attitudes towards marriage (Lead Agency – ACF; Measure ID – 22G)*** [28]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | 77.4% | 77.9% | 87.0% |
| **Result** | N/A | N/A | 87.52% | 87.38% | 85.60% | 3/31/21 | 3/31/22 | 3/31/23 |
| **Status** | N/A | N/A | Actual | Actual | Actual | Pending | Pending | Pending |

The Healthy Marriage Relationship Education Grant Program (HMRE) is part of HHS's community-based efforts to promote strong, healthy relationships; family formation; and maintenance of economically secure, two-parent, married families. ACF HMRE grants fund 46 organizations that provide comprehensive healthy relationship and marriage education services and job and career advancement activities.

At program exit, adults in healthy marriage programs are asked the extent to which they agree or disagree with two statements: "It is better for children if their parents are married"; and "Living together is just the same as being married" (this statement is reverse-coded). These questions measure the perceived benefits clients see of marriage following involvement of a healthy marriage program. In particular, responses to these questions show whether clients, at program exit, value marriage as positive for children and something more valuable than just living together without marriage. In

[28] This is a new measure. ACF is in the process of collecting data and determining targets.

FY 2017, 87.52 percent of the 11,494 adults who answered these questions on their exit survey expressed positive views toward marriage at program exit. This proportion remained relatively stable in FY 2018 at 87.38 percent, but this represented a larger number of clients (15,596). In FY 2019, 85.6 percent of the 17,908 adults who answered these questions expressed positive views at program exit, a decrease from FYs 2018 and 2017. In FY 2021 and FY 2022, ACF aims to increase the proportion of participants who, at program exit, express positive attitudes toward marriage to 78 and 87 percent, respectively.

***(For adult-serving programs) Increase the proportion of married couples who, at program exit, view their marriage as lifelong (Lead Agency – ACF; Measure ID – 22H)*** [29]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | 85.1% | 85.2% | 94.9% |
| **Result** | N/A | N/A | 94.9% | 94.2% | 94.7% | 3/31/21 | 3/31/22 | 3/31/23 |
| **Status** | N/A | N/A | Actual | Actual | Actual | Pending | Pending | Pending |

At program exit, adults in healthy marriage programs who are in relationships are asked the extent to which they agree or disagree with the following statement: "I view our marriage/relationship as lifelong." This question measures whether clients, following involvement in a healthy marriage program, view their relationships as a lifelong commitment. In FY 2017, 94.9 percent of 8,975 adult clients (in couple relationships) who answered this question on their exit survey viewed marriage as lifelong. In FY 2018 this number was 94.2 percent, which again reflects a higher number of clients (11,829). In FY 2019 this number was 94.7 percent, which reflects a higher number of clients (13,485) than answered the question in FYs 2017 and 2018. In FY 2021 and FY 2022, ACF aims to reach a target of 85 percent and 95 percent, respectively, for the couples who, at program exit, view their marriage as lifelong.

***(For youth-serving programs) Increase the proportion of youth who express attitudes supportive of the success sequence (Lead Agency – ACF; Measure ID – 22I)*** [30,31]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | 50.4% | 58.5% | 66% |
| **Result** | N/A | N/A | 61.33% | 65.15% | 69.20% | 3/31/21 | 3/31/22 | 3/31/23 |
| **Status** | N/A | N/A | Actual | Actual | Actual | Pending | Pending | Pending |

At program exit, youth in Healthy Marriage programs are asked the extent to which they agree or disagree with five statements "It is okay to live with a boyfriend/girlfriend without being married," "It is okay to live with a boyfriend/girlfriend without a plan to be married," "It is okay to have kids without being married," "It is okay to have kids without a plan to be married," and "It is hard on kids to be raised by a single parent." These questions measure the perceived benefits of marriage and of adhering to the "success sequence,"[32] following involvement in the youth-focused healthy marriage program. Responses to these questions show whether youth view marriage as something positive for children and

[29] This is a new measure. ACF is in the process of collecting data and determining targets.
[30] This is a new measure. ACF is in the process of collecting data and determining targets.
[31] To align with the school year, grantees serving youth clients in schools will likely stop offering services in the summer of 2020, several months before the end of the fiscal year in September. Thus, the FY 2020 results might primarily reflect the attitudes of youth clients not served in schools. This pattern also happened in FY 2016 and the percentage of youth who were supportive of the success sequence was much lower than other years (56.4 percent). Therefore, ACF proposes a lower target, aligning with our proposed adjustments for COVID-19 in FY 2020.
[32] The Millennial Success Sequence: Marriage, Kids, and the "Success Sequence" among Young Adults. 2017. Wang W. and Wilcox W.B. AEI/Institute for Family Studies.

value marriage over other types of relationships. In FY 2017, 61.33 percent of 8,026 youth clients who answered these questions on their exit survey expressed attitudes supportive of the success sequence. In FY 2018, this rate was 65.15 percent of 8,617 youth clients who answered these questions, and in FY 2019 this rate was higher at 69.2 percent of 14,691 youth clients who answered these questions. In FY 2021 and 2022, ACF aims to increase the proportion of youth who express positive attitudes toward relationships to 58.5 and 66 percent, respectively.

## Goal 3. Objective 4: Maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers

Older adults and people with disabilities face a complex set of difficulties. About 1 in every 7, or 14.9 percent, of the population is an older American. Approximately 12 percent of working-age adults in the United States have some type of disability. Of these adults, 51 percent had a mobility disability, and 38.3 percent had a cognitive disability.

To support older adults, people with disabilities, and the system of friends, family, and community members that support them, the Department collaborates across the Federal Government and, with states, tribes, territories , and faith-based and community organizations. Aging and Disability Resource Centers provide a gateway to a broad range of services and supports for older adults and people with disabilities. Centers for Independent Living are community-based centers that offer services to empower and enable people with disabilities to stay in their communities. Every state and territory has an Assistive Technology Act program that can help people find, try, and obtain assistive technology devices and services. Assistive technology includes resources ranging from "low tech" helping tools—like utensils with big handles—to higher-tech solutions like talking computers.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, CDC, CMS, HRSA, IHS, OASH, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 3.4 Table of Related Performance Measures

***Demonstrate improvement in nursing home health care quality by reducing the number of one-star nursing homes (Lead Agency - CMS; Measure ID - QIO7.3)[33]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | N/A | Baseline | 8.8% | Discontinued |
| **Result** | N/A | N/A | N/A | N/A | N/A | 9.4% | 10/1/22 | N/A |
| **Status** | N/A | N/A | N/A | N/A | N/A | Actual | Pending | N/A |

To protect more than 3 million nursing home residents, CMS provides strategies to guide local, state, and national efforts to improve the quality of care in nursing homes. In December 2008, CMS added a star rating system to the Nursing Home Compare website to track nursing home quality. This rating system serves three purposes: 1) to provide residents and their families with an assessment of nursing home quality, 2) to distinguish between high and low performing nursing homes, and 3) to provide incentives for nursing homes to improve their performance. The one-star rating is the lowest rating and the five star rating is the highest.

In April 2019, CMS made improvements to each of the rating system domains under the Five Star Quality Rating System. In October 2019, CMS removed measures related to residents' reported

[33] CMS will base the FY 2021 result on the newer methodology and this will make future results inconsistent with the previously reported targets.

experience with pain. As a result, CMS set a new baseline for the period describing performance from 2019 through 2021. CMS advised providers that thresholds for quality measure ratings will be updated every six months beginning April 2020, however CMS is no longer able to calculate future targets or results based on the former methodology. Therefore, CMS will discontinue reporting on this goal as of FY 2022.

***Decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication (Lead Agency - CMS; Measure ID - MSC5)***

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 17.9% | 16.7% | 16% | 16% | 15.5% | 15.4 % | 15.3% | 15.0% |
| **Result** | 17.1% | 16.7% | 15.4% | 14.6% | 14.0% | 7/31/21 | 4/30/22 | 4/30/23 |
| **Status** | Target Exceeded | Target Met | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending | Pending |

Antipsychotic medications have common and dangerous side effects when used for the behavioral and psychological symptoms of dementia. National scientists and thought leaders have review a number of evidence-based non-pharmacological interventions and approaches have been reviewed through the National Partnership to Improve Dementia Care. CMS has posted clinical practice guidelines and various tools and resources on the CMS website at National Partnership to Improve Dementia Care in Nursing Homes. State coalitions are reaching out to providers in every state and encouraging the use of these resources, as well as Hand in Hand, which is a CMS-developed training program for nursing home staff. A number of meta-analyses have reviewed the use of non-pharmacological approaches to behaviors in people with dementia. Studies have shown that these interventions may be effective in reducing behaviors associated with dementia that may be distressing to residents or families.

For this goal, CMS reports the prevalence of antipsychotic use in the last three months of the fiscal year. Success has varied by state and CMS region, with some states and regions seeing a reduction of greater than 45 percent.

***Improve dementia capability of long-term support systems to create dementia-friendly, livable communities (Lead Agency ACL; Measure ID – ALZ.3)[34,35,36]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Baseline | Baseline | 15% | 17% | 19% |
| **Result** | N/A | N/A | N/A | 22% | 13% | 20% | 1/31/22 | 1/31/23 |
| **Status** | N/A | N/A | N/A | Actual | Actual | Actual | Pending | Pending |

Of the community dwelling individuals living with Alzheimer's Disease and Related Dementias (ADRD), approximately one-third live alone, exposing them to numerous risks, which include unmet needs,

[34] Program participants report annually on program progress in advancement of the dementia-capability of program partners and provide appropriate technical assistance to address areas of concern. Data reported include changes in the range of services and supports each grantee provides to people with dementia, grantee capacity to provide specialized services to people with a cognitive impairment or dementia and their caregivers, and the degree to which the grantee organizations have standardized their procedures or assessing dementia among their consumers. ACL uses grantee responses to calculate grantee level of improvement between reporting periods.

[35] This is a developmental measure. ACL is currently collecting sufficient data to establish a baseline. To set a baseline, the agency relies on 3 years of data. This process ensures that the data are stable and show a clear trend.

[36] Based on the first year of data, ACL set ambitious targets. After receiving the second year of data, ACL revised the targets downward realizing that the first year improvement was artificially high because only one grantee cohort was included. The first year of the grants are training-heavy, so grantees typically show significant improvement. In later grant years, the assessment scores increase at a slower rate as grantees become more engaged in the delivery of dementia-capable services.

malnutrition and injury, and various forms of neglect and exploitation.[37] With the number of people living with ADRD in the United States projected to grow by almost 300 percent by 2050[38], it is important to develop effective and coordinated service delivery and health care systems that are responsive to the needs of these individuals and their caregivers.

ACL's Alzheimer's Disease Program provides funding for the development and enhancement of dementia-capable, person-centered systems of services and supports through partnerships with public and private entities. In 2017, ACL developed a new tool to measure the program's success at improving the dementia capability of long-term services and support systems. Through the tool, program grantees and their partners assess organizational activities in the following three areas:

- Identification of people with possible cognitive impairment or dementia and their primary caregiver;
- Staff training about cognitive impairment, dementia and dementia care, and
- Provision of specialized services for people with a cognitive impairment or dementia and their caregivers.

Program participants report annually on program progress in advancement of the dementia-capability of grantees and program partners. Data reported include changes in the range of services and supports each grantee provides to people with dementia, grantee capacity to provide specialized services to people with a cognitive impairment or dementia and their caregivers, implementation of dementia training for staff, and the degree to which the grantee organizations have standardized their procedures for assessing dementia among their consumers. ACL uses grantee responses to calculate grantee level of improvement between reporting periods. ACL is currently collecting sufficient data to establish a baseline and reasonable targets for future years. This requires data from baseline to grant completion for more than one grant cohort; to date, only 2 grants in the dataset have reached program completion. Many more are expected in the next 1-2 years. After the first cohort has completed its grant cycle, we do not expect the improvement score to increase across cohorts over time, but we will recalibrate the target improvement score once we have sufficient data. Improvement is not expected to occur evenly across the course of the grant, as the first year is focused largely on planning; the second year is expected to see the most significant improvements, as grantees focus on implementation of new procedures and programs. ACL ensures the quality of the assessment results through frequent contact with grantees, clear guidance for grantees regarding their grant activities and reporting expectations, and timely review of grantee performance data. If grantees appear to be underperforming based on the data provided, grant officers provide technical assistance.

[37] Gould, E., Maslow, K., Yuen, P., Wiener, J. *Providing Services for People with Dementia Who Live Alone: Issue Brief.* Accessed April 14, 2014.
[38] Alzheimer's Association. *2017 Alzheimer's Disease Facts and Figures.* Accessed May 9th, 2017 at http://www.alz.org/alzheimers_disease_facts_and_figures.asp

***Increase the success rate of the Protection and Advocacy Program's individual or systemic advocacy, thereby advancing individuals with developmental disabilities right to receive appropriate community based services, resulting in community integration and independence, and have other rights enforced, retained, restored and/or expanded (Lead Agency ACL; Measure ID – 8F)[39]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | N/A | 79.6% | TBD | TBD |
| **Result** | N/A | N/A | 78.1% | 78.9% | 78.8% | 1/31/22 | 1/31/23 | 1/31/24 |
| **Status** | N/A | N/A | Actual | Actual | Actual | Pending | Pending | Pending |

Under the Developmental Disabilities Assistance and the Bill of Rights Act of 2000 (DD Act), each state and territory has a Developmental Disabilities Protection and Advocacy (P&A) program designated by the state's governor. The DD Act and other authorizing statutes give the P&A the authority to advocate for the rights of individuals with disabilities. The DD Act states that each P&A has the authority to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State."[40] P&As provide a range of legal services and use a range of remedies, including self-advocacy assistance, negotiation, investigation, and litigation, to advocate for traditionally unserved or underserved individuals with developmental disabilities. P&A authorities are critical to preventing abuse and neglect of people with disabilities and safeguarding individuals' right to live with dignity and self-determination.

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

[39] This is a developmental measure. ACL is currently collecting sufficient data to establish a baseline. To set a baseline, the agency relies on 3 years of data. This process ensures that the data are stable and show a clear trend. The agency will set targets for this measure once a baseline is established.

[40] 42 U.S.C. 15043

## Goal 4. Objective 1: Improve surveillance, epidemiology, and laboratory services

The Department is dedicated to conducting and funding scientific research that leads to evidence-based, high-quality care and responsive interventions to mitigate health crises. Data and information from surveillance, epidemiology, and laboratory services can aid in the prevention and early intervention of foodborne illnesses, such as listeria and norovirus, and infectious disease outbreaks, such as COVID-19, Zika and Ebola. To achieve this objective, the Department facilitates information exchange to identify risks quickly and efficiently, strengthens the quality and safety of our nation's laboratories, and strengthens the alignment of surveillance, epidemiology, and laboratory services.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ASPR, CDC, CMS, FDA, NIH, OCR, OGA, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 4.1 Table of Related Performance Measures

***Maintain the percentage of laboratory reports on reportable conditions that are received through electronic means nationally (Lead Agency - CDC; Measure ID - 3.5.2)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 70% | 75% | 80% | 82% | 90% | 90% | 90% | 90% |
| **Result** | 69% | 75% | 80% | 86% | 90% | 12/31/20 | 12/31/21 | 12/32/22 |
| **Status** | Target Not Met | Target Met | Target Met | Target Exceeded | Target Met | Pending | Pending | Pending |

Advancing national implementation of Electronic Laboratory Reporting (ELR) is a priority in CDC's efforts to protect the public's health. ELR replaces paper-based reporting, which accelerates reporting to public health labs; reduces the reporting burden on clinicians, hospitals, and commercial laboratories; and decreases errors and duplicate reporting. As of FY 2019, electronic laboratory reports accounted for nearly 90 percent of laboratory reports for reportable conditions received, which met the target and was an improvement over FY 2018. These results continue the upward trend begun FY 2012.

Since there are diminishing returns after reaching an ELR volume higher than 90 percent, the program considers moving from 62 percent in 2013 to 90 percent a success. In FY 2021 and FY 2022, CDC will continue to monitor the implementation of ELR as part of its efforts to protect the public health.

***Increase the percentage of notifiable disease messages transmitted in HL7 format to improve the quality and streamline the transmission of established surveillance data (Lead Agency – CDC; Measure ID - 8.B.1.4)***[41]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | Baseline | 10% | 40% | 40% | 40% | 40% | 40% | 40% |
| **Result** | 1% | 3% | 5% | 5% | 7.24% | 49% | 2/1/22 | 2/1/23 |

[41] The initially reported FY 2018 result of seven percent reflected only a segment of these data. The FY 2018 result has been revised to reflect final data.

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Status** | Actual | Target Not Met but Improved | Target Not Met but Improved | Target Not Met but Improved | Target Not Met but Improved | Target Exceeded | Pending | Pending |

During FY 2020, the investments CDC made in technology and infrastructure positioned CDC to efficiently receive data related to the COVID-19 outbreak. Within hours of the COVID-19 emergency declaration, CDC's National Notifiable Disease Surveillance System (NNDSS), which helps public health monitor, control, and prevent diseases, issued a COVID-19 event code, which states used to notify CDC of cases. CDC also updated the system used to receive this information so the COVID-19 data could be available to CDC programs. The data received as a result of this work positioned CDC's disease experts and Emergency Operations Center to better understand and support the national response.

As of December 2020, data indicate the high volume of COVID-19 messages transmitted to CDC helped significantly improve the results for Measure 8.B.1.4 to 49%, enabling CDC to exceed the goal for FY 2020. During the last quarter of FY 2020, NNDSS processed an average of 2,086,701 case notification messages in a standardized electronic format (HL7), 17 times as many as were processed in January of 2020 (123,960), due mainly to the volume of reporting associated with the COVID-19 response. The prioritization of COVID-19 response activities has temporarily delayed implementation of Message Mapping Guides (MMG) – a way to transmit data on diseases, for the other disease conditions. At the onset of the response, 46 of the 57 jurisdictions reporting data were at various stages of bringing reporting for diseases in this standardized electronic format (HL7 MMGs) online. Forty-five jurisdictions are using CDC's NNDSS to send their COVID-19 case notifications to CDC. Of these, 28 jurisdictions are sending them in the standardized electronic format (HL7). In addition to the increase in the percentage of notifiable disease messages transmitted in the standardized format resulting from the COVID-19 response, data transmissions continue to improve and remain much more stable indicating that CDC has achieved a more routine and reliable mode to transmit this disease information.

With the influx of data modernization funding and the best practices adopted to date, CDC anticipates more states participating in the system and for states to begin transmitting health data related to sexually transmitted diseases, vaccine preventable diseases, and foodborne diseases once we return to normal operations. Efforts in 2021 will focus on continued progress on and completion of the modernization process. As CDC moves beyond 2021, NNDSS will transition from modernization to an operations mode that seeks continuous innovation and enhancement while laying the foundation for next generation case-based surveillance.

### *Number of medical product analyses conducted through the FDA's Sentinel Initiative (Lead Agency – FDA; Measure ID – 292203)*

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | 50 | 55 | 60 | 65 |
| **Result** | N/A | N/A | N/A | 74 | 68 | 79 | 1/31/22 | 1/31/23 |
| **Status** | N/A | N/A | N/A | Actual | Target Exceeded | Target Exceeded | Pending | Pending |

The Sentinel Initiative comprises multiple components including the Sentinel System, and its Active Risk Identification and Analysis (ARIA) program, FDA Catalyst, and the Biologics Effectiveness and Safety System. The Sentinel Initiative has continued to evolve rapidly in the last two years. In 2019, Congress required that FDA build on Sentinel's core successes by establishing a new Real-World Evidence Medical Data Enterprise with access to at least 10 million electronic medical records. The year 2021 marks six

years of the Sentinel System serving as a fully-functional and integrated part of FDA's regulatory process. Sentinel has proven to be a vital source of safety information that informs regulatory decision-making and expands our knowledge of how medical products perform once they are widely used in medical practice. In 2020, FDA began to leverage Sentinel in novel ways as part of a multi-layered response to the COVID-19 pandemic. These activities range from developing the capability for near real-time drug monitoring to inform the potential for drug shortages, describing the course of illness among patients with COVID-19, and evaluating the impact of therapies being used in COVID-19 patients under real-world conditions.

## Goal 4. Objective 2: Expand the capacity of the scientific workforce and infrastructure to support innovative research

Tomorrow's scientific breakthroughs depend on a highly trained and ethical scientific workforce, working in facilities and with tools that foster innovation. Efforts to expand the capacity of the scientific workforce and infrastructure can better prepare the nation for global health emergencies, extend the reach and impact of scientific investigations, and contribute to research of national or global significance.

Through various initiatives and programs, HHS recruits and trains students, recent graduates, and other professionals to conduct rigorous and reproducible research. HHS provides research training and career development opportunities to ensure that highly trained investigators will be available across the range of scientific disciplines necessary to address the nation's biomedical and scientific research needs. Scientific integrity is a priority for the Department. Divisions responsible for research have developed policies and procedures to ensure the highest degree of scientific integrity in the research HHS conducts, funds, and supports—to ensure that our research is credible and worthy of the public's confidence.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, CDC, FDA, NIH, OASH, OGA, and SAMHSA. HHS has determined that performance toward this objective is progressive. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 4.2 Table of Related Performance Measures

***By 2021, develop, validate, and/or disseminate 3-5 new research tools or technologies that enable better understanding of brain function at the cellular and/or circuit level (Lead Agency - NIH; Measure ID - SRO-2.12)***

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | N/A | N/A | N/A |
| **FY 2018** | Develop four novel neurotechnologies for stimulating/recording in the brain to enable basic studies of neural activity at the cellular level | Projects funded through the BRAIN Initiative led to novel innovations in four neurotechnologies to enable basic studies of neural activity at the cellular level. | Target Met |
| **FY 2019** | Test new and/or existing brain stimulation devices for two new therapeutic indications in humans through the BRAIN Public-Private Partnership. | The BRAIN Initiative Public-Private Partnership Program initiated testing of brain stimulation devices for six new therapeutic indications in humans and continued to enable current and potential BRAIN investigators to gain access to medical device tools and technologies from some of the top medical device manufacturers. | Target Met |

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2020** | Provide broad access to new research approaches and techniques for acquiring fundamental insight about how the nervous system functions in health and disease | The BRAIN Initiative supported the development of novel technologies for brain stimulation and recording and efforts to disseminate resources and integrate them into neuroscience research practice. | Target Met |
| **FY 2021** | Expand our understanding of brain function at the cellular or circuit level using three to five new tools and technologies | 12/31/21 | In Progress |

The NIH-funded Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative® accelerates the development and application of new neurotechnologies that will enable researchers to gain deeper understanding of how the human brain functions in normal conditions as well as states of disease or dysfunction. One of the BRAIN Initiative programs is the BRAIN Public-Private Partnership Program. This program facilitates partnerships between clinical investigators and manufacturers of the latest-generation invasive brain stimulation and recording devices. These partnerships accelerate the dissemination of tools and technologies to investigators and spur research progress.

In FY 2020, the program supported the development of novel technologies that focused on restoring sleep in Parkinson's disease (adaptive deep brain stimulation) and improving locomotor and bladder function in individuals with acute spinal cord injury (closed-loop systems with implanted neurostimulator). Furthermore, the program continued supporting current and potential BRAIN investigators in accessing medical device tools and technologies from some of the top medical device manufacturers. Currently, seven medical device companies participate in the program, offering a total of 24 resources to BRAIN investigators who are studying how the nervous system functions in health and disease.

In FY 2021, NIH plans to expand our understanding of brain function at the cellular or circuit level using newly developed tools and technologies. Although this measure is scheduled to discontinue beginning in FY 2022, the BRAIN Initiative programs will continue to fund promising research that will help expand the critical knowledge base for researchers seeking new ways to treat, cure, and even prevent brain disorders.

***Increase the percentage of scientists retained at FDA after completing the Fellowship or Traineeship programs (Lead Agency- FDA; Measure ID – 291101)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 40% | 40% | 40% | 50% | 50% | 50% | 20% | 20% |
| **Result** | 80% | 81% | 72% | 53% | 86% | 80% | 2/28/22 | 2/20/23 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending |

To support the Department's mission and FDA's scientific expertise, FDA is launching a new FDA Traineeship Program while continuing other Fellowship programs. This performance goal focuses on FDA's efforts to retain a targeted percentage of the scientists who complete these programs. The size and focus of the new agency-wide Traineeship Program will be greater in number and scope than the current Fellowship Program. Since the scope of the program will increase, FDA will reset the retention target to 20 percent for FY 2021 to reflect the new program's expected baseline. Whether "graduates"

from these programs continue to work for FDA or choose to work in positions in related industry and academic fields, they are trained in an FDA-presented understanding of the complex scientific issues in emerging technologies and innovation, which furthers the purpose of this strategic objective. For now, the retention target will remain at 20 percent in FY 2021 and 2022. Although it is unclear what the ultimate impact on the program will be, COVID-19 has affected FDA's ability to sponsor fellow, and has limited the experience of those fellows to train onsite in FDA labs, and with the appropriate mentors. FDA will continue to monitor and adjust this goal moving forward as necessary.

## Goal 4. Objective 3: Advance basic science knowledge and conduct applied prevention and treatment research to improve health and development

HHS conducts, funds, and supports a broad and diverse portfolio of biomedical research in a range of scientific disciplines, including basic and translational research, to augment scientific opportunities and innovation for public health needs. HHS works to strengthen basic and applied science and treatment pipelines to assess potential health threats and bolster the fundamental science knowledge in these risk areas to expedite the development of therapies. As described in Strategic Objective 4.2, Expand the capacity of the scientific workforce and infrastructure to support innovative research, HHS conducts research is conducted ethically and responsibly.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, AHRQ, CDC, FDA, NIH, and OASH. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 4.3 Table of Related Performance Measures

***By 2021, develop, optimize, and evaluate the effectiveness of nano-enabled immunotherapy (nanoimmunotherapy) for one cancer type (Lead Agency - NIH; Measure ID - SRO-2.1)***

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2014** | N/A | N/A | N/A |
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | N/A | N/A | N/A |
| **FY 2018** | Optimize properties of three nanoformulation for effective delivery and antigen-specific response in immune cells. | Developed, tested, and optimized, in animal models, three unique nanodelivery systems for effective anti-cancer immunotherapeutics | Target Met |
| **FY 2019** | Further optimize top two candidate nanoformulation for co-delivery of multiple antigens to enhance anti-tumor response in one animal model. | Further optimized two unique nanodelivery systems for effective anti-cancer immunotherapeutics in different animal models and showed promising results for consideration in clinical trials | Target Met |
| **FY 2020** | Further optimize the top candidate nanoformulation for co-delivery of antigens, adjuvants and immuno-modulators and evaluate its efficacy and long-lasting immunity (over 3 months) in preclinical models with established tumors. | Further optimized two nanodelivery systems that were identified as the top candidates. Researchers are testing both systems in cancer patients who have advanced stages of cancer. | Target Met |
| **FY 2021** | Further optimize the top candidate nanoformulation for co-delivery of antigens, adjuvants and immuno-modulators and evaluate its efficacy towards near and | 12/31/21 | In Progress |

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| | distance metastatic lesions in preclinical models with established tumors. | | |

Nanoparticles are extremely tiny particles that can coat, attach to, or encapsulate drugs. Scientists use nanoparticles in drug delivery systems to enhance the effectiveness of cancer drugs, which include immunotherapies. NIH supports research to enhance existing immunotherapies with nanotechnologies and facilitate the development of new, more efficacious nano-based immunotherapies.

Results from recent studies have shown that optimizing nanoparticle drug delivery systems improves the effectiveness of cancer immunotherapy. The optimization process of both drugs and delivery systems involves many different steps, which include testing the drug systems in different animal models and in different stages of disease (e.g., localized tumors and tumors that have spread to other parts of the body). In FY 2019, two NIH-funded research teams further optimized two unique nanoparticle drug delivery systems. Their work provides additional evidence that these systems are effective in delivering drugs to different tumor types and at different stages of disease, which include stages when the tumors have spread to other parts of the body. Building on these results, in FY 2020, the two research teams evaluated the delivery systems in cancer patients to identify the most tolerated dose with minimal toxicity. In FY 2021, the research teams are testing the effectiveness of these delivery systems in treating patients with advanced stages of cancer.

By delivering drugs directly to the tumor, nano-enabled immunotherapy will help overcome current limitations with immunotherapy, such as development of treatment resistance, relapse, low response rates, and systemic side effects. This measure highlights foundational proof of principle studies resulting in clinical trials that could lead the way for viable targeted drug delivery systems for cancer. Nano-enabled immunotherapies could provide safer, more efficacious, and less expensive alternatives to traditional immunotherapies and bring exciting new treatment options to groups of cancer patients.

This measure is scheduled to discontinue beginning in FY 2022, but improving the effectiveness of cancer immunotherapy delivery will remain a priority for NIH.

### *By 2022, evaluate the safety and effectiveness of 1-3 long-acting strategies for the prevention of HIV (Lead Agency - NIH; Measure ID - SRO-2.9)*

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | Strategy 1: Continue enrolling participants into two studies to test the safety, tolerability, and effectiveness of VRC01 as an intravenous prevention strategy. | Enrollment of participants continued for both studies. | Target Met |
| **FY 2018** | Strategy 2: Analyze primary results of a Phase 2a study examining the long-acting injectable, cabotegravir, for the prevention of HIV | Analysis of primary results has been conducted and results are in press. | Target Met |
| **FY 2019** | Strategy 3: NIH-funded investigators complete final analysis of an open-label extension study that builds on the findings of an earlier trial and aims to assess the continued safety of the | NIH-funded investigators completed final analysis of an open-label extension study that built on the findings of an earlier trial and aimed to | Target Met |

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| | dapivirine vaginal ring in a more real-world context and study participants' adherence | assess the continued safety of the dapivirine vaginal ring and study participants' adherence to its use. | |
| **FY 2020** | Strategy 1: Complete follow-up of participants in studies testing the safety, tolerability, and effectiveness of VRC01. | NIH-funded investigators completed follow-up of participants in two studies testing the safety, tolerability, and effectiveness of VRC01. | Target Met |
| **FY 2021** | Strategy 1: Analyze data of two studies testing the safety, tolerability, and effectiveness of VRC01 broadly neutralizing antibody (bnAb). | 12/31/21 | In Progress |
| **FY 2022** | Initiate an open label extension of two studies, HPTN 083 and HPTN 084, investigating the safety and efficacy of the long-acting injectable antiretroviral drug cabotegravir (CAB). | 12/31/22 | In Progress |

NIH-funded research has led to the identification of highly effective, non-vaccine prevention strategies that have the potential to significantly reduce HIV infection rates around the world. However, adhering to daily or near-daily dosing has proved challenging for both HIV-infected and uninfected individuals.

Since FY 2016, NIH has funded two proof-of-concept studies to assess whether giving people without HIV an infusion of VRC01, a "broadly neutralizing antibody" or bnAb (capable of stopping a wide range of HIV strains from infecting human cells), every eight weeks was an effective way to protect against HIV. In FY 2020, the research teams completed the studies in Sub Saharan Africa, the United States, and South America and demonstrated that VRC01 prevented the acquisition of HIV strains that were sensitive to the bnAb. However, VRCO1 did not prevent the acquisition of HIV strains that were resistant to the bNAb (nearly 70% of the circulating strains in these regions), and there was no overall prevention efficacy when the VRC01 subgroups were compared with the placebo subgroup.

In FY 2021, NIH will initiate an open-label extension of two studies to investigate the long-term safety and efficacy of cabotegravir, a long-acting injectable drug recently approved by the FDA for treating HIV infection in adults. (An open-label extension study enrolls participants of a previous clinical trial and is designed to gather information about the long-term safety and tolerability of a potential new drug beyond the time period of the previous clinical trial.) In FY 2022, NIH aims to complete enrollment of both of these studies. Having a long-acting method for prevention, whether a broadly neutralizing antibody or injectable drug, would help reduce adherence issues and give people a safe, more discreet, convenient option for preventing HIV.

***By 2023, identify risk and protective alleles that lead to one novel therapeutic approach, drug target, or pathway to prevention for late-onset Alzheimer's disease (Lead Agency - NIH; Measure ID - SRO-5.3)***

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2014** | Complete Discovery Phase whole genome sequencing and analysis of 582 family members from 111 families with late onset AD to identify genomic regions associated with increased risk of AD; sequencing of the coding regions of the DNA (whole exome | Sequencing and an initial level of analysis were completed. | Target Met |

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| | sequencing) of 5,000 cases / 5,000 controls for both risk raising and protective loci; and whole exome sequencing and analysis of one individual from ~1,000 additional AD families to identify regions associated with increased risk or protection from AD. | | |
| **FY 2015** | Initiate Replication Phase to validate genes / regions of interest identified from case-control and family sequencing in ~50,000 samples from well phenotyped individuals by targeted sequencing and/or genotyping. | Sample selection for whole genome sequencing on additional multiply affected families was initiated. Planning of the Replication Phase has begun. | Target Met |
| **FY 2016** | Begin confirmation of genomic regions of interest identified in the Discovery Phase using samples from the Replication phase.<br><br>Begin harmonization of data from Discovery phase datasets with data from Replication Phase for confirmation of regions of interest. | Sample selection/sequencing Discovery Extension phases completed (4,000 additional whole genomes). Data analysis for Extension Phase initiated. Genomic Center for Alzheimer's Disease funded (all ADSP quality control and data harmonization). | Target Met |
| **FY 2017** | Continue confirmation of genomic regions of interest in the Discovery and Replication phase datasets.<br><br>Continue harmonization of Discovery Phase and Replication Phase datasets. | NIH met its target of confirming genomic regions of interest in the Discovery and Replication phase data sets and continues to harmonize the Discovery Phase and Replication Phase data sets. | Target Met |
| **FY 2018** | Continue confirmation of genomic regions of interest in the Discovery phase using samples from the Replication phase.<br><br>Continue harmonization of Discovery Phase and Replication Phase datasets.<br><br>Begin analysis of genomic regions of interest in the genomes of minority cohorts. | NIH continued confirmation of genomic regions of interest in the Discovery Phase using samples from the Replication Phase, continued harmonization of Discovery Phase and Replication Phase datasets, and began analysis of genomes of minority cohorts. | Target Met |
| **FY 2019** | Begin analysis of genomic regions of interest in the ADSP Discovery Follow-Up Phase using whole genome sequence data from ethnically diverse cohorts.<br><br>Continue confirmation of genomic regions of interest in the Discovery Phase using samples from the Follow-Up phase.<br><br>Continue harmonization of Discovery Phase and Follow-Up Phase datasets. | The ADSP Discovery Follow-Up Phase has begun to analyze genomic regions of interest using whole genome sequence data from ethnically diverse cohorts. The ADSP has continued its confirmation of genomic regions identified in the Discovery Phase of the project. Genetic data for all phases of the ADSP have been harmonized. | Target Met |
| **FY 2020** | Continue analysis of ADSP Discovery Follow-Up Phase in ethnically diverse cohorts. Continue confirmation of genomic regions of interest from Discovery Phase and Discovery Follow-Up Phase in ethnically diverse | Data analysis for the ADSP Discovery follow-up Phase continued. Ongoing data analysis includes analysis from genomic regions of interest in ethnically diverse cohorts with | Target Met |

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| | datasets. Compare data on genomic regions of interest by ethnicity. | increased sample size and data comparison on genomic regions of interest by ethnicity. | |
| **FY 2021** | Continue analysis of ADSP Discovery Follow-Up Study in ethnically diverse cohorts. Continue confirmation of genomic regions of interest from Discovery Phase and Discovery Follow-Up Phase in ethnically diverse datasets. Begin harmonization of phenotypic data with ADSP genetic data across multiple types of study approaches from large epidemiology and clinical cohorts that are outside of the ADSP. | 12/31/21 | In Progress |
| **FY 2022** | Continue analysis of ADSP Discovery Follow-Up Study in ethnically diverse cohorts. Continue confirmation of genomic regions of interest from Discovery Phase and Discovery Follow-Up Phase in ethnically diverse datasets. Continue harmonization of phenotypic data with ADSP genetic data across multiple types of study approaches from large epidemiology and clinical cohorts that are outside of the ADSP. Begin analysis of ADSP genetic data using artificial intelligence approaches. | 12/31/22 | In Progress |

There is an urgent need for effective interventions to prevent, delay, and treat Alzheimer's disease (AD). As many as 5.5 million Americans age 65 and older are living with AD. Available treatments do not target the underlying molecular pathways believed to be involved in AD's development; thus, they neither halt nor reverse disease progression.

The overall goal of the NIH-supported Alzheimer's Disease Sequencing Project (ADSP) is to identify genetic variants associated with risk of and protection from AD. More than 150 investigators from institutions across the globe participate in the project. In FY 2020, the ADSP continued its efforts to identify and confirm genes associated with AD and examine them in ethnically diverse populations. Ongoing data analysis includes analysis from genomic regions of interest in ethnically diverse cohorts with increased sample size and data comparison on genomic regions of interest by ethnicity.

In FY 2021 and continuing into FY 2022, the ADSP is expanding on the results of its prior-year efforts. Upon completion, the project will provide critical information to enable NIH and AD researchers to explore new, promising pathways for preventing and treating AD.

## Goal 4. Objective 4: Leverage translational research, dissemination and implementation science, and evaluation investments to support adoption of evidence-informed practices

Translational research, dissemination, and implementation science help increase understanding about how best to support knowledge, adoption, and faithful implementation of best practices in the community. Selecting and adopting evidence-based approaches to tackle health, public health, and human services challenges can be a complex undertaking. HHS programs balance requirements to implement high-quality programs with fidelity, while acknowledging the unique needs of specific individuals or target populations, recognizing differences in program and community settings and resources, and respecting linguistic or cultural differences. Understanding threats to successful implementation of a promising practice can help the Department prevent and mitigate those risks early.

In the previous administration, the Office of the Secretary led this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, AHRQ, CDC, FDA, HRSA, NIH, OASH, and SAMHSA. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 4.4: 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 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 64.1 % | 62.4 % | 57.3% | 56.4% | 64.5% | 65.8% | Prior Result +3PP | Prior Result +3PP |
| **Result** | 59.4 % | 53.4% | 53.4% | 61.5% | 62.8% | 10/30/21 | 10/30/22 | 10/30/23 |
| **Status** | Target Not Met | Target Not Met | Target Not Met | Target Exceeded | Target Not Met, but Improved | Pending | Pending | Pending |

Currently, the Children's Bureau and its National Center for CBCAP are working closely with the states to promote more rigorous evaluations of their funded programs. The Children's Bureau defines evidence-based and evidence-informed programs and practices along a continuum. The continuum includes four categories of programs or practices: Emerging and Evidence Informed; Promising; Supported; and Well-Supported.

The FY 2018 result represented an increase with grantees reporting 61.5 percent of funds directed at evidence-based practices, which then increased again in FY 2019 with an actual result of 62.8 percent. ACF will continue to promote evaluation and innovation to expand the availability and use of evidence-informed and evidence-based practice over time. In FY 2021 and FY 2022, ACF is committed to continuing to work with CBCAP grantees to invest in known evidence-based practices, as well as to focus on one-on-one and peer learning technical assistance on increased accuracy of data reporting for this measure.

***By 2020, develop and test the effectiveness of two strategies for translating cancer knowledge, clinical interventions, or behavioral interventions to underserved communities in community-based clinical settings (Lead Agency - NIH; Measure ID - SRO-5.1)***

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2014** | N/A | N/A | N/A |
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | Develop two strategies for translating validated basic knowledge, clinical interventions, or behavioral interventions to diverse communities and clinical practice through establishing the Partnerships to Advance Cancer Health Equity (PACHE) program between Minority Serving Institutions (MSI) and NCI-designated Cancer Centers (CC). | Several U54 PACHE Partnerships have developed and/or validated evidence-based interventions and tools to help reduce the burden of cancer disparities in underserved communities across the United States. They are working with various community-based organizations (including faith-based organizations and community-based clinical practices and organizations) to disseminate/translate the interventions and tools in the diverse communities. | Target Met |
| **FY 2018** | Develop and support two partnerships to test validated basic cancer knowledge, clinical or behavioral interventions to diverse communities in clinical practice. | The U54 PACHE Partnerships, through 2 new efforts, developed and/or validated evidence-based interventions and tools to help reduce the burden of cancer disparities in underserved communities across the United States. These partnerships continued to work with various community-based organizations (including faith-based organizations and community-based clinical practices and organizations) to disseminate/translate the interventions and tools for use in diverse communities. | Target Met |
| **FY 2019** | Finalize testing and validating the strategies to translate basic cancer knowledge, clinical or behavioral interventions to underserved communities and into clinical practice. | Two U54 PACHE partnerships finalized testing and validating evidence-based interventions and tools to help translate basic cancer knowledge and clinical or behavioral interventions to underserved communities across the United States. They continue to work with various community-based organizations to disseminate these interventions and tools. | Target Met |
| **FY 2020** | Finalize testing and validating the strategies to translate basic cancer knowledge, clinical or behavioral interventions to underserved communities and into clinical practice. | Building on earlier efforts, two U54 PACHE partnerships validated strategies to help translate basic cancer knowledge and clinical or behavioral interventions to underserved communities across the United States | Target Met |

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| | | and U.S. territories. These partnerships continue to work with various community-based organizations to disseminate these interventions and to assess their effectiveness in promoting health equity. | |

NIH's Partnerships to Advance Cancer Health Equity (PACHE) is a program that fosters partnerships among institutions serving underserved health disparity populations, underrepresented students, and National Cancer Institute-designated Cancer Centers. PACHE partnerships train scientists from diverse backgrounds in cancer research and to effectively deliver knowledge on cancer to underserved communities.

PACHE partnerships continued to flourish in FY 2020. For example, one partnership developed interventions led by trained community health advisors in collaboration with churches to promote cancer screening in African American and Latinos communities in the South Los Angeles area. This partnership resulted in raised awareness about cancer screening tests and led to a better understanding of regional differences in screening rates that could inform future interventions for African American communities in South Los Angeles. Another partnership continues to work with faith-based and community-based organizations to advance health equity in Guam, Hawai'i, and the US-associated Pacific Islands through cancer research, training, and outreach. The partnership has contributed to the passage of significant cancer prevention and control legislation in Hawaii, Guam, and Saipan, including Hawaii's recent administrative rules change (HAR 11-167) requiring HPV vaccination for seventh grade entry, effective July 1, 2020. As a result, Hawaii is now one of only two states nationwide with this school entry requirement.

This measure has been completed and discontinued. However, NIH remains committed to funding future projects to develop and assess new strategies to help bring cancer advances to underserved communities.

## Goal 5. Objective 1: Ensure responsible financial management

HHS is responsible for almost a quarter of federal outlays and administers more grant dollars than all other federal agencies combined. Ensuring the integrity of direct payments, grants, contracts, and other financial transactions requires strong business processes, effective risk management, and a financial management workforce with the expertise to comply with legislative mandates, which include the Federal Managers' Financial Integrity Act of 1982 (Pub. L. 97–255), the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), and the Payment Integrity Information Act of 2019 (Pub. L. No. 116-117).

HHS aims to better understand the nature of improper payments and their relationship to payment integrity and to demonstrate stewardship of taxpayer dollars. By identifying root causes of monetary loss, strategic uses of data, and mitigation strategies to avoid monetary loss for its large programs (e.g., Medicare, Medicaid, and the Child Health Insurance Program (CHIP)), HHS improves agency and government-wide results. This focus on getting government payments right the first time and preventing monetary loss allows HHS to build public trust in the government.

All divisions contribute to the achievement of this objective. In the previous administration, the Office of the Secretary led this objective. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 5.1 Table of Related Performance Measures

***Reduce the percentage of improper payments made under Medicare Part C, the Medicare Advantage (MA) Program (Lead Agency - CMS; Measure ID – MIP5)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 [42] | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 8.5% | 9.14 % | 9.5 % | 8.08% | 7.9% | 7.77% | TBD | TBD |
| **Result** | 9.5% | 10% | 8.3% | 8.10% | 7.87% | 6.78% | 11/15/21 | 11/15/22 |
| **Status** | Target Not Met | Target Not Met | Target Exceeded | Target Met | Target Exceeded | Target Exceeded | Pending | Pending |

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

In FY 2020, CMS exceeded its target of 7.77 percent with an actual improper payment estimate of 6.78 percent, or $16.27 billion. The FY 2022 target will be established in the FY 2021 Agency Financial Report (AFR). The FY 2021 target has not been established. Due to HHS's temporary policy to stop documentation requests to providers as a result of the Public Health Emergency (PHE) for COVID-19

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

pandemic, the Medicare Part C Improper Payment Measurement medical record submission did not follow the same pattern as in previous years. Per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

### *Reduce the percentage of improper payments made under the Part D Prescription Drug Program (Lead Agency - CMS; Measure ID - MIP6)*

| | FY 2015 | FY 2016 [43] | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 3.5% | 3.4% | 3.3% | 1.66% | 1.65% | 0.74% | 1.14% | TBD |
| **Result** | 3.6% | 3.41% | 1.67% | 1.66% | 0.75% | 1.15% | 11/15/21 | 11/15/22 |
| **Status** | Target Not Met | Target Met | Target Exceeded | Target Met | Target Exceeded | Target Not Met | Pending | Pending |

The purpose of this measure is to reduce the percentage of improper payments in the Part D Prescription Drug program. Measuring Part D payment errors protects the integrity of the Part D program by ensuring that CMS has made correct payments to contracting private health plans for coverage of Medicare-covered prescription drug benefits. The Medicare Prescription Drug Program (Part D) payment error estimate measures the payment error related to Prescription Drug Event (PDE) data, where most errors for the program exist. CMS measures inconsistencies between information reports on PDEs and supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication orders as appropriate) and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error. A representative sample of beneficiaries undergoes a simulation to determine the Part D improper payment estimate.

In FY 2020, CMS did not meet its target of 0.74 percent, reporting an actual improper payment estimate of 1.15 percent, or $927.50 million. The increase from the prior year's estimate of 0.75 percent is due to year-over-year variability. As the rate is already low, any variation can cause shifts that are relatively (but not absolutely) large. The FY 2021 target is 1.14 percent. The FY 2022 target will be established in the FY 2021 AFR. Per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

### *Reduce the improper payment rate in the Medicare Fee-for-Service Program (Lead Agency - CMS; Measure ID - MIP1)*

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 12.5% | 11.5% | 10.4% | 9.4% | 8.0% | 7.15% | 6.17% | TBD |
| **Result** | 12.1% | 11.0% | 9.5% | 8.12% | 7.25% | 6.27% | 11/15/21 | 11/15/22 |
| **Status** | Target Met | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending |

CMS calculates the Medicare FFS improper payment estimate under the Comprehensive Error Rate Testing (CERT) program and reports the result in the HHS AFR. CMS initiated the CERT program in FY 2003 and produced a national Medicare FFS improper payment rate for each year since its inception. Please refer to the 2020 HHS AFR for information on the Medicare FFS improper payment methodology.

[43] Ibid.

In FY 2020, CMS exceeded its target of 7.15 percent, with an actual improper payment estimate of 6.27 percent, or $25.74 billion. This year's estimate decreased from the prior year's reported 7.25 percent improper payment estimate due to a reduction in improper payments for home health, and SNF claims. Although the improper payment rate for these services and the gross Medicare FFS improper payment rate decreased, improper payments for hospital outpatient, IRF, SNF, and home health claims were major contributing factors to the FY 2020 Medicare FFS improper payment rate, comprising 34.22 percent of the overall estimated improper payment rate. The FY 2021 target is 6.17 percent. CMS will establish the FY 2022 target in the FY 2021 AFR. Per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

CMS has developed a number of preventive and detective measures for specific service areas with high improper payment rates, which include Skilled Nursing Facility, hospital outpatient, Inpatient Rehabilitation Facility, and home health claims. CMS believes implementing targeted corrective actions will continue to prevent and reduce improper payments in these areas and reduce the overall improper payment rate. Please refer to the 2020 HHS AFR for detailed information on corrective actions.

***Reduce the improper payment rate in the Medicaid Program (Lead Agency - CMS; Measure ID - MIP9.1)[44]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 6.70% | 11.5 % | 9.57% | 7.93% | N/A | N/A | N/A | TBD |
| **Result** | 9.78% | 10.48% | 10.10% | 9.79% | 14.90% | 21.36% | N/A | 11/15/22 |
| **Status** | Target Not Met | Target Exceeded | Target Not Met but Improved | Target Not Met but Improved | Actual | Actual | N/A | Pending |

***Reduce the improper payment rate in the Children's Health Insurance Program (Lead Agency - CMS; Measure ID - MIP9.2)[45]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 6.50% | 6.81% | 7.38% | 8.20% | N/A | N/A | N/A | TBD |
| **Result** | 6.80% | 7.99% | 8.64% | 8.57% | 15.83% | 27.00% | N/A | 11/15/22 |
| **Status** | Target Not Met | Target Not Met | Target Not Met | Target Not Met but Improved | Actual | Actual | N/A | Pending |

The Payment Error Rate Measurement (PERM) program measures improper payments for the FFS, managed care, and eligibility components of both Medicaid (MIP9.1) and CHIP (MIP9.2). CMS measures improper payments in 17 states each year to calculate a rolling, three-year national improper payment rate for both Medicaid and CHIP. CMS based the national Medicaid and CHIP improper payment rates reported in the FY 2020 HHS AFR on measurements that CMS conducted in FYs 2018, 2019, and 2020. Please refer to the 2020 HHS AFR for information on the Medicaid and CHIP statistical sampling process and review period.

Since FY 2014, errors due to state noncompliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements have driven the Medicaid improper payment rate. Most

[44] These measures are being suspended until three years of new eligibility data are gathered and can be inserted into a new baseline in FY 2021. After establishing a full baseline, including eligibility, CMS will publish reduction targets in the FY 2021 HHS AFR.
. The FY 2021 AFR will report a target established for 2022.
[45] Ibid.

improper payments cited on claims are those where a newly enrolled provider was appropriately screened by the state, did not have the required NPI on the claim, or was not enrolled. While the screening errors described above are for newly enrolled providers, states also must revalidate the enrollment and rescreen all providers at least every 5 years. States were required to complete the revalidation process of all existing providers by September 25, 2016. In FY 2020, HHS measured the third cycle of states for compliance with requirements for provider screening at revalidation. Improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major error source in the Medicaid improper payment rate. CMS completed the measurement of all states for compliance with provider revalidation requirements in FY 2020 in order to establish a baseline. Moving forward, CMS will be able to track improvement in compliance with revalidation requirements as each cycle of states is measured a second time.

The national Medicaid improper payment (MIP 9.1) estimate for FY2020 HHS AFR is 21.36 percent or $86.49 billion. The national Medicaid component rates are 16.84 percent for Medicaid FFS, 0.06 percent for Medicaid managed care, and 14.94 percent for the Medicaid eligibility component.

The national CHIP gross improper payment (MIP 9.2) estimate for FY 2020 is 27.00 percent or $4.78 billion. The national CHIP component rates are 14.15 percent for CHIP FFS, 0.49 percent for CHIP managed care, and 23.53 percent for the CHIP eligibility component.

One area driving the FY 2020 CHIP improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the PPACA requirements in the PERM eligibility reviews. A federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of CHIP eligibility determinations, and increases the oversight of identified vulnerabilities. Based on the measurement of the first two cycles of states, eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with eligibility redetermination requirements.

In order to reduce the national Medicaid and CHIP improper payment rates, states are required to develop and submit states-specific Corrective Action Plans (CAPs) to CMS. Each year, CMS also outlines actions the agency will implement to prevent and reduce improper payments for all error categories on a national level. Please refer to the 2020 HHS AFR for detailed information on corrective actions.

## Goal 5. Objective 2: Manage human capital to achieve the HHS mission

As the Department looks to the future, it envisions all the achievements that can be reached when workforce performance is heightened, efficiencies are achieved, and accountability is strengthened. The Department must continue its progress to create a flexible and agile 21st century workforce that responds and adapts to change: change in technology, change in society, change in expectations, and change in scientific findings. HHS needs to grow the leaders of tomorrow today. To that end, the Department will continue to build a world-class management team and workforce ready to collaborate with colleagues across the Department, among other federal departments, and outside the Federal Government, to improve and enhance the health and well-being of Americans.

In the previous administration, the Office of the Secretary led this objective. All divisions contribute to the achievement of this objective. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 5.2 Table of Related Performance Measures

***Increase HHS employee engagement through Federal Employee Viewpoint Survey (FEVS) (Lead Agency - ASA; Measure ID - 2.6)*** [46,47]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | 67% | 68% | 69% | 72.5% | 73% | 75% | 73% | 73% |
| **Result** | 68% | 70% | 72% | 72.8% | 73.5% | 76.5% | 12/31/21 | 12/31/22 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending |

Employee engagement is foundational to achieving the level of active strategic management needed for building and sustaining the 21st century workforce. The Office of Personnel Management (OPM) FEVS measures employee engagement because it drives performance.[48] Engaged employees look at the whole of the organization and understand their purpose within the agency's mission. This understanding leads to better decision-making. The FEVS survey usually opens in May each year; however, due to COVID-19 and workplace disruptions, OPM postponed the survey twice. The late release of the survey and results impacted HHS's ability to meet the performance reporting deadline of December 31, 2020. Furthermore, the delayed release coupled with the need to focus on COVID-19 response and the lack of in-person events, decreased the level of FEVS promotion communications compared to FY 2019. Despite these challenges, HHS significantly improved its Department-wide Employee Engagement Index score, rising from 73.5% in FY 2019 to 76.5% for the FY 2020 survey.

Because OPM reduced the number of questions asked in the survey, added additional COVID-19 related questions, and removed some long-running indices (e.g., New Inclusion Quotient), HHS's ability to act on FEVS results and compare to prior years will be further impacted. In FY 2021 and 2022, HHS will

[46] This measure reports employee engagement index results collected through the FEVS. HHS anticipates 2020 FEVS results from OPM in January 2021.
[47] HHS 2021 and 2022 FEVS targets for this measure are adjusted considering COVID-19 government response.
[48] FEVS assesses whether an employee's sense of purpose is evident in their display of dedication, persistence, and effort in their work or overall attachment to their organization and its mission.

continue to use FEVS data to monitor the impact of its efforts to support organizational improvement.

***Decrease the cycle time to hire new employees (Lead Agency - ASA; Measure ID - 2.8)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 80 days | 80 days | 80 days | 80 days | 80 days |
| **Result** | N/A | 108 days | 101 days | 94 days | 113 days | 83 days | 12/31/21 | 12/31/22 |
| **Status** | N/A | Actual | Actual | Target Not Met but Improved | Target Not Met | Target Not Met but Improved | Pending | Pending |

In 2010, the Office of Personnel Management issued guidance encouraging agencies to implement an 80-day hiring process. In order to meet this goal, HHS continues to modernize its hiring practices to simplify and streamline the process. The Department is working to reduce duplicative effort through standardization and sharing of available candidates across staffing organizations.

During FY 2020, the customer base grew due to a surge in hiring in response to the COVID-19 crisis. Overall, HHS hiring increased more than 14% in FY 2020 compared to FY 2019 and more than 52% from FY 2018. Even with more customers and hardships brought by the COVID-19 crisis, HHS made marked improvements in meeting the Time to Hire target. HHS's HR operations transitioned well to maximum telework with no loss of productivity in the recruitment process. The expanded use of shared certificates enabled by the maturation of the HireNow resume search tool, the launch of definitive shared certificate policies, and the acculturation to shared certificate use among HR Centers and customers led to a dramatic increase in shared certificate utilization. More than 61% of all HHS hires in FY 2020 were additional selections from existing certificates of eligible applicants that selected a candidate.

Average end-to-end Time to Hire (from recruitment request validation to entry on duty) for HHS significantly decreased from 113 days to 83 days. The end-to-end measure includes parts of the hiring process that are not controlled by HR and were impacted by COVID-19-related telework restrictions such as in-person badging and security. In FY 2021 and FY 2022, HHS will continue to refine the process and will identify and implement additional ways to streamline the time-to-hire cycle.

Please refer to the ReImagine Maximize Talent initiative in the Major Management Priorities section of this report for more information.

## Goal 5. Objective 3: Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals

HHS information technology investments help achieve the Department's mission by acquiring and managing the technology infrastructure and systems for its health care and human services programs and mission-support programs. From externally facing websites such as HHS.gov to internal applications that manage programs and resources, HHS needs information technology solutions to be modernized, secure, and responsive to customer demands. The Department's current modernization investments include cloud computing, data center consolidation and improvements, information technology portfolio reviews, shared services, and a digital strategy that makes it easier to access information using HHS websites and tools. In addition, HHS is working to increase partnerships with industry, academia, and other organizations to leverage their technology expertise as well.

In the previous administration, the Office of the Secretary led this objective. All divisions contribute to the achievement of this objective. HHS has determined that performance toward this objective is progressing. The Department is progressing in this objective, but HHS plans to enhance that progress moving forward. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 5.3 Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Baseline | 96.5% | 97% | 100% | 100% |
| **Result** | N/A | N/A | N/A | 96% | 95% | 98% | 12/31/21 | 12/31/22 |
| **Status** | N/A | N/A | N/A | Actual | Target Not Met | Target Exceeded | Pending | Pending |

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

It is the responsibility of the OpDiv Chief Information Security Officers and StaffDiv system owners to maintain their system ATOs. In FY 2020, OpDivs implemented new training sessions for Information System Security Officers with guidelines and outreach as well as investing in a transformation project that streamlined the ATO process. In addition, an OpDiv implemented a Customer Engagement Team to assist customers through the ATO process. The Office of the Secretary also established its HHS Emergency Response Authorization Policy, which includes processes and requirements in the event of an emergency that requires implementation of a new information system in an expedited and secure manner. As a result of these proactive initiatives coupled with the creation of several new information systems in support of HHS' COVID-19 response, HHS successfully met the overall ATO FY 2020 compliance target.

***Improve the score to an "A" in each of the Federal Information Technology Acquisition Reform Act (FITARA) related Scorecard Metrics, per GAO and the House Oversight and Government Reform Committee (Lead Agency - ASA; Measure ID - 3.4)*** [49]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 90% | 90% | 90% | 90% | Discontinued |
| **Result** | N/A | 64% | 64% | 89% | 70% | 70% | 12/31/21 | N/A |
| **Status** | N/A | Actual | Historic Actual | Target Not Met but Improved | Target Not Met | Target Not Met | Pending | N/A |

FITARA established standards for buying and managing computer technology. The FITARA scorecard reports agency progress towards IT modernization. Scorecard results demonstrate the connection of technology capability to agency leadership and the agency's ability to use technology to drive change. The scorecard reports progress on a biannual basis.

HHS received a C- (i.e., 70%) on the scorecard released in June 2020. While grades may be flat, they signal a connection of the technology capability to the leadership of the agency and using technology to truly drive change. HHS will continue to work to combat cyber threats and incidents as well as work towards a holistic view of the enterprise.

[49] HHS will retire this measure in FY 2021. Throughout the history of the scorecard, sub-category measures of the scorecard have changed or have been retired. The House Committee on Oversight and Reform has signaled several more changes over the coming year, which creates uncertainty that would challenge HHS's ability to execute on such a broad goal. Instead, HHS will focus on other priorities that provide better metrics (e.g., increase percentage of systems with an Authority to Operate) in measuring this objective's performance.

## Goal 5. Objective 4: Protect the safety and integrity of our human, physical, and digital assets

Providing security for HHS involves more than preventing breaches or cybersecurity attacks. The Department's OpDivs and StaffDivs participate in efforts to preserve physical security; personnel security and suitability; security awareness; information security (including the safeguarding of sensitive and classified material); and security and threat assessments. In addition, the Department has established a network of scientific, public health, and security professionals internally, as well as points of contact in other agencies (e.g., intelligence community and the Information Sharing Environment Council). The Department has specialized staff to provide policy direction to facilitate the identification of potential vulnerabilities or threats to security, conduct analyses of potential or identified risks to security and safety, and work with agencies to develop methods to address them.

In the previous administration, the Office of the Secretary led this objective. All divisions contribute to the achievement of this objective. HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

### Objective 5.4 Table of Related Performance Measures

***Decrease the Percentage of Susceptibility among personnel to phishing (Lead Agency - ASA; Measure ID - 3.5)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Baseline | 6.8% | 6.5% | 6.2% | 6.0% |
| **Result** | N/A | N/A | N/A | 7% | 4.5% | 4.7% | 12/31/21 | 12/31/22 |
| **Status** | N/A | N/A | N/A | Actual | Target Met | Target Met | Pending | Pending |

Phishing is a fraudulent attempt to obtain sensitive information (e.g., user names and passwords) to access a system or network. Statistics suggest phishing attacks remain one of the main threat vectors targeting the health care industry. Data from Google, CheckPoint, Gartner, and others indicate that both phishing attacks in general and those on registered COVID-19 related domains skyrocketed. HHS trains and educates its personnel to reduce the likelihood of staff mistaking phishing email attempts for legitimate communications through a combination or training, education, and tools. The response rates to phishing training drills remain well below the industry average. HHS will continue this program in FY 2021 and strive to improve user reporting and resistance rates.

***Maintain the number of days since last major incident of personally identifiable information (PII) breach (Lead Agency - ASA; Measure ID - 3.6)***[50]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Baseline | 365 | 366 | 365 | 365 |
| **Result** | N/A | N/A | N/A | 365 | 365 | 366 | 9/20/21 | 9/20/21 |
| **Status** | N/A | N/A | N/A | Actual | Target Met | Target Met | Pending | Pending |

If an employee misuses, loses, or otherwise compromises PII, the action may result in steep financial costs and damage to the Department's reputation. This measure serves as an enterprise-wide

[50] HHS has updated the FY 2020 target for this measure to reflect that this is a leap year.

countdown since the last breach, based on the OMB definition of a major incident in the Department. HHS has not reported a major breach in more than 1096 days. HHS works closely with OpDiv privacy programs to continue to protect PII that is collected, used, maintained, shared, and disposed of by HHS information systems. HHS will continue to work with privacy programs across the Department to ensure staff training in protecting and safeguarding PII.

## Evidence Building Efforts

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

**Implementation of the Evidence Act:** HHS is in the initial stages of implementing the Foundations for Evidence-Based Policymaking Act of 2018 ("the Evidence Act"). The Evidence Act requires the Department to develop and implement a four-year Evidence-Building Plan, with annual evaluation plans. These plans will guide HHS's progress towards addressing the questions and priorities articulated in the Evidence-Building Plan. Per OMB Guidance M-19-23, HHS is presently developing interim Evidence-Building Plans and an evaluation plan for FY 2022. HHS also designated the Assistant Secretary for Planning and Evaluation as the Evaluation Officer for HHS.

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

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

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

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

## Cross-Government Collaborations

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

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

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

## Regulatory Reform

On January 20, 2021, President Biden rescinded Executive Orders (EOs) 13771 *Reducing Regulation and Controlling Regulatory Costs* and EO 13777 *Enforcing the Regulatory Reform Agenda* from the previous administration. EO 13771 required agencies to identify two deregulatory actions for every new significant regulatory action issued and EO 13777 directed agencies to establish a Regulatory Reform Task Force to review and evaluate existing regulations and to make recommendations for repeal or simplification. HHS tracked progress on these two EOs through six measures until FY 2020.

***Number of evaluations to identify potential EO 13771 deregulatory actions that included opportunities for public input and/or peer review (RR1)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 44 | 12 | 6 |
| **Result** | N/A | N/A | N/A | 111 | 15 | 6 |
| **Status** | N/A | N/A | N/A | Target Exceeded | Target Exceeded | Target Met |

***Number of EO 13771 deregulatory actions recommended by the Regulatory Reform Task Force to the agency head, consistent with applicable law (RR2)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 19 | 12 | 6 |
| **Result** | N/A | N/A | N/A | 61 | 14 | 6 |
| **Status** | N/A | N/A | N/A | Target Exceeded | Target Exceeded | Target Met |

***Number of EO 13771 deregulatory actions issued that address recommendations by the Regulatory Reform Task Force (final/published) (RR3)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 4 | 4 | 4 |
| **Result** | N/A | N/A | N/A | 25 | 15 | 13 |
| **Status** | N/A | N/A | N/A | Target Exceeded | Target Exceeded | Target Exceeded |

***Number of EO 13771 regulatory actions issued (final/published) (RR4a)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 6 | 15 | 12 |
| **Result** | N/A | N/A | N/A | 4 | 13[51] | 10 |
| **Status** | N/A | N/A | N/A | Target Exceeded | Target Exceeded | Target Exceeded |

***Number of EO 13771 deregulatory actions issued (final/published) (RR4b)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 4 | 4 | 4 |
| **Result** | N/A | N/A | N/A | 25 | 14[51] | 13 |
| **Status** | N/A | N/A | N/A | Target Exceeded | Target Exceeded | Target Exceeded |

***Total incremental cost of all EO 13771 regulatory actions and EO 13771 deregulatory actions (RR5)***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | -$28.7 million | -$550 million | -$100 million |
| **Result** | N/A | N/A | N/A | -$12,487.3[51] million | -$11,400.7[51] million | $21,981.9 million |
| **Status** | N/A | N/A | N/A | Target Exceeded | Target Exceeded[51] | Target Not Met |

## Major Management Priorities

In the previous administration, the Department identified four Major Management Priorities:

- Moving to a 21st Century Workforce
- Restoring Market Forces
- Making HHS More Innovative and Responsive
- Generating Efficiencies through Streamlined Services

Below HHS has provided detailed information on its progress with each initiative, including performance goals, performance indicators, and milestones.

### Moving to a 21st Century Workforce

*Supporting Initiative: Maximize Talent*

The Maximize Talent Initiative aimed to transform HHS's business processes and practices to meet modern-day human capital management and human resources operational challenges now and in the

[51] Results have been updated since the FY 2021 Annual Performance Plan and Report released in March, 2020 to match the results published in the Federal Register. Please reference *Regulatory Reform under Executive Order 13771: Final Accounting for Fiscal Year 2018* and *2019* for more detailed information.

future. Through the Maximize Talent efforts, the Initiative enhanced the Department's most important resource – its people. The transformation focused on three primary goals:

1. Optimizing HR Service Delivery by exploring ways to standardize core HR processes and implementing more efficient, effective, customer-focused, and cost-effective service delivery models.
2. Transforming the Employee Performance and Engagement Culture by taking steps to institutionalize an environment that empowers and engages employees to maximize their talents to their full potential and enhance our performance management program to motivate, reward, and recognize high performance.
3. Modernizing Human Resources Information Technology Infrastructure by upgrading and integrating enterprise IT systems that support the workforce and increase the data available to inform management decision-making.

Salient accomplishments under the Maximize Talent Initiative include:

- Envisioned a culture of accountability and data-driven decision making to improve workforce conditions and took action to achieve that vision:
    - HHS FEVS Employee Participation increased by 14.7 percentage points to 71.9 percent
    - HHS Employee Engagement Index increased by 0.7 percentage points to 73.5 percent;
    - Effective Communication Index increased by 0.8 percentage points to 71.2 percent; and
    - Global Satisfaction increased by 0.5 percentage points to 71.7 percent.
- Implemented a simplified recruitment process in the District of Columbia Human Resources Center, which included sharing certificates with multiple managers with similar hiring needs to expedite the hiring process. The simplified recruitment process reduced the average time to issue a certificate of eligible candidates to hiring officials using the new shared certificates process from 140 calendar days, on average, to 65.5 calendar days, on average and decreased the time-to-hire by saving 74.5 calendar days, on average, in the hiring process. Since February 2019, 80% of candidates were selected from simplified recruitments; with a 200% increase in number of new hires on-boarded.
- Implemented two pilots of Better Assessment Tools for Better Quality Candidates in partnership with OPM, including USA Hire, purchased now for use Enterprise-wide; and Subject Matter Expert Quality Assurance in collaboration with US Digital Services - HHS Office of the Chief Information Officer and Office of the Chief Technology Officer selected 35+ qualified candidates to fill critical vacancies.
- Transitioned SES performance management from manual, paper-based processes to electronic system in October 2018, automating all tracking/reporting for SES HHS-wide.
- Successfully launched the Enterprise Human Capital Management system upgrade from PeopleSoft 8.9 to 9.2 in May 2019, creating a lasting baseline for managing HHS personnel transaction and reporting, using a single enterprise cloud-based solution.

On September 30, 2019, HHS transitioned the work of the Maximize Talent Initiative to the Strategic Initiatives Group (SIG) within the Office of Human Resources (OHR). SIG is responsible for coordination, communication, development, and implementation of transformational and strategic initiatives for OHR. SIG activities focus on Maximize Talent's three primary goals: Optimizing HR Service Delivery; Modernizing HR Information Technology; and Improving the Employee Performance and Engagement Culture at HHS. OHR will continue to identify, pilot, scale improvements and reforms across HHS through the SIG.

**Designated Official:** Bahar Niakan, Former Initiative Lead, Deputy Chief Human Capital Officer

**Performance Goal:** Increase overall HHS employee participation in the FEVS survey, as well as the overall Employee Engagement Index Score by August 2019.

**Data Source and Validation:** Employee Engagement Score and Participation Rate from FEVS Survey. Validated by OPM.

**Performance Indicator:** FEVS Employee Engagement Index [52]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | 70% | 72.5% | 73% | 75% | 73% | 73% |
| **Result** | N/A | N/A | 72.2% | 72.8% | 73.5% | 1/31/21 | 12/31/21 | 12/31/22 |
| **Status** | N/A | N/A | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending | Pending |

**Performance Indicator:** FEVS Employee Participation[53]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | 54% | 56% | 58% | 60% | TBD | TBD |
| **Result** | N/A | N/A | 58.5% | 57.2% | 71.9% | 9/30/20 | 9/30/21 | 9/30/22 |
| **Status** | N/A | N/A | Target Exceeded | Target Exceeded | Target Exceeded | Pending | Pending | Pending |

| | Milestones | Planned Completion Date | Status |
|---|---|---|---|
| 1. | 2019 FEVS guidance from the ASA to OPDIV and STAFFDIV Heads and Executive Officers | 10/31/2018 | Completed |
| 2. | Held Employee Engagement Forum Kickoff | 10/17/2018 | Completed |
| 3. | Held FEVS Program Managers Best Practice Exchange | 11/1/2018 | Completed |
| 4. | Provided pre-populated OPM reporting template to FEVS Program Managers | 11/6/2018 | Completed |
| 5. | Compiled initial report of HHS 20 by 20 by 2020 data for submission to OPM | 11/15/2018 | Completed |
| 6. | Submit HHS Report to OPM | 11/23/2018 | Completed |
| 7. | ASA/CHCO Endorsement of “Sprint to 2019” and ”Marathon to 2020” | 11/23/2018 | Completed |
| 8. | Set Up EVS ART Training for OpDiv/StaffDiv | 1/19/2018 | Completed |
| 9. | Leaders at all levels present FEVS data to work units and commit to action. | 3/31/2019 | Completed |
| 10. | Collect insight on employee engagement from the employee perspective. | 2/28/2019 | Completed |
| 11. | Release a call for Organization Development services/providers to support SPRINT 2019 | 2/28/2018 | Completed |

[52] HHS anticipates 2020 FEVS results from OPM in January 2021. HHS 2021 and 2022 FEVS targets for this measure are adjusted in light of COVID-19 government response.

[53] The FY 2021 target will be established upon evaluation of 2019 FEVS results.

| | Milestones | Planned Completion Date | Status |
|---|---|---|---|
| 12. | Managers and supervisors lead work units in action planning for quick sprint improvement. | 3/29/2019 | Completed |
| 13. | Active, visible, and meaningful action to improve employee engagement. | 4/30/2019 | Completed |
| 14. | Encourage participation in the FEVS. | 6/21/2019 | Completed |
| 15. | Employ long term strategies for success including FEVS Program Manager offsite, lessons learned from SPRINT to 2019, assessment of FEVS program metrics (leading and lag indicators), continued engagement of Employee Engagement Community of Practice, and other | 6/21/2019 –8/30/2020 | Ongoing |

## Restoring Market Forces

*Supporting Initiative: Bring Common Sense to Food Regulation; Enhance state produce safety infrastructure to improve farm compliance with Produce Safety Rule.*

The Bring Common Sense to Food Regulation Initiative aimed to increase collaboration between food regulatory programs to minimize dual jurisdiction and improve state produce safety infrastructure. To address these issues, this Initiative consisted of two sub-Initiatives: Regulatory Oversight and State Produce Safety Infrastructure. The objective of the State Produce Safety Infrastructure sub-Initiative was to fully develop and implement a state produce safety infrastructure to assist FDA in implementing the Food Safety Modernization Act (FSMA) Produce Safety regulations. The core objective of the Regulatory Oversight sub-Initiative was to increase regulatory efficiency and advance food safety in the context of "dual jurisdiction establishments," where the Food and Drug Administration and the U.S. Department of Agriculture's Food Safety and Inspection Service both have jurisdiction to conduct food inspections and exercise oversight. FDA is working on joint efforts between USDA and FDA to reduce the duplication of inspections and create efficiencies with regulatory oversight. This includes the consolidation and updating of existing memorandums of understanding between the agencies and the creation of a Field Management Directive.

On September 30, 2019, HHS transitioned the work of this Initiative to the Office of Regulatory Affairs and the Center for Food Safety and Applied Nutrition within FDA. In ongoing efforts to implement the FSMA, FDA has provided over $133 million in support to 48 grantees (47 states and 1 territory) to conduct outreach as well as establish regulatory programs. By working with states to develop these programs and having states conduct their own inspection and compliance/enforcement work, FDA is working towards building an Integrated Food Safety System where states and FDA can mutually rely on each other's work. As a result of the COVID-19 Pandemic, FDA imposed a Stop Work Order on the Produce Safety Cooperative Agreement between March 22, 2020 through June 5, 2020. The Stop Work Order limited all face to face work grantees of the program could conduct. As a result, the number of produce inspections conducted in this period is less than expected, but the outcome still exceeded the target.

**Designated Official:** Erik P. Mettler, Former Initiative Lead, Assistant Commissioner for Partnerships and Policy

**Performance Goal:** Create a more effective and efficient food safety system by partnering and leveraging the role of the states in improving produce safety as measured by 85 percent of states and

territories (out of 55 total, 50 states and 5 territories) participating in the Produce Safety Implementation Cooperative Agreement Program (State CAP) by September 30, 2019.

**Data Source and Validation:** State CAP

**Performance Indicator:** Number of States and Territories (Grantees) Participating in State CAP[54]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | Baseline | Baseline | 47 | 47 | 48 | Discontinued |
| **Result** | N/A | 42 | 43 | 47 | 48 | 48 | N/A |
| **Status** | N/A | Actual | Actual | Target Met | Target Exceeded | Target Met | N/A |

**Performance Goal:** Create a more effective and efficient food safety system by increasing the role of the states in improving produce safety as measured by an increase in inspections being conducted by state partners participating in State CAP by December 31, 2021.

**Data Source and Validation:** State inspection reporting.

**Performance Indicator:** Number of Inspections being conducted by State Partners Participating in State CAP[55,]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | Result +10% | Result |
| **Result** | N/A | N/A | N/A | N/A | 219 | 1,190 | 6/30/22 |
| **Status** | N/A | N/A | N/A | N/A | Actual | Target Exceeded | Pending |

| | Milestones | Planned Completion Date | Status |
|---|---|---|---|
| 1. | Complete detailed assessment of state produce regulatory programs, to include projected availability of resources and jurisdictional assessment. | 6/2019 | Completed |
| 2. | Develop plan(s) that includes: potential funding sources, business practices, funding opportunity announcements, monitoring job aids, partners for leveraging, outreach opportunities, and measures of success. | 12/2019 | Completed |
| 3. | Execution of plan (s) | 6/2021 | In Process/On-Track |

[54] The HHS target for FY 2019 was to have 48 grantees participating in state CAP. HHS has achieved this target and is discontinuing this performance indicator.

[55] After the initial ramp up of inspections, HHS expects for progress to plateau.

## Making HHS More Innovative and Responsive

*Supporting Initiative: Optimize NIH*

The *Optimize NIH* Initiative aimed to increase the efficiency and effectiveness of administrative functions for employees and the agency in support of the NIH mission. *Optimize NIH* is focused on administrative areas that could be more effective and efficient if: 1) managed enterprise-wide, 2) managed through service centers, or 3) harmonized.

*Optimize NIH* initially focused its efforts on achieving enterprise-wide efficiencies in: Committee Management, Freedom of Information Act (FOIA), and Ethics. Harmonization was achieved through implementation of a standard format for Institutes and Centers to use as they update their Strategic Plans to be in alignment with the overall NIH Strategic Plan.

The remaining functional areas of Acquisitions, Information Technology Security, Title 42(f) Processing, Travel, and Property functions are optimizing using a combination of strategies best suited for each business area.

Salient accomplishments under *Optimize NIH* include:

- Expanded the Committee Management Module (CMM) within existing Electronic Research Administration grants systems to add functionality and made it available for select stakeholders in a sandbox environment in September 2020. Also, with the full implementation of the USA Staffing Onboarding System for Special Government Employees (SGEs) in March 2020 and the elimination of Committee Management courier services to HHS, there is a cost savings of $11,000 per year.
- Rolled out a customizable commercial off-the-shelf FOIA platform (FOIAXpress) and public access portal in early 2019 to improve FOIA management and standardize processes across all of NIH's Institutes and Centers. Since the launch of FOIAXpress and the portal, the number of requests received through portal has risen to 77 percent, the number of processed FOIA requests increased by 272 percent.
- Expanded the capabilities of the NIH Ethics Enterprise System, including electronic submission of the OGE Form 450 Confidential Financial Disclosure Report for SGEs and 278T Periodic Transaction Report.
- Created dashboards for data-based decision making in the areas of travel reporting, contract analytics, and IT security.

**Designated Official:** Janet Shorback, Initiative Lead

**Performance Goal:** Increase the efficiency and effectiveness of NIH administrative functions to better support the agency's mission while maintaining support of the workforce, increasing employee engagement, and overseeing the use of taxpayer dollars.[56] HHS completed the following performance goal: Make management of Freedom of Information Act (FOIA) requests more efficient by reducing the number of systems used to track and submit FOIA requests by December 17, 2018.

[56] Since HHS has met this performance goal, the Department is discontinuing the measure.

**Data Source and Validation:** Tracking system – systems to track and submit FOIA reports. The new, unified system permits data review and validation at the individual FOIA request level to monitor and improve quality of data and process management.

**Performance Indicator:** Number of Systems Used to Track and Submit FOIA Reports[57]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Baseline | 1 | Discontinued |
| **Result** | N/A | N/A | N/A | 8 | 1 | N/A |
| **Status** | N/A | N/A | N/A | Actual | Target Met | N/A |

| | Milestones | Planned Completion Date | Status |
|---|---|---|---|
| 1. | Due diligence to identify suitable FOIA platform | 7/2018 | Completed |
| 2. | Finalize FOIA implementation plan | 8/2018 - 9/2018 | Completed |
| 3. | Begin implementing FOIA plan | 9/2018 | Completed |
| 4. | Selected platform for FOIA effort and began portal customization | 10/2018 | Completed |
| 5. | Customize selected FOIA platform and perform user-acceptance testing | 11/2018 | Completed |
| 6 | Train all NIH FOIA staff on selected FOIA platform | 12/2018 | Completed |
| 7. | Launch selected FOIA platform across NIH | 12/2018 | Completed |
| 8. | Customize portal and launch customized portal to public | 3/2019 | Completed |

## Generating Efficiencies through Streamlined Services

*Supporting Initiative: Buy Smarter*

The *Buy Smarter* Initiative is transformative and data-driven, leveraging the collective purchasing power of HHS to secure lower prices, achieve operational efficiencies, and generate cost avoidances on goods and services. *Buy Smarter* is creating a leaner, more accountable, and efficient government by using technology to improve underlying business processes and mission outcomes.

*Buy Smarter* serves the mission and acquisition communities. The immediate beneficiary is the HHS acquisition community through the group purchasing model. This will ultimately benefit HHS's overall mission, through efficiencies gained from the rationalization of duplicative contracts and lower variance on prices paid for similar products and services.

*Buy Smarter* established an operating model, developed an implementation plan, and created a funding strategy for procurement process improvements that will realize projected cost avoidances. The *Buy Smarter* Operating Model is based on the General Services Administration (GSA) Category Management structure. *Buy Smarter* uses Artificial Intelligence (A.I.) technology to analyze current HHS contract data

[57] The HHS target for FY 2019 was to reduce the number of systems from eight to one. HHS has achieved this target and is discontinuing this performance indicator.

and the underlying mission requirements. This identifies opportunities to consolidate contract vehicles across HHS to ensure best pricing and smarter buying for the federal government.

*Buy Smarter* is moving from the planning phase to the implementation phase along the parallel tracks of people, process, and technology, which will result in millions of dollars in savings when the improvements are implemented and realized. *Buy Smarter* leverages new and emerging technologies (e.g., cloud-native technology, A.I., machine learning, etc.) to analyze HHS-wide spend data, thereby achieving economies of scale and cost avoidance across the Department.

**Designated Official:** David Dasher, Initiative Lead

**Performance Goal:** Establish an HHS-wide Executive Steering Committee to analyze data and make enterprise acquisition decisions for goods and services. This will operationalize OMB Memo M-19-13 for Category Management and increase throughput (# of *BUY*SMARTER acquisitions), thereby, achieving economies of scale and cost avoidance across the Department.[58]

**Data Source and Validation:** Five HHS contract writing systems. Data from all five contract writing systems will be consolidated in HHS's Accelerate model, which leverages Blockchain Technology and Artificial Intelligence for advanced data analytics.

**Performance Indicator:** Achieve increased year over year throughput (# of contracts executed through *BUY*SMARTER enterprise acquisition program), coverage (total spend based on throughput, and impact (projected cost avoidance under the *BUY*SMARTER enterprise acquisition program [annual, overall, and average percent avoided compared to previous prices paid).[59]

| | FY 2014 | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | NA | N/A | NA | Baseline | Result +10% |
| **Result** | N/A | N/A | N/A | N/A | NA | N/A | NA | 9/30/21 | 9/30/22 |
| **Status** | N/A | N/A | N/A | N/A | N/A | N/A | N/A | Pending Actual | Pending |

| | Milestones | Planned Completion Date | Status |
|---|---|---|---|
| 1. | Analyzed 18 months of HHS-wide spend data through an A.I. tool to give never-before visibility into HHS-wide goods and services spending. | 3/2018 | Completed |
| 2. | Determined initial savings hypotheses based on category benchmarks. | 3/2018 | Completed |
| 3. | Establish BUYSMARTER Operating Model framework for all GSA Categories, which will cover all HHS spending. | 7/2018 | Completed |
| 4. | Developed an overview of current spending, including top categories and vendor fragmentation. | 12/2018 | Completed |

[58] HHS is retiring the original performance goal and performance indicator because *BUY*SMARTER is transitioning from an initiative to a program and graduating from ReImagine HHS into ASFR OA on September 30, 2020. The new realigned performance goal and performance indicator reflect this transition from initiative to an ongoing program.

[59] The initiative has realigned the performance goal and performance indicator based on the current focus of the work effort.

| | Milestones | Planned Completion Date | Status |
|---|---|---|---|
| 5. | Establish Category Collaborative Model to focus on GSA Categories of Spend | 1/2019 | Completed |
| 6. | Leverage Accelerate block chain data layer for initial BUYSMARTER Operating Model. | 3/2020 | Ongoing |
| 7. | Conducted initial business-case analysis to focus on understanding current purchasing fragmentation and potential inefficiencies of the current acquisition function (e.g., initial spend analysis, initial acquisition function review). | 7/2019 | Completed |
| 8. | Conducted additional validation and implementation (e.g., detailed spend analysis, detailed acquisition function review). | 10/2019 | Completed |
| 9. | Establish the *BUY*SMARTER Executive Steering Committee (ESC) to provide strategic oversight of the *BUY*SMARTER Operating Model. | 4/2020 | Completed |
| 10. | The ESC approves and votes for the first *BUY*SMARTER goods and/or services to pursue as an enterprise. | 6/2020 | Completed |
| 11. | Design, develop and implement the initial version of the *BUY*SMARTER Full Contract Scan AI Tool for the Medical Category to support the *BUY*SMARTER Operating Model.. | 3/2020 | Completed |
| 12. | Enhance and extend the initial version of the *BUY*SMARTER Full Contract Scan AI Tool to further support the *BUY*SMARTER Operating Model. | 9/2020 | Pending |
| 13. | Put enterprise-wide contracts in place for 80 percent of AI identified common spend categories. The 80 percent metric covers the majority of HHS's spend while recognizing that there are unique requirements that may not fall under common spend categories. | 10/2023 | Pending |

## Lower-Priority Program Activities

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

## Changed Performance Goals

Please refer to https://www.hhs.gov/about/budget/fy2021/performance/performance-plan-changes-in-performance-measures/index.html?language=es for Information on performance goal changes.

## Data Sources and Validation

Please refer to https://www.hhs.gov/about/budget/fy2021/performance/performance-plan-data-sources-and-validation/index.html?language=es for supporting information on the performance goals in the HHS FY 2021 Annual Performance Plan and Report.