FISCAL YEAR 2015

Annual Performance Report and Performance Plan

Released March 2014

PERFORMANCE

RESULTS

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SUCCESS

U.S. Department of Health & Human Services

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Message from the HHS Performance Improvement Officer

The Department of Health and Human Services is outcome-oriented in the delivery and administration of health and human services. HHS staff, as well as grantees, contractors, volunteers, and community members implement programs for millions of citizens to: support Americans in securing quality, affordable health care; keep food and medical products safe; protect against chronic and infectious diseases; increase preparedness; assist access to affordable child care; perform pioneering medical research; and fulfill our commitments to tribal communities for health care and human services; among other worthwhile ends.

Efficiency, transparency, accountability, and effectiveness of programs are continually emphasized to strengthen health care, advance scientific knowledge and innovation, and support the health, safety, and well-being of the American people. This report represents part of the Department's efforts to monitor the performance of its activities and provide that information to the public. In FY 2013, HHS tracked six priority goals and more than 900 performance measures to manage and improve the efficiency and effectiveness of departmental operations. Included in this report is a representative set of 136 performance measures that illustrate progress toward achieving the Department's strategic goals. The information provided spans HHS's eleven operational divisions and sixteen staff divisions and includes work across the country and throughout the world. Each HHS component has reviewed their submissions and I confirm, to the best of my ability, that the data are reliable and complete. When results are not available because of delays in data collection, the report notes the date when the results will be available.

The results from the past year show that HHS is making excellent progress organization-wide in enhancing performance. The Department completed its two year period of focused attention on the achievement of six priority goals. Significant progress was made in each priority goal and these efforts produced improvements in the quality of care provided by health centers, patient safety through a reduced rate of healthcare-associated infections, the use of health information technology, and the quality of early childhood education, as well as helped reduce cigarette smoking and foodborne illness in the population. Additionally, the Department has developed five priority goals for FY 2014-2015 which will build on the successes of previous goals, support GPRAMA requirements, and align to the new Strategic Plan. Our outstanding and dedicated staff ensures that the Department's performance in meeting its mission will continue to improve. We are proud to present here many of the accomplishments achieved by HHS and its plans to build upon that success.

Ellen G. Murray
Assistant Secretary for Financial Resources
Health and Human Services

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Overview

The U.S. Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS is responsible for almost a quarter of all Federal expenditures and administers more grant dollars than all other Federal agencies combined.

Eleven operating divisions, including eight agencies in the United States Public Health Service and three human service agencies, administer HHS's programs. In addition, staff divisions provide leadership, direction, and policy and management guidance to the Department. The organizational structure and chart of the Department is provided in the following sections.

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 a special obligation to provide services for American Indians and Alaska Natives (AI/ANs) based on these individuals' relationship to tribal governments. HHS works with tribal governments and with urban Indian and other 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 partners in the private sector, such as regulated industries, academic institutions, trade organizations, and advocacy groups. The Department recognizes that leveraging resources from organizations and individuals with shared interests allows HHS to accomplish its mission in ways that are the least burdensome and most beneficial to the American public. Grantees in the private sector, such as academic institutions and faith-based and neighborhood partnerships, provide many HHS-funded services at the local level. In addition, HHS works closely with other Federal departments and international partners to coordinate its efforts to ensure the maximum impact 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 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 eleven operating divisions that administer HHS programs. These operating divisions are:

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

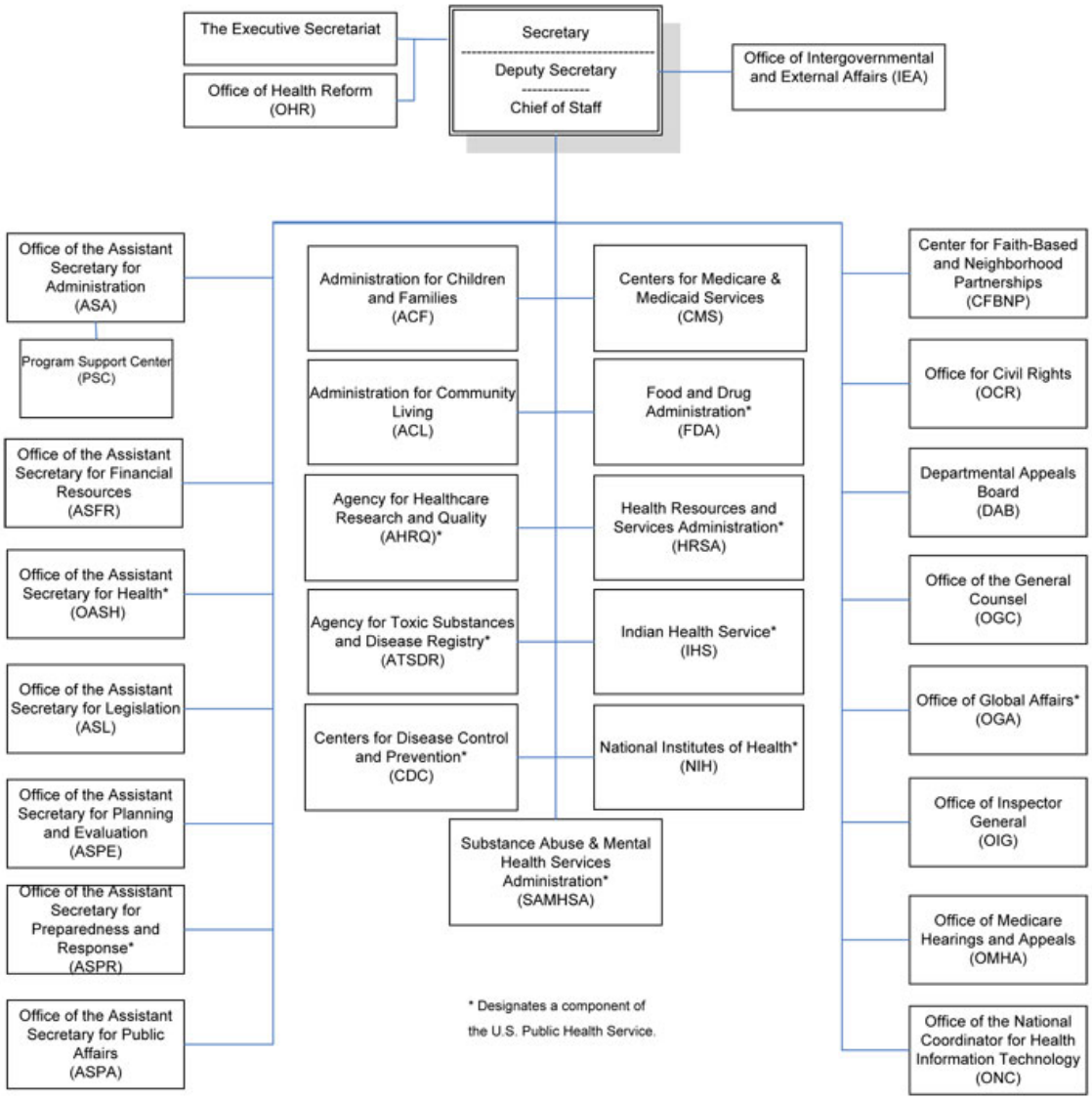
- National Institutes of Health (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

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

- Office of the Assistant Secretary for Administration (ASA)
- Assistant Secretary for Preparedness and Response (ASPR)
- Immediate Office of the Secretary (IOS)
- Office of the Assistant Secretary for Health (OASH)
- Office of Inspector General (OIG)
- Office of Medicare Hearings and Appeals (OMHA)
- Office of the National Coordinator for Health Information Technology (ONC)

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

Organizational Chart Department of Health and Human Services



Also, see the **text version of the HHS Organizational Chart** with links to agencies and their charts**.**

Cross-Agency Priority Goals

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

Strategic Goals Overview

HHS developed a new strategic plan in 2013 to encompass the period from FY 2014 to 2018. This plan replaces the previous FY 2010–2015 HHS Strategic Plan. The new plan, available at http://www.hhs.gov/secretary/about/priorities.html, identifies four strategic goals and 21 related objectives. The four strategic goals are:

Goal 1: Strengthen Health Care
Goal 2: Advance Scientific Knowledge and Innovation
Goal 3: Advance the Health, Safety, and Well-being of the American People
Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

Management Objectives and Priorities

The structure of the FY 2014-2018 HHS Strategic Plan aligns Strategic Goals 1 through 3 to mission-focused efforts while Strategic Goal 4 aligns to HHS's overall management objectives. The emphasis on efficiency, transparency, accountability, and effectiveness of HHS programs in Goal 4 serves to highlight efforts across the Department to enable enhanced program performance in strengthening program integrity, creating innovations for data access and use, investing in the HHS workforce, and promoting sustainability. The planned actions, performance targets, and indicators used to measure progress for these can be found in the Goal 4 section of the Annual Performance Plan in this document. These management objectives were aligned to Goals 4 and 5 in the previous HHS Strategic Plan covering FY 2010-2015. The current results located in the Annual Performance Report section of this document, in addition to performance targets and indicators, are based on this Plan.

HHS priorities extend to innovation, customer service, as well as effectiveness and efficiency.

Innovation

Fraud Prevention: Support comprehensive efforts across the Department and partners to combat health care fraud, waste, and abuse, including prevention focused activities, improper payment reductions, provider education, data analysis, audits, investigations, and enforcement.

Information Transparency: To increase government transparency, HHS has published more government information online in ways that are easily accessible and usable. Agencies have developed and disseminated accurate, high-quality, and timely information via a number of online resources. HHS remains committed to expanding access and use of its data to encourage public participation in the analysis of the health problems facing our Nation.

Innovation Promotion: HHS established the HHS Innovation Council, with a mission of advancing a culture of innovation and success within HHS. The Innovation Council plays an important role in identifying barriers to innovation and promoting crosscutting solutions involving policy change and

project execution. The Innovation Council initiates and oversees a number of activities to foster innovation among employees.

Customer Service

Online Program Improvements: CMS has several web-based service projects to address the changing needs of Medicare beneficiaries and to achieve efficiencies and cost savings. These projects range from developing online projects that improve on well-known print resources to creating mobile-friendly websites and tools to improve use of customer data and enhance the online experience.

Enforcement Program Improvements: The Federal Office of Child Support Enforcement (OCSE) oversees the national child support program, which touches the lives of approximately 17.5 million children nationwide. To achieve its primary objective of providing faster and more efficient service to families through its State and business partners, OCSE has developed the Federal Parent Locator Service Enterprise Services Portal, which provides a variety of services, applications and systems to users in an easy, intuitive format, removing barriers to child support services and improving efficiency and effectiveness while reducing administrative burden on program partners and stakeholders.

Health Care Customer Service Improvements: HRSA's Bureau of Primary Health Care (BPHC) implements customer service improvements and burden reduction initiatives for its grantees and stakeholders. Since 2007, BPHC has conducted an extensive annual grantee satisfaction survey that looks at many facets of BPHC operations, including asking grantees for their input on their technical assistance experiences, satisfaction in working with their regional divisions and branches, and many other core areas of interaction with BPHC offices and divisions.

Effectiveness and Efficiency

Medicare Appeals: OMHA plans to increase its administrative law judges and support staff necessary to address the increasing number of Medicare appeals while maintaining the quality and accuracy of its decisions. OMHA continues to utilize technology to offer appellants access to multiple hearing venues and service.

Acquisition Reform: HHS will move forward with an initiative in contract and acquisition reform. Resources will be used to increase the capacity and capabilities of the Department's acquisition workforce.

Cybersecurity: In FY 2015, HHS plans to implement the full operations of the Trusted Internet Connection, which consolidate the Department's internet traffic into three secure portals and provide for advanced threat monitoring capabilities.

Human Capital: HHS continues to implement the HHS Accelerated Hiring Process and is preparing guidance on integrating hiring processes to improve the timeliness of background investigations.

Performance Management

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

Responding to opportunities afforded by GPRAMA, HHS has instituted significant improvements in performance management since FY 2011 including:

- Developing, analyzing, reporting, and managing six Priority Goals for the period of FY 2012-2013 and implementing quarterly performance reviews between HHS component staff and HHS leadership to monitor progress toward achieving key performance objectives.
- Formulating a new set of Priority Goals to be achieved by the end of FY 2015, with continued quarterly progress reviews.
- Enhancing the coordination of performance measurement, budgeting, strategic planning, and program integrity activities within the Department.
- Continuing to foster a network of component Performance Officers, who support, coordinate, and implement performance management efforts across HHS.
- Sharing of best practices in performance management at HHS through webinars and other media.

HHS Priority Goals

HHS, along with other Federal agencies, uses Priority Goals to improve performance and accountability. HHS established a set of near-term (18 – 24 month) Priority Goals aligned to a HHS Strategic Plan Goal and began holding quarterly data-driven reviews to monitor progress towards these Priority Goals in FY 2012. These Priority Goals completed their two year period of quarterly reviews in FY 2013 and the summary results are included below.

A new set of Priority Goals below have been established for FY 2014-2015. They were developed through gathering input and collaboration across the Department to identify those activities that would reflect HHS priorities and benefit from the focus and communication of the Priority Goal process. Some of these Goals are the same as those from FY 2012-2013, reflecting their continued importance across the Department. These Priority Goals are largely cross-cutting in nature, requiring active management across HHS components for success. Priority Goals are included in the Strategic Plan and Annual Performance Plan with targets displayed until at least FY 2015. HHS will actively monitor progress and work towards the achievement of these goals through quarterly data-driven reviews and other mechanisms. Please refer to www.Performance.gov for information on Priority Goals and the HHS components' contributions to those goals.

Summary Review of HHS Priority Goals FY 2012 – FY 2013

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

> **Results Reported:** HRSA achieved the HHS goal for Health Center Patient Centered Medical Home recognition. All targets and milestones were exceeded for the FY 2013 fourth quarter, as 33 percent of health centers have at least one site recognized as a PCMH and 978 health centers grantees initiated surveys to become PCMH recognized.

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

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

> **Results Reported**: CMS, CDC, AHRQ and OASH collaborated to coordinate programs across HHS, in addition to working closely with public and private partners towards the goal to reduce HAIs of CLABSI and CAUTI. Current CLABSI results show a 19 percent reduction. Although final results are still pending (late March 2014) confidence exists that the CLABSI target to reduce the Standardized Infection Ratio (SIR) by 25 percent will be achieved. The anticipated reduction of the CAUTI SIR by 20 percent has not yet been demonstrated, and recent data trends (reflecting March 2013) show an increase in CAUTI SIR by 9 percent. This unanticipated increase is thought to be a result of several factors, including the influx of new CAUTI reporters during this period. HHS partners will continue to use a combination of programmatic levers and evidence-based infection control interventions in order to show substantial future reductions in CAUTI.

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

> **Results Reported:** ONC and CMS joined together to exceed this goal by qualifying and delivering an incentive payment to more than 325,000 eligible providers. This program has achieved broad coverage, registering 73 percent of Medicare Eligible Professionals, 137,136 Medicaid Eligible Professionals in 49 States, and 91 percent of eligible hospitals.

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

> **Results Reported:** ACF continued progress toward this goal. The most recent results (FY 2013) show 27 States had a QRIS that met all seven high-quality benchmarks for child care and other early childhood education programs developed by HHS, exceeding the FY 2013 target of 25 States. In addition, at least five States have incorporated six quality benchmarks and at least seven States have incorporated five quality benchmarks. Also as part of this Priority Goal, the ACF Office of Head Start is striving to increase the percentage of Head Start children in high quality classrooms using CLASS: Pre-K. An analysis of CLASS scores for a cohort of 359 Head Start grantees that received on-site monitoring in the 2012-2013 Head Start "school year" indicates that 31 percent of grantees scored in the low range, thus missing the target of 23 percent. All grantees scoring in the low range in FY 2013 did so for the Instructional Support domain, which indicates that improving Instructional Support scores is difficult and requires more time and intensive effort relative to the other domains.

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

> **Results Reported:** OASH, FDA, NIH, and CDC continued to make progress together toward this goal, although the pace of has slowed, reaching a rate of 1,196 cigarettes per capita in the most recent results, not quite meeting the target but improving on the previous result. While HHS is relatively confident to achieve the final goal of reducing adult per capita cigarette consumption

by more than 17 percent from our 2010 baseline, serious obstacles do exist. The supporting measure that tracks smoking cessation (percentage of adult smokers aged 18 years and older who last smoked 6 months to 1 year ago) has been trending downward since 2010 and it appears that it is on track to continue to exceed future targets. There has been steady progress on the other two supporting measures that tracks smoking among young adults and retail compliance inspections.

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

Results Reported: FDA and CDC continue to make progress toward achieving this goal. In the most recent results CDC reported the illness rate during the 12-month period ending in September 2013 was 2.3 illnesses per 100,000. This is a decrease from the 2010 rate (3.5 cases per 100,000) and is also less than the 2007-2009 baseline of 2.6 cases per 100,000 population. Despite the consistent decline of the illness, the rate of decrease may not be fast enough to reach the goal of 2.1 cases per 100,000. In support of this goal, FDA had conducted inspections of all registered large egg producers and 296 of the planned 300 small egg firm inspections were completed.

HHS Priority Goals FY 2014 – FY 2015

Improve health care through meaningful use of health information technology: By the end of FY 2015, increase the number of eligible providers who receive incentive payments from the CMS Medicare and Medicaid Electronic Health Record () Incentive Programs for the successful adoption or demonstration of meaningful use of certified EHR technology to 425,000.

Reduce foodborne illness in the population: By December 31, 2015, decrease the rate of Salmonella Enteritidis illness in the population from 2.6 cases per 100,000 (2007-2009 baseline) to 1.9 cases per 100,000.

Reduce combustible tobacco use: By December 31, 2015, reduce the annual adult combustible tobacco consumption in the United States from 1,342 cigarette equivalents per capita to 1,174 cigarette equivalents per capita, which will represent an approximate 12 percent decrease from the 2012 baseline.

Improve patient safety: To reduce the national rate of healthcare-associated infections (HAIs) by September 30, 2015 by demonstrating a 10 percent reduction in national hospital-acquired catheter-associated urinary tract infections (CAUTI) from the current SIR of 1.02 to a target SIR of 0.92.

Improve the quality of early childhood education: By September 30, 2015, improve the quality of early childhood programs for low-income children through implementation of the Quality Rating and Improvement Systems in the Child Care and Development Fund, and through implementation of the Classroom Assessment Scoring System in Head Start.

Organization of this Document

To facilitate the transition from the previous Strategic Plan to the new Strategic Plan, this document is divided into two parts. The first part is the Annual Performance Report, aligned to the FY 2010–2015

HHS Strategic Plan goals listed below. It contains the final report of performance results for this Strategic Plan.

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

The second part of this document is the Annual Performance Plan, which presents the representative set of measures that will track HHS's performance relative to the corresponding goals and objectives of the FY 2014-2018 Strategic Plan.

Goal 1: Strengthen Health Care
Goal 2: Advance Scientific Knowledge and Innovation
Goal 3: Advance the Health, Safety, and Well-being of the American People
Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

Annual Performance Report - FY 2010 – 2015 Strategic Plan

The Annual Performance Report provides information on HHS's progress toward achieving the goals and objectives described in the HHS Strategic Plan and Annual Performance Plan. This section closes out reporting related to performance measures aligned to the FY 2010–2015 Strategic Plan and is organized around the goals and objectives contained therein. The information shown here reflects the most recent results available at the end of FY 2013 for HHS representative measures. The Goals and Objectives contained in this Strategic Plan can be found in Appendix A of this document. An archived copy of this Strategic Plan can be found at http://aspe.hhs.gov/hhsplan/archives.shtml.

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

Before the Affordable Care Act (ACA), millions of Americans lacked access to affordable health insurance. Many who did have health insurance had gaps in coverage, such as exclusions for pre-existing conditions, or they were one step away from losing coverage because of a change in employment. Individuals with health insurance face increasingly high premiums and medical costs that drive some to bankruptcy or force choices between maintaining health insurance coverage and paying for other household essentials. HHS has been identified as the lead federal agency responsible for implementing the ACA, which contains many new health insurance market reforms and programs to address these and other issues.

Starting in 2010 and continuing in 2013, HHS has implemented new regulations aimed at increasing consumer protections and at creating a more competitive insurance market to both lower cost and improve quality. These new protections and increased oversight of the insurance industry help ensure that consumers are receiving value for their premium dollars; this oversight will also make the healthcare system more responsive to the needs of its patients, providers, and other stakeholders.

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

Objective 1.A Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	8.4 Million	8.7 Million	9.7 Million
Result	8.3 Million	9.5 Million	10.2 Million	Nov 30, 2014
Status	Historical Actual	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%
Result	90%	92%	90%	91%
Status	Target Met	Target Exceeded	Target Met	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%
Result	91%	92%	91%	91%
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

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

Increase the Proportion of Legal Residents under Age 65 Covered by Health Insurance by Establishing Health Insurance Marketplaces (Exchanges) (Lead Agency - CMS; Measure ID - PHI4.1)

	FY 2010	FY 2011	FY 2012	FY 2013
Target		Number of States in which stakeholder consultation has been performed to gain public input into Exchange planning process (50 States and DC)	Award all qualifying applications for Establishment Grants within 60 days of receiving the application	1. Release 2014 payment notice and payment parameters
Result		45 States plus DC	Target met.	Target met.
Status		Target Not Met	Target Met	Target Met
Target				2. Data sharing agreements for hub use in place with every State
Result				Target met.
Status				Target Met
Target				3. Health plans certified in all Federally-facilitated Exchange States
Result				Target met.
Status				Target Met

Analysis of Results

The accessibility of care is a critical component of an effective system of health insurance. CMS is committed to assuring high levels of health care access. For example, since 2010 both Medicare Fee-for-Service and Medicare Advantage programs have demonstrated a high rate of beneficiary satisfaction with at least 90 percent of beneficiaries reporting access to care. These results met or exceeded targets for this time period and demonstrate CMS's continuing commitment to making healthcare broadly available to beneficiaries.

To expand health insurance coverage for the public under the ACA, CMS was tasked with overseeing the implementation of the Health Insurance Marketplaces, designed to help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, services, and quality. The Marketplaces began operation in October of 2013. Consequently, this report includes interim process measures that tracked CMS's progress towards setting up the Marketplaces. In FY 2013, CMS met all three progress targets. Beginning in 2010, another ACA provision designed to expand coverage allows young adults between 19 and 26 to be covered as dependents on their parent's employee-sponsored health plans. Since FY 2010, the number of adult children covered as dependents on a parent's insurance policy has increased by more than 1.9 million, with the total exceeding the target in FY 2012. This shows a significant increase in the availability of health insurance for a population that has traditionally experienced a high uninsured rate.

The Affordable Care Act also included changes to Medicare to enhance the affordability of prescription drugs. Through the Coverage Gap Discount Program, CMS seeks to reduce the costs Medicare Part D enrollees are required to pay for their prescription once they reach the coverage gap (commonly known as the "donut hole"). The program will accomplish these reductions through significant manufacturer discounts and increased Medicare coverage according to a predetermined scale for FY 2011 through 2020. In FY 2012, CMS exceeded its target for reductions. In FY 2013, beneficiaries in the coverage gap saw their average out-of-pocket share of prescription drug costs reduced to 47.5 percent for brand drugs and 79 percent for generic drugs. Since this program began, more than 7.3 million beneficiaries saved almost $8 billion on their medications. These savings averaged about $1,209 per person.

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

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

Several HHS components focus on achieving goals that improve health care quality. FDA protects the Nation's health by ensuring the safety, effectiveness, and security of human and veterinary drugs, vaccines, and other biological products and medical devices. HHS also ensures quality of care and patient safety through HAI surveillance activities at FDA and CDC. Additionally, CDC's HAI program protects patients receiving care in U.S. healthcare settings through establishing prevention guidelines and supporting staffing to improve healthcare practitioner and hospital system practice. AHRQ develops strategies to strengthen quality and promotes improved practices through Patient Safety Organizations. The IHS Improving Patient Care (IPC) initiative is implementing the patient centered medical home model to help transition IHS to more continuous quality improvement and a greater focus on improvement through the use of measures and other results. IHS is demonstrating its commitment to quality of care by striving to have 100 percent of their hospitals and clinics maintain accreditation.

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

Objective 1.B Table of Related Performance Measures

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

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	57%	58%	60.5%	61%
Result	56.8%	59.8%	61.2%	61.2%
Status	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	92%	97.5%	98%	98.5%
Result	97%	97.8%	98%	Jun 30, 2014
Status	Target Exceeded	Target Exceeded	Target Met	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	1900	2000	2000	2000
Result	2079	2276	2313	1302
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	55.0%	67.0%	87.0%	Discontinued
Result	53.0%	80.0%	87.0%	N/A
Status	Target Not Met but Improved	Target Exceeded	Target Met	Discontinued

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	100%	100%	100%	100%
Result	100%	100%	100%	100%
Status	Target Met	Target Met	Target Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	88%	88%	56%	44%
Result	95%	73%	53%	28%
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	5,000	6,500	12,000
Result	2,619	5,000	10,900	12,400
Status	Baseline	Target Met	Target Exceeded	Target Exceeded

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

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		Work with States to ensure that 70 percent of States report on at least one quality measure in the CHIPRA core set of quality measures.	Work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 85 percent of States report on at least seven quality measures in the CHIPRA core set of quality measures.
Result		84 percent of States reported on at least one quality measure.	92% of States reported on at least five quality measures	Mar 31, 2014
Status		Target Exceeded	Target Exceeded	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	580 users of research	900 users of research	1032 users of research	1300 users of research
Result	885 users of research	1032 users of research	1128 users of research	1627 users of research
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

Analysis of Results

CMS is committed to strengthening and modernizing the Nation's health care system to provide access to high quality care and improved health at a lower cost. To fulfill this commitment and ensure beneficiaries receive high quality, coordinated, effective, and efficient care, CMS is measuring a variety of strategies from multiple perspectives designed to improve quality of care. For instance, pressure ulcers or "bed sores" can cause damage to a patient's tissues and other serious complications like infection. Since 2007 there has been a steady decrease in the reported prevalence in pressure ulcers. A decrease of even 0.1 percent represents more than 1,000 fewer nursing home residents with pressure ulcers, not only reducing the cost of care but also improving nursing home residents' quality of life. The FY 2012 result is 6.5 percent, which exceeds the target of 6.9 percent.

Another quality initiative at CMS aims to increase the percentage of End Stage Renal Disease (ESRD) patients who have access to arteriovenous fistula (AVF) for hemodialysis (the most common form of treatment for ESRD). Increasing the rate of AVF access for ESRD patients improves the quality of hemodialysis treatment, while decreasing unnecessary complications and hospitalizations. The performance since FY 2011 represents progression towards maintaining previous achievements as the program approaches a full participation rate. The 2013 target has been exceeded, with data representative of a 95 percent participation rate. CMS has also focused on administering effective antibiotics before surgery to prevent the establishment of infection during the time that the surgical incision is open, reducing both the rate of potentially fatal infections and unnecessary and costly rehospitalizations. Through Quality Improvement Organizations (QIOs) that work closely with States and other collaborative efforts, CMS met its 98 percent FY 2012 target.

Improving current medical products and medications and creating new ones is crucial to improving health care and patient safety. Generics play an important and increasing role in providing safe, effective, and affordable drugs to the American public and thereby in controlling health care expenditures. FDA's Center for Drug Evaluation and Research has launched initiatives to streamline and modernize the generic review program. The growing capacity of the program is measured in total actions taken on generic drug applications. In FY 2013, the actual number of actions taken on applications was less than the FY 2013 target due to a provision in the new Generic Drug User Fee Act legislation, which changes the methodology for counting the total actions. This change does not reflect a drop in program performance and will prove beneficial to the process in the long run. Additionally, the FDA's voluntary electronic medical device reporting helps the FDA maintain safety surveillance of FDA-regulated products. This performance measure was retired in FY 2013, after the number of enrollees participating voluntarily in this program increased dramatically from 13 percent in 2008 to 87 percent in FY 2012.

AHRQ, CDC, OMHA, IHS, and CMS are leading on a number of approaches which spread best practices. To illustrate, both IHS and OMHA are focusing on core services they deliver. For example, OMHA is measuring the rate at which it adjudicates cases within the 90-day statutory timeframe. OMHA has not met targets and has experienced reduced performance because it lacks enough Administrative Law Judges to provide hearings to all Medicare appeals within the 90-day statutory timeframe. It has sought strategies, in addition to increased funding, to improve performance. IHS, in turn, uses outside accrediting bodies, such as the Joint Commission and the Accreditation Association for Ambulatory Health Care, to develop national standards of quality of care and then manages IHS-operated hospitals and ambulatory centers to meet these standards. IHS has consistently maintained 100 percent accreditation of IHS-operated hospitals and clinics that voluntarily participate in accreditation visits.

In a similar capacity building effort, CDC's National Healthcare Safety Network (NHSN) is a surveillance system used for tracking and prevention of HAIs across healthcare settings, including hospitals in all 50 States, and non-hospital settings (e.g. hemodialysis and long-term acute care facilities). Exceeding its goal for FY 2013, CDC extended tracking capacity to more than 12,400 facilities. Since FY 2011, CDC has nearly tripled the number of healthcare facilities reporting data for HAI prevention. The success of this capacity building effort to measure quality of care more effectively has had the intended effect of supporting a host of quality improvement initiatives, such as CMS's aim to increase the percentage of End Stage Renal Disease (ESRD) patients who have access to AVF treatment for hemodialysis, and HHS's priority goal to reduce HAI infections (see Objective 1.D). The net result is that certain HAIs, a leading preventable cause of illness and death in the U.S., have been reduced—saving billions in excess healthcare expenditures annually.

To complement HHS's efforts to improve health care quality through targeted interventions that directly impact quality of care, the Department's agencies are committed to building capacity to more effectively measure quality of care and spread best practices. To illustrate, AHRQ developed the *Hospital Survey on Patient Safety Culture* so hospitals could determine how well they were doing in establishing a culture of safety in comparison to other similar hospitals. In FY 2013, 1,627 hospitals participated in the report, exceeding the target as the program has consistently for years. Meanwhile, CMS continues to work closely with States to improve children's health care quality across Medicaid and CHIP, as required by the CHIP Reauthorization Act of 2009 (CHIPRA). In collaboration with States, CMS developed and published the Child Core Set of quality measures. CMS is encouraging all States to use and report on the Child Core Set to collect data that will lead to improved health outcomes and to enhance the accuracy and applicability of the pediatric quality measures program specific to the Medicaid and CHIP programs. In FY 2012, 92 percent of States reported on at least five quality measures in the Child Core Set. In addition, the ACA requires that HHS develop a core set of adult quality performance measures for voluntary use by States to assess the care received by adults in the Medicaid program. By encouraging States to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting and improvement for adults in Medicaid. CMS met its FY 2012 target to publish the core set of adult quality measures in the Federal Register.

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

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

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

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

Objective 1.C Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline		13%	25%
Result	1%		13%	33%
Status	Baseline		Target Met	Target Exceeded

Increase percent of pregnant women who received prenatal care in the first trimester. (New Baseline - FY 2006: 69%) (Lead Agency - HRSA; Measure ID - 10.III.A.3)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	69%	70%	71%
Result	73.1%[1]	73.7%	74.1%	Nov 30, 2015
Status	Target Not In Place	Target Exceeded	Target Exceeded	Pending

[1] Due to differences in the number of states using the 2003 Standard Certificate of Live Births (i.e., revised birth certificate) for reporting on prenatal care utilization, natality data for FY 2010, FY 2011, and FY 2012 are not directly comparable.

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	572,397	583,730	872,565	1,200,000
Result	1,200,000	679,531[2]	May 30, 2014	May 29, 2015
Status	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%
Result	92%	92%	91%	Sep 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	64.2 %	68 %	68.3 %
Result	67.4 %	68.3 %	70.2 %	Dec 30, 2014
Status	Baseline	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target			Set Baseline	2.8 million
Result			3.2 million	Jun 30, 2014
Status			Baseline	Pending

[2] A decline from FY 2010 is due to a change in reporting requirements. Previously, Ryan White-funded providers reported on all HIV testing regardless of the source of funding for the testing. Now, only HIV testing supported by the Ryan White program is reported.

By 2018, identify three effective system interventions generating the implementation, sustainability and ongoing improvement of research-tested interventions across health care systems. (Lead Agency - NIH; Measure ID - SRO-8.7)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Identify at least three systemic (or services) intervention studies which utilize implementation mechanisms, strategies or techniques to improve the uptake of effective interventions in healthcare settings	Identify at least 3 mechanisms for tracking successful implementation within studies to improve the uptake of research-tested interventions in health care settings.	Complete target by identifying three effective implementation strategies that enhance the uptake of research-tested interventions in service systems such as primary care, specialty care and community practice.	Identify three key factors influencing the sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice.
Result	Three intervention studies that utilize implementation mechanisms, strategies, or techniques were identified to improve the uptake of effective interventions for mental health services, HIV and drug use disorders, and alcohol screening and treatment in healthcare or community settings.	Three mechanisms for tracking successful implementation within studies were identified to improve the uptake of research-tested interventions in health care settings.	NIH identified three approaches that enhance the uptake of research-tested interventions in service delivery systems addressing child mental health, attention deficit hyperactivity disorder, and depression.	NIH researchers identified three influences on sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice: Community Development Teams in child mental health service systems; barriers and facilitators to evidence-based interventions to control blood pressure in community practice; and a set of factors to enhance sustainability of health care interventions across multiple settings.
Status	Target Met	Target Met	Target Met	Target Met

Analysis of Results

More than 133 million Americans have at least one chronic illness, and many Americans have several chronic conditions. Moreover, these chronic diseases disproportionately affect low-income communities and individuals. HHS components are committed to improving primary and preventive care that address chronic diseases in communities, especially those communities with underserved populations. A Patient Centered Medical Home (PCMH) is a delivery model designed to improve the quality of care through enhanced access, planning, management and monitoring of patient care. In FY 2010 about 1 percent of HRSA-funded health centers had at least one site recognized as a PCMH. Through the concerted efforts

of staff working on this Priority Goal, by the end of 2013 33 percent of HRSA health centers have at least one site recognized as a patient centered medical home, exceeding the FY 2013 target of 25 percent.

Performance results emphasizing primary and preventive care with community services include national data reported by HRSA related to the receipt of prenatal care by expectant mothers in the first trimester and the number of people who learn their serostatus from Ryan White HIV/AIDS programs. Prenatal care is an area where early detection matters, as early interventions help ensure the health of pregnant women and their newborn babies. In FY 2012, 74.1 percent of the nation's pregnant women received prenatal care in the first trimester. In FY 2010, 1.2 million uninsured or underinsured individuals were able to determine their HIV status through Ryan White HIV/AIDS programs—contributing to slowing the spread of the disease, allowing treatment to start earlier, and vastly improving the quality and length of life among people with HIV infection. In FY 2011, HRSA exceeded its target for the number of people who learn their serostatus from Ryan White HIV/AIDS programs, with nearly 700,000 individuals learning their HIV status. The substantial decline in results from FY 2010 to FY 2011 was due to a change in reporting requirements. Previously, Ryan White-funded providers reported on all HIV testing, regardless of the source of funding for the testing. Under the new reporting requirements, only HIV testing funded by the Ryan White Program is reported, thus the results from FY 2011 are lower than data reported from previous years.

CDC works to tackle the biggest health problems causing death and disability in America. For young children this means promoting immunization coverage for recommended vaccines. Prior to wide-spread immunization nearly all children in the U.S. came down with the measles and about 500 people a year would die, 48,000 would be hospitalized, 7,000 had seizures, and about 1,000 suffered permanent brain damage or deafness. CDC exceeded its target with 91 percent of children 19 to 35 months of age receiving MMR vaccination. In addition to preventing diseases in young children, CDC is working on population-level approaches to address one of the America's most important problems - obesity. CDC exceeded its target of increasing the proportion of adults that engage in at least some leisure-time physical activity. CDC is working with communities, businesses, early care providers and schools to increase the number of people who participate in at least 150 minutes of physical activity a week.

The Affordable Care Act enables Medicare recipients to have an annual assessment of their health risks including personalized health advice and referrals to health education and prevention counseling. The Annual Wellness Visit is available at no out-of-pocket cost to the beneficiary and in FY 2012 more than 3.2 million Medicare beneficiaries took advantage of this new benefit.

NIH has broadened its portfolio of implementation research by encouraging teams of scientists and practice stakeholders to work together to overcome barriers to implementing research-tested interventions. In FY 2013, NIH researchers examined influences on sustainability of research-tested mental health care interventions in service systems such as primary care, specialty care, and community practice.

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

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

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

Objective 1.D Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target			Reviewed & Valued appropriately 20% of potentially misvalued codes identified 2008 to 2011	Reviewed & Valued appropriately 40% of potentially misvalued codes identified in 2012, Reviewed & Valued appropriately 20% of unreviewed potentially misvalued codes identified 2008 to 2011
Result			78% (911 of 1167 codes)	47% (46 of 98) of potentially misvalued codes identified in 2012 91% (232 of 256) of unreviewed potentially misvalued codes identified - 2008 to 2011
Status			Target Exceeded	Target Exceeded

Reduce by 25 percent hospital-acquired central-line associated bloodstream infections (CLABSI) by the end of FY 2013. (Lead Agency - CMS; Measure ID - MCR28.1)3

	FY 2010	FY 2011	FY 2012	FY 2013
Target			12.5%[4]	25%[5]
Result			17%	Mar 31, 2014[6]
Status			Target Exceeded	Pending

Reduce by 10 percent hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2015. (Lead Agency - CMS; Measure ID - MCR28.2)7

	FY 2010	FY 2011	FY 2012	FY 2013
Target			10%[8]	20%[9]
Result			-17%	Mar 31, 2014[10]
Status			Target Not Met	Pending

Reduce all-cause hospital readmission rates for Medicare beneficiaries by one percent over the previous year's target rate (Lead Agency - CMS; Measure ID - MCR26)

	FY 2010	FY 2011	FY 2012	FY 2013
Target			N/A	18.5%[11]
Result			18.7%[12]	18.6%[13]
Status			Historical Actual	Target Not Met but Improved

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[3] Targets and results in this table reflect a reduction from a baseline with positive numbers. Consequently, a negative number indicates an increase from the baseline (the opposite of the desired result).

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

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

[6] National Healthcare Safety Network (NHSN) CLABSI data as of March 2013 (FY 2013 midpoint) was calculated at 0.55 Standardized Infection Ratio (SIR) or a 19 percent reduction in the SIR over the baseline of 0.68 SIR, and is ahead of the midway goal of 0.60 SIR or a 12.5 percent reduction.

[7] Targets and results in this table reflect a reduction from a baseline with positive numbers. Consequently, a negative number indicates an increase from the baseline (the opposite of the desired result).

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

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

[10] NHSN CAUTI data through March 2013 (FY 2013 midpoint) was calculated at 1.02 SIR or a 9 percent increase (opposite of desired outcome) in the SIR over the baseline of 0.94 SIR, and is behind the midway goal of 0.85 SIR or a 10 percent reduction.

[11] Based on CY 2011 data.

[12] Based on CY 2010 data.

[13] Based on CY 2011 data.

Analysis of Results

Healthcare-associated infections (HAIs) are a significant cause of death in the United States. At any given time, about one in every 20 hospitalized patients has an HAI and more than 1 million HAIs occur across the U.S. health care system every year. Of these, central line-associated bloodstream infections (CLABSI) have a strong potential to cause serious illness or death and catheter-associated urinary tract infections (CAUTI) are among the most common. HHS is making progress in the reduction of CLABSI, showing a greater than originally anticipated decline of 17 percent, versus a target decline of 12.5 percent. This measure continues to trend in the desired direction. CAUTI data shows an increase of 17 percent (opposite of desired outcome) versus a target desired target to decline 10 percent. There are a number of reasons for this result, including 2,000 new hospitals that began reporting into the National Healthcare Safety Network as part of CMS's Hospital Inpatient Quality Reporting Program. The recently added hospitals had higher rates for CAUTI than the original set of hospitals used to determine the CAUTI baseline. These and other issues affecting CAUTI have contributed to the need to continue widespread implementation of prevention strategies. The final FY 2013 end of year results for both CLABSI and CAUTI will be available late March 2014.[14]

In order the reduce Medicare expenditures and improve patient quality, CMS has chosen to measure preventable Medicare inpatient hospital readmissions. A hospital readmission occurs when a patient, who has recently been discharged from a hospital (within the last 30 days of the admission), is once again readmitted to a hospital. Discharge is a critical transition in a patient's care and incomplete handoffs at discharge can lead to costly adverse events and avoidable re-hospitalizations. In 2013 CMS established the Hospital Readmissions Reduction Program, which will reduce a portion of Medicare's payment to certain hospitals based on the hospital's excess Medicare readmissions for specific conditions. In addition, CMS leverages other efforts including Partnership for Patients to reduce preventable complications during a transition. Though it barely missed the FY 2013 target of 18.5 percent, CMS will continue to improve hospital performance and reduce readmissions with the long-term aim to reduce the growth of health care costs, while promoting high-value, effective care.

CMS exceeded the targets and improved results related to potentially misvalued codes. The purpose of this measure is to achieve more accurate pricing under the Medicare physician fee schedule, consistent with CMS's goal of moving to a value driven health care system. Like other payment systems, the Medicare Physician Fee Schedule (PFS) is not perfect and is vulnerable to mispricing. The ACA directed the HHS Secretary to establish a systematic process for identifying and reviewing misvalued services. This measure aims to quantify CMS progress in determining misvalued services under the Medicare PFS and setting the appropriate values. From the start of the misvalued code initiative in 2008 through the end of 2013, CMS reviewed 1189 codes. CMS revised targets in 2013 and 2014 to reflect an expanding baseline, since reviewed codes may result in new codes or other revisions in order to better describe the service in question.

[14] National Healthcare Safety Network (NHSN) CLABSI data as of March 2013 (FY 2013 midpoint) was calculated at 0.55 Standardized Infection Ratio (SIR) or a 19 percent reduction in the SIR over the baseline of 0.68 SIR, and is ahead of the midway goal of 0.60 SIR or a 12.5 percent reduction. NHSN CAUTI data through March 2013 (FY 2013 midpoint) was calculated at 1.02 SIR or a 9 percent increase (opposite of desired outcome) in the SIR over the baseline of 0.94 SIR, and is behind the midway goal of 0.85 SIR or a 10 percent reduction.

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

With the growing diversity of the U.S. population, healthcare providers are increasingly called on to address their patients' differing social and cultural experiences and language needs. Provision of culturally competent care can increase quality and effectiveness, increase patient satisfaction, improve patient compliance, and reduce racial and ethnic health disparities. A number of HHS programs help make health care more accessible to people whose circumstances call for special attention, including older adults, children, people with disabilities, uninsured populations, persons with limited English proficiency, low income individuals, and those who live in remote areas. The 2012 National Healthcare Disparities Report issued by AHRQ finds that many racial and ethnic minorities have more limited access to care and receive lower quality care.

CMS programs facilitate health services for older adults, people with disabilities, and many low-income adults and children. Since the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), CMS has set targets to significantly increase the proportion of low-income children with health coverage. Service delivery programs in HRSA, IHS, and SAMHSA enhance the availability of care in areas of high need. These HHS components strive to improve the quality of care their programs deliver. AHRQ regularly monitors healthcare quality and disparities, and through its grants and contracts, it focuses on improving how providers deliver care. Given the federal government's unique legal and political relationship with tribal governments, IHS has a special trust obligation to provide health services for American Indians and Alaska Natives. HHS follows the President's 2009 tribal consultation policy to partner with tribes to ensure access to quality health care.

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

Objective 1.E Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	20.15 million	19.7 million	20.6 million	21.6 million
Result	19.5 million	20.2 million	21.1 million	Aug 31, 2014
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	380,000	385,000	390,000	395,000
Result	383,776	615,849	747,952	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	$487.3 M	$551.3 M	$616.1 M	Prior Result +0
Result	$551.2 M	$616.1 M	Apr 30, 2014	Apr 30, 2015
Status	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	30 M	31 M	33 M	30 M
Result	34.5 M	37.4 M	35.9 M	Nov 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	12 M	13 M	14 M	15 M
Result	14.3 M	14.8 M	14.2 M	Nov 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	43,212,512 children	45,592,385 children
Result	42,146,940 children	43,542,385 children	44,453,639 children	Mar 31, 2014
Status	Historical Actual	Historical Actual	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	1,413,000	1,324,000	1,296,300	1,340,300
Result	1,417,219	1,333,149	1,247,525	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	82%	82%	83%	83%[15]
Result	82.9%	82.1%	84.1%	83.5%
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	25.6 %	25.6 %	25.6 %	25.6 %[16]
Result	29.4 %	33 %	35.7 %	44.9 %
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	62.9 %	66.1 %	63.1 %	64.2 %[17]
Result	66.1 %[18]	63.1 %[19]	64.2 %	62.7 %
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Not Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		3 recommendations	3 recommendations	3 recommendations
Result		7 recommendations	4 recommendations	4 recommendations
Status		Target Exceeded	Target Exceeded	Target Exceeded

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

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

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

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

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	53%	51.9%	56.5%	58.6%
Result	52%	56.5%	61.9%	65.1%
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	33%	30.2%	32.7%	Set Baseline
Result	32%	31.9%	33.2%	48.3%[20]
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Baseline

Analysis of Results

HRSA plays a vital role in ensuring access to quality, culturally competent care for vulnerable populations through its mission to improve health and achieve health equity through access to quality services. Health centers are community-based, patient-directed organizations that serve populations lacking access to high quality, comprehensive, cost-effective primary health care. Health centers served 21.1 million patients in FY 2012. This is 0.9 million more than the 20.2 million patients served in FY 2011 and represents a greater than 86 percent increase within a ten year period. Success in increasing the number of patients served has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics. Through the Office of Rural Health Policy, HRSA improves access to care in rural communities by utilizing Outreach grants that focus on community coalitions and partnerships. In FY 2012, 747,952 persons received direct services supported by these grant programs, exceeding the target substantially. HRSA supports State AIDS Drug Assistance Programs (ADAPs), through the Ryan White HIV/AIDS program, to provide assistance to low-income persons living with HIV/AIDS who have limited or no access to needed medications. State ADAPs use a variety of strategies to contain costs and achieved savings of more than $616 million in 2011—an additional 64.8 million dollars in drug cost savings over the previous year.

HRSA's contribution to this objective also includes the Maternal and Child Health (MCH) Block Grant Program, which serves vulnerable populations by seeking to improve the health of all mothers, children, and their families. In FY 2012, 35.9 million children were served by the Block Grant program—a decrease of 1.1 million from the previous year, but still in excess of the target. In a similar vein, the number of children receiving MCH Block Grant services who are covered by Medicaid and CHIP decreased 0.6 million to 14.2 million from FY 2011 to FY 2012, yet still exceeded the target. Complementary to this effort, CMS tracks combined Medicaid and CHIP enrollment of children. The most recent results report

[20] In FY 2013 this measure changes from Ideal Glycemic Control to Good Glycemic Control with an A1c (blood sugar) value of less than 8.0% to align with new diabetes standards of care. More patients will meet this goal; therefore, annual targets and results will increase. Prior to 2013, the A1c value for Ideal Glycemic control was set at less than 7.0%

more than 44 million children were enrolled in 2012, exceeding the target by greater than 1 million. CHIP funding provides options to maintain State programs and to cover more uninsured children. The ACA provides funding for CHIP through FY 2015 and will require the maintenance of eligibility standards for children in Medicaid and CHIP through 2019.

Another example of HHS's support for providing care to a vulnerable population is evident through the provision of family planning and related preventive health services in Title X family planning clinics. Through these clinics, the Title X program co-led by HRSA and OASH seeks to screen young women for Chlamydia. An untreated Chlamydia infection can lead to pelvic inflammatory disease and potential infertility. The number of screenings declined in FY 2012, the most recent year data is available, continuing a trend.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Increasing the percentage of adults who have had no substance use in the past month contributes to positive health outcomes. The performance of SAMHSA's Access to Recovery (ATR) adult substance abuse recovery program has consistently met or exceeded its targets over time, recording a result of 83.5 percent in FY 2013. This represents a slight decline over the previous year, attributed to the change of treatment cohorts. The ATR program is supported from a pool of funds intended to test new and innovative approaches to address substance abuse. The program will end in FY 2014 having completed its test period. As part of efforts to reduce homelessness by promoting access to permanent housing, treatment, and recovery support, SAMHSA is focused on increasing the percentage of those suffering from mental illness and/or a substance use disorder who have a permanent place to live in the community. Results are positive showing an increase from 23.6 percent in FY 2008 to 44.9 percent in FY 2013, exceeding targets each year. Permanent residence is an integral part of one's well-being.

Another SAMHSA initiative seeks to increase the percentage of children receiving Systems of Care mental health services who report positive functioning at 6 month follow-up. A "system of care" is an organizational philosophy and framework that involves collaboration across agencies, families, and youth, while positive functioning relates to the general ability of the child to perform the tasks associated with routine life activities. Since 2008, grantee performance has shown a 7 percent improvement. In FY 2013, the percentage of children reporting positive functioning declined slightly to 62.7 percent, missing the target due to attrition rates and a new data system. Using a new implementation grant and with additional technical assistance, performance is expected to meet the target during FY 2014.

The Indian Health Service, which incorporates tribal consultation to improve services for American Indians and Alaska Natives, has focused on some key health related issues for vulnerable tribal members. These include increasing the number of adults screened for depression when visiting IHS facilities, and helping diabetic patients maintain good glycemic control. As a result of a more focused educational campaign conveying the benefits of early identification of depression, depression screening within Indian Health Service funded facilities increased to 65.1 percent, beating its target. Good glycemic control among diabetic patients can help prevent associated health problems caused by diabetes. In FY 2013, IHS implemented new clinical standards of care, changing the glycemic control measure threshold. Therefore a new baseline of 48.3 percent was established. To strengthen the federal/tribal partnership, IHS engages American Indian and Alaska Native Tribes in open, continuous, and meaningful consultation. Out of this process in FY 2013, IHS implemented four recommendations, exceeding the target.

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

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

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

Objective 1.F Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		N/A	80,000 eligible professionals and hospitals	230,000 eligible professionals and hospitals
Result		10,700 eligible professionals and hospitals	156,758 eligible professionals and hospitals	325,124 eligible professionals and hospitals
Status		Historical Actual	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	23% of office-based primary care physicians	35% of office-based primary care physicians	45% of office-based primary care physicians	55% of office-based primary care physicians
Result	30% of office-based primary care physicians	39% of office-based primary care physicians	49% of office-based primary care physicians	53% of office-based primary care physicians
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met but Improved

Analysis of Results

To promote the use of health IT, the Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals as they adopt, implement, upgrade, or demonstrate "meaningful use" of certified EHR technology. Because the EHR Incentive Program is seen as key to HHS's goal to strengthen healthcare, it has been chosen as one of HHS's six Priority Goals. This increased focus has led to the pursuit of coordinated strategies that have resulted in a dramatic increase in the number of eligible providers who received EHR incentive payments. ONC far exceeded its target of 230,000 providers who receive an incentive payment for successful adoption or meaningful use of certified EHRs. The Recovery Act helped to set the groundwork for the expansion of electronic health care records and HHS used a variety of strategies to increase the number of providers using electronic health care systems by funding Health IT Regional Extension Centers, by working with State Health Information Exchanges and with Beacon Communities. Since 2011 the number of providers who received an incentive payment from CMS for meaningful use of electronic healthcare records increased 30 fold to 325,124 providers.

The wide scale adoption of appropriate HIT will enable providers to communicate with fewer errors to pharmacies, better coordinate care across settings, alert physicians and caregivers of preventive care options that would benefit the patient, and reduce duplicative testing results—among many other potential benefits. HHS measures the percentage of office-based primary care physicians who have adopted electronic health records. In 2008, about 20 percent of primary care providers were estimated to have adopted basic EHRs. EHRs have the potential to improve the delivery of health care services, reduce unnecessary health care costs, and improve population health outcomes. A basic EHR system would be expected to include: patient demographics, patient problem lists, medications, clinical notes, prescriptions, ability to view laboratory results, and the ability to view imaging results. By FY 2013, 53 percent of office-based primary care physicians had systems that met the basic EHR standard, falling just short of the target. However, this was an increase over the previously reported result of 44 percent of office-based primary care physicians meeting the basic standard for EHRs.

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

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

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

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

Objective 2.A Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Demonstrate defective nerve function in infected armadillos.	Use DNA evidence to link leprosy transmission from armadillos to humans.	Pursue relevant animal model for human leprosy.	Pursue relevant animal model for human leprosy.
Result	Defective nerve function demonstrated	leprosy link demonstrated	Defined parameters of nerve dysfunction in armadillos infected with the leprosy bacillus.	Mar 31, 2014
Status	Target Met	Target Met	Target Met	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	23 EHC products	65 EHC products	26 EHC products	65 EHC products
Result	51 EHC products	68 EHC products	128 EHC products	108 EHC products
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Establish 35 new assays in the Molecular Libraries Program (MLP) Portfolio.	Increase depositions of bioassays in PubChem to a rate of five (5) per month.	Deposit chemical structure and biological data for 200 new small molecule probes in PubChem.	Establish 400 primary biochemical, cell-based or protein-protein interaction assays that can be miniaturized and automated as high throughput screens in the Molecular Libraries Program (MLP) Portfolio.
Result	98 new high-throughput assays were added to the MLP Portfolio.	NIH increased the assay deposition into PubMed to a rate greater than eight HTS assays per month, resulting in a total deposit of 103 assays.	The Molecular Libraries Program deposited chemical structure and biological data for 294 new small molecule probes in PubChem since the program began.	Established 570 primary biochemical, cell-based or protein-protein interaction assays that were miniaturized and automated as high throughput screens in the Molecular Libraries Program (MLP) Portfolio.
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Begin accrual of two patient cohorts presenting in childhood, one with a monogenic autoinflammatory disorder and one with a genetically complex autoinflammatory disorder.	Complete phenotypic characterization of a patient cohort.	Complete genetic, biochemical, or cellular studies aimed at identifying a molecular pathway underlying the disease in the patient cohort.	Identify at least one molecular pathway suitable for targeting in the patient cohort by performing detailed genetic mapping and confirmatory analyses for markers and pathways identified through genome-wide association.
Result	Two cohorts are being accrued by NIH investigators – one with neonatal-onset multisystem inflammatory disease and another with systemic-onset juvenile idiopathic arthritis.	NIH researchers completed recruitment of a cohort of well-characterized patients with systemic-onset juvenile idiopathic arthritis through an international consortium of investigators.	A genome-wide association study has been performed on the cohort of 982 systemic-onset juvenile idiopathic arthritis patients and over 7000 healthy controls for 1.4 million genetic markers.	Researchers have identified a genetic variant that confers an increased risk of developing systemic juvenile idiopathic arthritis (sJIA) and that indicates the CD4+ T cell activation pathway as a therapeutic target.
Status	Target Met	Target Met	Target Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Describe phenotypic characteristics of a group of asthma patients prone to exacerbations.	Characterize cellular and molecular inflammation in the distal lung that may contribute to severe disease with frequent exacerbations.	Investigate the role of mucus gel formation in healthy controls and asthma patients.	Conduct investigations to elucidate the dynamic, pathophysiologic phenotypes of severe asthma.
Result	Histoblood group antigens were explored as susceptibility factors for asthma exacerbations. O-secretor mucin glycan phenotype was identified as a risk factor for asthma exacerbations.	Scientists characterized the molecular pathways in fibroblasts (the principal active cells of connective tissue) from two regions of the lung. Their findings suggest that fibroblasts from the distal lung may be the more important fibroblast cell type in processes that contribute to disease progression and severity in asthma.	Researchers investigated two proteins associated with mucus formation, CLCA1 and TMEM16A, that may serve as potential targets for treating asthma.	The Severe Asthma Research Program is conducting investigations
Status	Target Met	Target Met	Target Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Establish a >7000 compound library for testing in quantitative high throughput screens (qHTS) and test in >20 qHTS, test >50 compounds (a subset of the main library) in at least 50 mid-throughput assays.	Identify an additional 3,000 compounds to the library for testing, complete compound analytical analysis, and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 50 qHTS and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 25 qHTS and test 180 compounds in densely sequenced human lymphoblastoid cell lines to assess genetic diversity in response to toxicants.
Result	7,000 compounds were selected and collected as an establishment of the compound library. A subset of this library, "the 1408 compound library," has screened an additional 20 qHTS assays. 50 compounds were identified for testing in 50 mid-throughput assays but testing was not conducted and was rescheduled for 2011.	The 10,000 compound library was completed. Performance on mid-throughput assays surpassed the target. Analytical or chemical analysis is in progress but not yet completed.	The library containing 10,000 compounds was screened in 65 quantitative high throughput screens (qHTS) or assays. Fifty compounds were screened in approximately 600 mid-throughput assays.	The 10,000 compound library was screened in 33 qHTS assays and data was analyzed on 179 compounds screened for cytotoxicity across 1086 human lymphoblastoid cell lines representing 9 racial groups to assess genetic diversity in response to toxicants.
Status	Target Not Met	Target Not Met	Target Met	Target Met

Analysis of Results

HRSA made further progress toward developing an animal model (the armadillo) for Hansen's disease, more commonly known as leprosy. Once the model is developed, researchers can further explore potential advances in scientific knowledge related to questions associated with pathogenesis, early diagnosis, vaccine development, and transmission of the disease. This program is tracked through a series of milestones. In FY 2012, the most recent year information is available, this research effort met its milestone, defining parameters of nerve dysfunction in armadillos infected with the leprosy bacillus.

HHS also enhanced information available to the public through the Effective Health Care Program. AHRQ manages this program, which seeks to improve patient care through patient-centered health research. To make more health information available to clinicians, consumers, and policymakers, AHRQ conducts state-of-the-science reviews of existing studies that compare the effectiveness of health care interventions. Examples of recent reviews include "Benefits and Harms of Routine Preoperative Testing: Comparative Effectiveness" and "Public Reporting of Cost Measures in Health." The number of products produced exceeded the target for FY 2013. These products serve to inform and facilitate evidence-based decision-making on treatments and health care services as well as identify knowledge gaps and future research needs.

Accelerating the process of scientific discovery for the purpose of improving health outcomes is important to Americans' well-being and health. The Molecular Libraries Probe Production Centers Network (MLPCN) is a nationwide scientific resource to accelerate the discovery of small molecule probes for use in biological research to prevent and treat diseases. The Molecular Libraries Program (MLP) made exceptional progress and exceeded the FY 2013 target by completing 570 high-throughput screens for the MLP portfolio and associated bioactivity data, all of which have been submitted to PubChem. To date, 790 HTS assays have entered the pipeline and have generated more than 412 chemistry projects, and the chemical structure and biological data for 343 probes have been deposited in PubChem. By disseminating results in PubChem, the NIH enables one of the largest sets of publicly available chemical biology information to be used by both governmental and private researchers.

Advances in technology and reductions in cost have made it possible to identify the causes of certain genetically complex diseases. A number of illnesses affecting the immune system in children tend to run in families, such as juvenile idiopathic arthritis (JIA), indicating a genetic basis. These illnesses may present with either excessive or impaired immune responses, and may lead to significant disability and even death. Systemic-onset JIA (sJIA) is another example, and is a genetically complex autoinflammatory disease. During FY 2013, NIH investigators, working with an international team, performed a genome-wide association study of 988 children with sJIA from 9 countries. The study identified genetic variants that are significant risk factors for sJIA near a particular gene. This gene affects an important immune response, which the variants may influence. Based on these results, therapies that alter this immune response may be suitable for targeting in sJIA.

Complementary to the potential of the genetic study of disease are more traditional methods of disease investigation, which continue to experience technical advancement. Asthma attacks are a significant cause of morbidity in patients with asthma and represent a substantial public health burden. The Severe Asthma Research Program (SARP) unites transdisciplinary teams in a collaborative platform to foster an understanding of severe asthma and its phenotypes at genetic, molecular, cellular, and clinical levels over time. HHS is tracking SARP and other severe asthma research through a series of annual milestones. In FY 2013 NIH achieved its milestone, conducting investigations to elucidate the dynamic, pathophysiologic phenotypes of severe asthma.

In addition to the cataloging of data about naturally occurring biological chemicals, NIH manages a program to investigate and catalog the potential health effects of many of the estimated 125,000 man-made chemicals in use commercially. NIH and the EPA began the program, titled Tox21, in early 2008 to collaborate on the research, development, validation, and translation of new and innovative test methods that characterize how chemicals interact with cellular pathways, determining chemical toxicity, as well as danger to human health. This is important for the development of prevention and mitigation strategies. Tox21 has a library of over 10,000 compounds. NIH exceeded expectations in FY 2013 by completing 33 quantitative high throughput screen (qHTS) assays in the Tox21 library. Also, data were analyzed on 179 compounds screened for cytotoxicity across 1086 human lymphoblastoid cell lines representing 9 racial groups to assess genetic diversity in response to toxicants, falling just short of the goal of 180 compounds while exceeding expectations in regard to the number of cell lines characterized.

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

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

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

Objective 2.B Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	311	317	340	346
Result	311	334	343	496
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	117	122	285	288
Result	179	282	366	1,025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	7	8	10	12
Result	6	8	10	12
Status	Target Not Met	Target Met	Target Met	Target Met

Analysis of Results

Enhancing opportunities for public participation and collaboration in HHS activities is a key priority for the HHS Open Government efforts. It is widely understood that to deliver effectively on our mission, we must leverage the collective creativity and wisdom of our stakeholders. Federal Advisory Committees are one key way of ensuring public and expert involvement and advice in Federal decision-making. Another way to involve the public in helping HHS to solve pressing agency problems is through the use of challenges and competitions in which members of the public can participate. An additional important vehicle to engage our stakeholders is through the development and release of application programming interfaces (API). APIs allow external websites and services to interface with HHS databases - thus allowing external partners to mix information and media from HHS services and datasets into their sites and applications. In FY 2013, HHS exceeded its targets, identifying 496 opportunities. In addition to the number of engagements secured, HHS enhanced its use of technology to facilitate public meetings, continued to grow and mature it challenges and competitions program, as well as added more than a hundred new APIs.

Developing new types of effective collaboration and participation initiatives at HHS often involves a focused effort by a select group of individuals. HHS's approach takes two forms: in some instances members of the HHS OS Innovations Team have seeded these new initiatives; and in others HHS operating and staff divisions have led. Each of the projects is labor-intensive, and thus only a few are selected in each year. In FY 2013, the HHS Innovations Staff and its agency collaborators (e.g. innovation staff from HHS operating and staff divisions who partner with OS on projects) successfully implemented 12 projects. These projects reflected HHS's desired to foster entrepreneurship and teamwork between internal and external partners toward developing solutions for health and human services challenges.

In addition to engaging the public, a high priority for the HHS Open Government Plan is to make HHS data more easily and broadly available through its Health Data Initiative (HDI). The mission of the HDI is to help improve health, healthcare, and the delivery of human services by harnessing the power of data and fostering a culture of innovative uses of data in a diverse array of public and private sector settings. This information can be used to increase agency accountability and responsiveness, improve public knowledge of the agency and its operations, further the core mission of the agency, create economic opportunity, or respond to need and demand as identified through public consultation. Also, researchers and analysts may use these data sets to add knowledge and understanding to existing health and human service issues. In FY 2013, HHS published 727 additional datasets bringing the total number of datasets to 1025. Passing the symbolic 1000 dataset milestone, which significantly exceeded initial projections, was the result of more focused efforts by every HHS division's Health Data Lead to locate and catalog the high quality datasets developed and maintained by HHS agencies.

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

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

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

Objective 2.C Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	9.0 working days	6.0 working days	5.0 working days
Result	10.0 working days	7.0 working days	6.0 working days	5.0 working days
Status	Historical Actual	Target Exceeded	Target Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Identify patterns in serum biomarkers to use in monitoring dietary intervention protocols to reduce obesity	Identify target genes that can predict potential for obesity and type 2 diabetes to provide individually tailored therapeutic treatment and dietary guidelines for use in improving health	1) Develop analytical methods to assess drug-induced heart damage 2) Identify target genes for obesity and the consequent development of metabolic syndrome diseases and heart disease	1) Analyze urine, blood , and tumor tissues samples to identity biomarkers that will facilitate early detection in new cases and in the reemergence of pancreatic cancer. 2) Develop a new targeted therapeutic approach to improve clinical management of breast cancer.
Result	Patterns were identified from analysis of 2009 CBPR data and preliminary analysis of 2010 CBPR data in serum biomarkers that can be used to monitor dietary intervention protocols to reduce obesity. (Target Met)	Statistical analyses of gene-phenotype interactions and nutrient levels were conducted and target genes identified, further results are pending a final analysis and publication (Target Met)	1) A model of drug-induced heart damage was developed and is being used to identify new predictive biomarkers of early stages of drug-induced cardiac tissue injury. (Target Met) 2) Research experiments have been completed and preliminary results suggest the involvement of a number of genes involved in lipid metabolism and sugar transporters. (Target Met)	Published results that found potential for new breast cancer therapy using epigenetic approach (Target Met)
Status	Target Met	Target Met	Target Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		Initiate multi-year studies on safety issues (1) for evaluating nanoparticles that cross multiple product areas and (2) surrounding use of nanoparticles in cosmetic products.	Continue regulatory science studies on evaluating nanomaterials from 2011.	Continue regulatory science studies on evaluating nanomaterials from 2011.
Result		FDA implemented the Collaborative Opportunities for Research Excellence in Science (CORES) Program to promote cross-center and external collaborative regulatory science research opportunities, focusing on studies evaluating nano-materials. (Target Met)	FDA implemented the Collaborative Opportunities for Research Excellence in Science (CORES) Program to promote cross-center and external collaborative regulatory science research opportunities, focusing on studies evaluating nano-materials. An additional, new component of this activity included inviting external experts to review proposals.	FDA continued the CORES program to promote cross-center and external collaborative regulatory science research opportunities, focusing on studies evaluating nano-materials. (Target Met)
Status		Target Met	Target Met	Target Met

Analysis of Results

HHS supports an extensive set of efforts to protect and promote food and medical product safety. FDA Foods Program scientists are evaluating commercially available instrumentation that can be adapted to support the FDA mission to prevent foodborne illnesses. The Center for Food Safety and Applied Nutrition has advanced two of these technology platforms to Field laboratories. The instrumentation is laboratory-based and provides broad-range and strain-specific identification of infectious organisms for multiple applications (clinical and environmental). These detection platforms are enhancing FDA regulatory activities and shortening FDA response time during foodborne outbreaks involving Salmonella. In FY 2013, FDA met the target of reducing the average number of days to serotype priority pathogens in foods to five working days.

The FDA does not focus on the protection of the food supply alone. The National Center for Toxicological Research's goal is to define the correlations between an individual's nutrition, genetic profile, health,

and susceptibility to chronic disease in support of personalized nutrition and health. This research will provide baseline data that supports the FDA goal of providing consumers clear and timely information to help promote personalized nutrition and health. Identifying biomarkers of health, susceptibility to chronic disease, and gene-micronutrient interactions is essential to gaining a more complete scientific understanding of health. NCTR is implementing a novel research program for personalized nutrition and health that relies on the "challenge homeostasis" concept for identifying markers of health and susceptibility. Since 2008, FDA/NCTR and USDA/ARS have had an ongoing partnership with a community development center in the Mississippi Delta region of Arkansas to conduct community-based participatory research (CBPR) that studies the effects of dietary intake and its influence on the development of obesity-associated diseases. This ongoing collaboration analyzes dietary intake patterns, micronutrient levels in the blood samples of children and adults, and calories expended. In FY 2013, the FDA met its goal by continuing research to identify new biomarkers to detect toxicity of FDA-regulated products sooner and to provide personalized medicine solutions, as well as finding potential for new breast cancer therapy using epigenetic approach.

In addition to addressing present health concerns, the FDA anticipates potential future issues with emerging technologies that pose regulatory challenges, such as nanotechnology. Like many new technologies, nanotechnology can bring potential benefits to food, medicine, and other FDA-regulated product areas, but the risks to human and animal health are not yet completely identified or understood. Establishing scientific standards and evaluation frameworks to guide nanotechnology-related regulatory decisions will promote innovation and predictability in the development of safe and effective nanotechnology-based products. In FY 2011, FDA implemented its proposed regulatory science research plan for nanotechnology, including developing the CORES (Collaborative Opportunities for Research Excellence in Science) Program to support studies that can serve as a platform for the targets above, building laboratory capacity to assess nanotechnology products, and investing in training and staff development in the area of nanotechnology. In FY 2013, FDA met its developmental goal, continuing the CORES program to promote cross-center and external collaborative regulatory science research opportunities, focusing on studies evaluating nano-materials.

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

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

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

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

Objective 2.D Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	52%	60%	65.3%	76.7%
Result	57%	62.3%	73.7%	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		Set Baseline	973,724	1,032,147
Result		927,357	1,220,956	1,359,772
Status		Baseline	Target Exceeded	Target Exceeded

Analysis of Results

The most efficient and effective programs often use evidence-based and evidence-informed practices. Currently, ACF's Children's Bureau and its National Resource Center for the Community-Based Child Abuse Prevention program are working closely with States to promote more rigorous evaluations of their funded programs. The Community-Based Child Abuse Prevention program developed an efficiency measure to gauge progress towards programs' use of these types of practices. For the purposes of this efficiency measure, the Children's Bureau defines evidence-based and evidence-informed programs and practices along a four level continuum (from least to most): Emerging and Evidence Informed;

Promising; Supported; and Well-Supported. The funding directed towards these types of programs (weighted by “evidence-informed” or “evidence-based” practices level) will be calculated over the total amount of funding used for direct service programs to determine the percentage of total funding that supports evidence-based and evidence-informed programs and practices. HHS selected the target of a three percentage point annual increase in the amount of funds devoted to evidence-based practice as a meaningful increment of improvement. This performance expectation takes into account the fact that this is the first time that the program has required grantees to target their funding towards evidence-based and evidence-informed programs, and it will take time for States to adjust their funding priorities to meet these new requirements. ACF has made steady progress on this measure, with the percent of Community-Based Child Abuse Prevention funding directed toward evidence-based or evidence-informed practices exceeding targeted increases from FY 2010 to FY 2012. In FY 2012 the percent of funding supporting the use of evidence-based and evidence informed practices increased significantly to 73.7 percent. This substantial increase (previous year actual was 62.3 percent) is a result of enhanced emphasis on the importance of evidence-based and evidence-informed practice.

Systematic reviews of scientific literature by the CDC form the basis for evidence-based Community Preventive Services Task Force recommendations about effective programs, services, and policies for improving health and preventing many chronic and infectious diseases and injuries. To achieve their maximum health impact, Task Force recommendations must be disseminated, adopted, and used by public health leaders, practitioners, and partners. Pursuing that purpose, CDC publishes the Guide to Community Preventive Services online. Currently a proxy measure, page views of the Community Guide website (www.thecommunityguide.org), tracks awareness and use of this guide. In FY 2013, the website received 1,359,772 page views, exceeding the target by 31 percent.

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

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

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

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

Objective 3.A Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target			Set Baseline	23%
Result			25%	31%
Status			Baseline	Target Not Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		Set Baseline	20 states	25 states
Result		17 states	19 states	27 states
Status		Baseline	Target Not Met but Improved	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	85%	85%	86%	86%
Result	87%	87%	89.4%	87.7%
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	80%	80%	80%	80%
Result	85.1%	84.6%	85.3%	Oct 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	73.3 %	75.3 %
Result	72.5 %	72.8 %	74.8 %	Oct 30, 2014
Status	Historical Actual	Historical Actual	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	91.9 %	91.7 %
Result	91.5 %	91.7 %	91.5 %	Oct 30, 2014
Status	Historical Actual	Historical Actual	Target Not Met	Pending

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

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A	76.1%[21]
Result	79%	73.5%	76.1%	65.9%
Status	Historical Actual	Historical Actual	Historical Actual	Target Not Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	20.0 %	20.0 %	20.0 %	20.0 %[22]
Result	24.0 %	21.5 %	19.1 %	18.1 %
Status	Target Not Met	Target Not Met but Improved	Target Exceeded	Target Exceeded

Analysis of Results

Strengthening the quality of early childhood education programs can provide a stronger foundation for each child's future. Because improving the quality of Head Start and Child Care programs will help achieve a more solid foundation for each child, HHS has made this initiative a Priority Goal - to improve the quality of early childhood programs for low-income children through implementation of the Quality Rating and Improvement Systems (QRIS) in the Child Care and Development Fund and through implementation of the Classroom Assessment Scoring System (CLASS: Pre-K) in the Head Start program. For the ACF Child Care program, the goal is to increase the number of States with a QRIS that meets the seven high quality benchmarks developed by HHS in coordination with the Department of Education for child care and other early childhood programs. ACF has provided ongoing training and technical assistance to at least 30 States/territories on QRIS implementation; as of FY 2013, a total of 27 States had a QRIS that met high quality benchmarks. Currently, many States meet some, but not all seven, of the outlined benchmarks – for example, as of FY 2013, at least five States have incorporated six quality benchmarks and at least seven States have incorporated five quality benchmarks. The ACF Office of Head Start completed a comprehensive data collection effort and analysis of a full program year of CLASS: Pre-K data as part of an ongoing effort to improve training and assistance, and thus enhance children's school readiness. In support of this effort, ACF is measuring the proportion of Head Start grantees that score in the low range on any of the three domains of the CLASS: Pre-K. An analysis of CLASS scores for FY 2013 indicates that 31 percent of grantees scored in the low range, missing the target of 23 percent. All grantees scoring in the low range (below 2.5) in FY 2013 did so for the Instructional Support domain. This shows that improving Instructional Support scores is far more difficult and requires more time and more intensive efforts. In response to the data from the FY 2013

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

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

CLASS reviews, the Office of Head Start plans to provide more intentional targeted assistance to those grantees that scored in the low range, using a case management approach.

ACF is committed to establishing permanency for some of our most vulnerable citizens—children who are in foster care and runaways. During FY 2013 and FY 2014, both the sequestration and the government shutdown significantly impacted these programs. For FY 2013, ACF exceeded the target for this performance measure with 87.7 percent of youth living in safe and appropriate settings after exiting ACF-funded TLP services. ACF has a suite of performance measures focused on ensuring positive permanent living situations for children in foster care, while ensuring children are placed in safe living arrangements. Since trauma can be aggravated further when a child is moved from one placement setting to another, ACF strives to have no more than two placement settings during the first 12 months of foster care. In FY 2012, ACF again exceeded its 80 percent target with 85.3 percent of children experiencing no more than two placement settings during their first year in care. Similarly, establishing permanency for children who are in foster care is a priority for ACF since children who remain in care for longer periods of time are less likely to exit to permanency and experience the benefits of stable living arrangements. Despite the challenges related to placing those children in foster care longer than 24 months, ACF exceeded its target for FY 2013, realizing permanency in 74.8 percent of exits. It fell just short of its ambitious target for those children in care less than 24 months, finding permanency for 91.5 percent.

The overuse of antibiotics can have a profound effect on children and their future, as more drug-resistant strains of infection develop. Ear infections (acute otitis media) are the most common reason children under age five receive antibiotics. Antibiotic prescription rates for ear infections in children under five years of age declined 2005-2007, but increased from 2008-2009. Although the rate improved in 2010, it remains high at 55.8 prescriptions per 100 children in this age group. Results for FY 2011 are unavailable due to delayed release of data. Results will be provided when data becomes available by March 31, 2014.

Through individuals, families, schools, and other organizations throughout the community, SAMHSA is promoting emotional health and preventing mental illness and substance abuse in children and adolescents. SAMHSA's National Child Traumatic Stress Initiative (NCTSI) is designed to improve behavioral health treatment, services, and interventions for children and adolescents (as well as their families) who were exposed to traumatic events. NCTSI provides training and technical support for interventions that reduce the mental, emotional, and behavioral effects of traumatic events. This program continues to be a principal source of child trauma training for our nation. In FY 2013, trauma treatment was provided to more than 24,000 children, adolescents, and family members. The drop in performance can be attributed to many factors, including awards being funded at the end of FY 2012. Despite the challenges associated with first-year implementation of services, almost one-third of the FY 2013 NCTSI grantees achieved a positive functioning at 6 month follow-up rate of 76 percent or more, and almost 50 percent of NCTSI grantees achieved a rate of between 70 and 75 percent. Positive functioning relates to psychological as well as social, emotional, and psychological well-being of the subject as well as a general ability to perform the tasks associated with routine life activities. It is expected that as service providers continue to develop their capacity to provide trauma-informed services, that the rate of positive functioning at 6 month follow-up will increase. The Youth Violence Prevention initiative implements an enhanced, coordinated, and comprehensive plan of activities, programs, and services that promote healthy childhood development, prevent violence, and prevent alcohol and drug abuse. Progress is measured via the reported rate of current substance abuse among middle and high school students. In FY 2013, the rate decreased to 18.1 percent, exceeding its target for the second year.

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

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

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

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

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

Objective 3.B Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	61	61	62	63
Result	60.5	62.8	63	Dec 31, 2014
Status	Target Not Met	Target Exceeded	Target Exceeded	Pending

Increase the number of caregivers served through the National Family Caregiver Support Program. (Lead Agency - ACL; Measure ID - 3.1)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	560,000	790,000	792,000	796,000
Result	761,000	819,598	867,546	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	78	75	80	85
Result	74[23]	78	83	Nov 30, 2014
Status	Target Not Met	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	110[24]	110	124	116
Result	118[25]	122[26]	114	Nov 30, 2014
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	89.4 %	89.7 %	90 %[27]
Result	89.3 %	90.7 %	90.3 %	May 30, 2014
Status	Baseline	Target Exceeded	Target Exceeded	Pending

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

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

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

[26] The FY 2011 actual result for this performance measure was updated (previously reported as 121) due to additional data validation.

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	38.4%	27.5%[28]	30.4%	30.7%
Result	29%[29]	30.1%	30.4%[30]	Oct 30, 2014
Status	Target Not Met but Improved	Target Exceeded	Target Not Met but Improved	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	67.88%	68.79%	71.75%	71.77%
Result	68.11%	71.04%	71.06%[31]	69.07%
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Target Not Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	40.87%	42.97%	51.02%	52.5%[32]
Result	42.13%	50.02%	52.91%	Dec 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	62%	61%	62%	62%
Result	62%	62%	63%	Nov 30, 2014
Status	Target Met	Target Exceeded	Target Exceeded	Pending

Analysis of Results

Community based services and assistance to caregivers are crucial to enabling frail elderly clients to delay or defer nursing home placement. According to LongTermCare.gov the average cost in the US for a semi-private room in a nursing home is $74,820 per year. For many people, that level of annual

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

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

[30] This data excludes territories, but includes the District of Columbia.

[31] The FY 2012 actual result for this performance measure has been updated as a result of revised data submissions from grantees.

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

expenditure for care cannot be obtained without spending down savings and liquidating other assets. Seeking alternatives to this level of costly care, while providing quality care in familiar surroundings for elderly individuals, is something that many senior citizens and family members prefer. ACL uses a "nursing home predictor" index which measures the prevalence of characteristics that frequently lead to nursing home placement. The FY 2012 result for this measure exceeded the target. As the score on the index increases it indicates an increase in the proportion of the high risk elderly population served through ACL funded services in the community. Since FY 2003, the index has improved nearly 35 percent, demonstrating that in tight economic times ACL is succeeding in targeting community services and diverting individuals from more costly care. One of the ways that ACL succeeds in serving community-based elderly individuals is to support family and friends who are caregivers of these frail individuals. In FY 2012, 867,778 caregivers were served, exceeding ACL's target and representing a 28 percent increase in the number of caregivers served compared to FY 2008.

ACF also focuses on targeting services to populations in need with its recipiency targeting index for families that receive Low Income Home Energy Assistance Program (LIHEAP) funding. The recipiency targeting index scores are the national percentage of LIHEAP eligible household that receive services and have either a senior citizen or a young child (under the age of five) in the household compared to the percentage of household estimated by the Census Bureau as being LIHEAP income eligible and have a senior citizen or young child in the household. If the recipiency score was 100, it would mean LIHEAP served these target populations at precisely the level they appear in the US population of eligible clients. The recipiency score for household with a senior citizen improved to 83 and exceeded its target of 80. Though the recipiency score for households with children declined from the previous year, since the result is more than 100, it shows that a slightly higher percentage of households with young children received services than exist in the eligible, general population.

Providing the survivors of domestic violence with tools that will assist them to remain safe is important to social and community well-being. The percentage of clients who have improved knowledge of safety planning is correlated with other long-term client safety and well-being measures. ACF again exceeded its target on a measure of the percentage of clients who reported improved knowledge of safety planning with more than 90 percent of clients served through Family Violence Prevention services programs.

HHS has several measures related to economic well-being. During FY 2012, the most recent results available, there was general economic uncertainty. The Department of Labor reported unemployment rates hovered around 8.2 percent for the first eight months of that year, and there were mixed signs of recovery. Despite these challenges, ACF did improve the percentage of newly employed Temporary Assistance to Needy Families (TANF) adults entering employment with a result of 30.4 percent. Refugees are another population targeted by ACF programming with economic well-being performance measures. In FY 2012, the percentage of refugees entering employment through ACF-funded refugee employment services exceeded the target of 51.02 percent with a result of 52.91 percent. This is a result of strong efforts by the States to reach out to employers, as well as effort to strengthen job training and development. ACF still faces challenges in terms of performance on this measure given the changing demographics of the U.S. Resettlement Program, as many populations require extended employment services in order to enter the U.S. labor market and integrate into U.S. society. In FY 2013, 69 percent of refugees served by the Matching Grant program were not dependent on any cash assistance within 180 days of arrival, slightly missing the target of 71 percent. ACF has put processes in place to improve future achievement including requiring Performance Improvement Plans for grantees with at least 50 refugee clients and who are performing below average. These plans include increased monitoring, professional development training, reassignment of personnel, and potential funding reductions.

In FY 2012, almost $28 billion in child support payments were distributed to families. This total represents a collection rate of 63 percent for current support. The Child Support Program continues to increase the current support collection rate by working with parents to ensure that they have the tools and resources they need to provide for their children, focusing on new and improved enforcement techniques, and preventing and addressing accumulated child support debt.

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

HHS is committed to strategies that streamline access to a full complement of integrated services for the elderly and persons with disabilities. Over the past decade, a number of policy reforms and initiatives have improved the effectiveness of efforts to promote home and community-based services and to decrease unnecessary reliance on institutional care. The Supreme Court's landmark 1999 Olmstead ruling requires States to place qualified individuals with disabilities in community settings whenever such placements are appropriate. ACL provides a number of services to older adults including those with disabilities; for example, transportation, personal care, meals, supportive services for family caregivers and elder rights services (including by not limited to legal services, pension counseling, prevention and protection from abuse, neglect, and exploitation). Through grants, technical assistance, and information-sharing, the Administration on Intellectual and Developmental Disabilities (AIDD) within ACL works with a network of State Developmental Disabilities Councils, State Protection and Advocacy Systems, national University Centers on Excellence in Developmental Disabilities, and Projects of National Significance to ensure that individuals with developmental disabilities and their families have access to culturally competent services and supports that promote independence, productivity, integration, and inclusion in the community. SAMHSA has been working with homeless clients who have mental health and/or substance abuse problems to overcome these conditions and improve their living situation.

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

Objective 3.C Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	30%	30%	28%	28%
Result	29%	30%	26%	Dec 31, 2014
Status	Target Exceeded	Target Met	Target Exceeded	Pending

Increase the percentage of older persons with severe disabilities who receive home-delivered meals. (Lead Agency - ACL; Measure ID - 3.5)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A	39.0%[33]
Result	40.2%	41.8%	43.5%	Dec 31, 2014
Status	Historical Actual	Historical Actual	Historical Actual	Pending

[33] Beginning with FY 2013 results, this measure replaces ACL measure 3.2. It reports the same data as the previous measure, but as a percentage, rather than a number. Reporting as a percentage provides greater clarity regarding the performance impact of the program.

Maintain at 90% or higher the percentage of clients receiving home delivered meal who rate services good to excellent. (Lead Agency - ACL; Measure ID - 2.9a)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%
Result	90.08%	90%	88%	Dec 31, 2014
Status	Target Exceeded	Target Met	Target Not Met	Pending

Maintain at 90% or higher the percentage of transportation clients who rate services good to excellent. (Lead Agency - ACL; Measure ID - 2.9b)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%
Result	98%	97%	98.5%	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

Maintain at 90% or higher the percentage of National Family Caregiver Support Program clients who rate services good to excellent. (Lead Agency - ACL; Measure ID - 2.9c)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%
Result	94%	96%	93.8%	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	4,927	5,420	5,420	5,420[34]
Result	5,163[35]	4,459	4,781	4,360
Status	Target Exceeded	Target Not Met	Target Not Met but Improved	Target Not Met

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

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	87.0 %	87.0 %	87.0 %	87.0 %[36]
Result	90.0 %	92.0 %	87.0 %	Jul 31, 2014
Status	Target Exceeded	Target Exceeded	Target Met	Pending

Analysis of Results

According to the 2009 Met Life/AARP study "Caregiving in the U.S." 36.5 million households, more than 30 percent of all US households, reported an unpaid family caregiver assisted elderly or disabled members with activities of daily living or other supports to enable individuals to remain at home. ACL provides grants to States and territories to fund a range of supports that assist family and informal caregivers. Since 2003, ACL has been working to reduce the frustration of caregivers and has set ambitious targets to reduce the number of caregivers who have had difficulty obtaining services from a high of 64 percent caregivers in 2003 to the current reported level of 26 percent of caregivers. Many of the individuals served by ACL are very frail with multiple chronic-conditions. Frequently these severely disabled clients are eligible to live in a nursing home and care can be substantially more expensive in these complex situations. ACL working in conjunction with State, tribal, and territorial grantees expected with constrained funding and increasing service costs that not only the number of individuals served with home delivered meals would decline, but the number of severely disabled clients expected to decline as well. Results proved otherwise, many States and localities have improved targeting services to clients at high risk of nursing home entry. Most recent results show an increase to nearly 43.5 percent of severely disabled people receiving meals delivered to their own home, enabling them to remain longer in their community, despite a stable budget and increasing costs related to food, fuel, and labor.

A high rating of service quality by consumers is a priority emphasized in the President's Executive Order 13571 "Streamlining Service Delivery and Improving Customer Service." ACL has a number of performance measures related to maintaining high levels of service quality while also serving frail, elderly individuals most in need of assistance to remain in their own homes. In general, ACL strives for service quality that meets or exceeds 90 percent of consumers rating services "good" to "excellent." The quality ratings by transportation consumers are exceptionally high with greater than 98 percent of consumers indicating the services are "good" to "excellent." Caregivers served by the National Family Caregiver Support Program reported nearly a 94 percent rating of services "good" to "excellent." While a high percentage (88 percent) of home delivered nutrition consumers reported the service as "good" to "excellent," this rating falls below the 90 percent target set by ACL, the reasons for which are complex. Further analysis of ACL data found that 93 percent of program participants report liking the meals served and that the majority of consumers who rate the overall program less than "good" report liking the meals served. Although the program meets the nutritional criteria of the Older Americans Act, some

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

consumers have reported reductions in the quantity of food in the meals and fewer meal choices. This last issue is most likely related to program budget pressures. ACL continues to explore: (1) if this is a continuing trend and (2) if a trend is established, the root cause and how to provide technical support to the Aging Network through the nutrition program staff and State liaisons in the ACL regional offices.

Individuals with severe mental illness, including homeless individuals, benefit from a variety of supports. Two measures from SAMHSA show differing approaches to addressing the needs of individuals with significant mental health challenges. For those individuals who are receiving services, SAMHSA strives to maintain or restore client rights by having a mechanism to assist individuals with complaints to try to resolve their issues and maintain personal decision making. Another form of support assists individuals who apply for Social Security (SSI) or Social Security Disability (SSDI) payments and related benefits including health insurance. SAMHSA has been training mental health professionals in SSI/SSDI outreach and assisting clients in applying for services for which they are eligible. Between 2010 and 2011 the program instituted efforts to ensure that people who attended trainings were committed to assisting applicants for SSI/SSDI by requiring all trainees to have signed confirmation from their supervisor that these professionals would be expected to assist applicants for SSI/SSDI. Though there was a drop in the number of people trained in 2013 because of a number of outside factors, more trainees were fulfilling their commitments. One barrier is that State and local funds for training have been dramatically reduced since the fiscal downturn. In addition, new federal restrictions were placed on travel and funding of meetings. A new on-line curriculum has been developed to overcome the obstacle of the travel restrictions, and get more people trained. In a separate program, Protection and Advocacy for Individuals with Mental Illness, individuals with significant mental illness (adults) and significant emotional impairments (children/youth) who are at risk for abuse, neglect, and right's violations, are given legal-based advocacy services. These programs are highly effective in assuring that the most vulnerable individuals with mental illness, especially those residing in public and private residential care and treatment facilities, are free from abuse and placed in appropriate, least restrictive, community-based settings. Targets have been met or exceeded during FY 2012 and each preceding year.

Goal 3. Objective D: Promote prevention and wellness

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

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

Objective 3.D Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	1,232.0 per capita	1,150.0 per capita[37]	1,062.0 per capita
Result	1,281.0 per capita	1,232.0 per capita	1,196.0 per capita	Jul 31, 2014
Status	Baseline	Target Met	Target Not Met but Improved	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	20.5 %	20 %	19 %
Result	19.3 %[38]	19 %	18.1 %	Jun 30, 2014
Status	Baseline	Target Exceeded	Target Exceeded	Pending

[37] Priority Goal expanded in FY14 as a new Priority Goal on all combustible tobacco. New baseline established.

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		18.9 %	18.6 %	18.2 %
Result		18.1 %	14 %[39]	Jun 30, 2014
Status		Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		N/A	84,000	75,000
Result		24,419	87,455	109,908
Status		Historical Actual	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	555,132	555,132	555,132	555,132[40]
Result	664,932	765,638	884,536	1,061,204
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	66.0 %	62.3 %	68.4 %	63.1 %
Result	62.3 %[41]	67.4 %[42]	66.7 %	66.1 %
Status	Target Not Met	Target Exceeded	Target Not Met	Target Exceeded

[39] NYTS data, which captures youth smoking prevalence in the interim years of YRBSS reporting. Targets are set per YRBSS data.

[40] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY 2013 performance targets reflect FY 2012 funding levels.

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

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	50.4%	50.4%[43]	55.9%	50%
Result	58%[44]	85%[45]	88%	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	1.09	1.06	1.03	1
Result	1.11	1.1	1.14	Dec 31, 2014
Status	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A	32.3%
Result	29%	32.8%	37.5%	46.7%
Status	Historical Actual	Historical Actual	Historical Actual	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	2.35 Million	2.48 Million	2.66 Million	2.85 Million
Result	2.46 Million	2.67 Million	2.88 Million	3.05 Million
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

Analysis of Results

Cigarette smoking and second hand smoke kills more than 443,000 people in the U.S. each year. For every smoker who dies from a smoking-attributable disease, another 20 live with a serious smoking-related disease. Between 2000 and 2004, smoking cost $96 billion in medical costs and $97 billion in lost productivity each year. For these reasons, HHS is leading the way to reduce tobacco consumption through the Tobacco Control Implementation Committee chaired by the Assistant Secretary for Health,

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

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

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

with CDC, FDA, NIH, and IHS playing key contributing roles. This committee, has taken a comprehensive, broad-based approach to reducing tobacco use that involves preventing people from initiating smoking, eliminating exposure to secondhand smoke, promoting quitting, and identifying and eliminating disparities in tobacco use among population groups. HHS's FY 2012–2013 Priority Goal on per capita cigarette consumption is making progress towards achieving its FY 2013 target of a 17.1 percent decrease from the 2010 baseline (1,281 cigarettes per capita) to 1,062 cigarettes per capita. Although the Department missed the target in FY 2012, it saw consumption continue to be reduced over the previous year. Two complementary efforts by the CDC also target smoking reduction in two populations, adults (18 and over) and adolescents (grade 9 – 12). The percentage of current adult smokers decreased from 20.6 percent in 2009 to 18.1 percent in FY 2012, while the percent of current teen smokers declined from 20.0 percent to 14.0 percent from FY 2007 to FY 2012. The six percentage point decrease from FY 2007 to FY 2012 is due to slight variance in results between the Youth Risk Behavior Surveillance System (YRBSS) and the National Youth Tobacco Survey (NYTS), which tracked closely from FY 2007 to FY 2011. Given the variance, YRBSS will be the sole data source beginning in FY 2014, which is reflected in the FY 2015 target of 17.6 percent. Possibly contributing to the drop in adolescent smoking is FDA's program to conduct compliance checks to assure that retailers refuse sales of tobacco to adolescents under the age of 18. In FY 2013, under contracts with 45 States and Territories, FDA conducted 109,908 compliance check inspections of retail establishments, substantially exceeding its target. Although this was a much higher number than expected, it reflects the high level of variability inherent in this goal requiring the estimation of the number of compliance checks that each State will be able to conduct.

Another significant cause of early death in the U.S. is suicide. The National Center for Health Statistics (CDC) reported in 2009 there were 36,891 suicides, ranking as the 10th leading cause of death among persons ages 10 years and older nationally. The National Suicide Prevention Lifeline (Lifeline), sponsored by SAMHSA, routes callers from anywhere in the U.S. to the closest certified crisis center within Lifeline's network of more than 150 centers. Trained counselors provide crisis counseling, link callers to emergency services, and offer behavioral health referrals. Studies have found that simply talking about thoughts of suicide with another person can prevent loss of life. SAMHSA has increased efforts to promote Lifeline broadly to the public, in order to enhance awareness of this resource. The success of this outreach effort is reflected in the 1,061,204 calls answered in FY 2013, an increase of more than 175,000 over the previous year. Targets have been exceeded each year.

In addition to suicide prevention, SAMHSA works to support those adults who may be severely mentally ill and homeless. Grants are awarded to organizations to assist this population in gaining access to sustainable permanent housing, treatment, and recovery supports. A measure of the performance of these grantees is the self-reported sense of positive functioning by the individual 6 months after beginning to receive homeless support services. In FY 2013, 66.1 percent reported improved functioning, exceeding the target. This was a result of a combination of factors including, but not limited to, grantees engaging and providing services to the population of focus in collaboration with community consortia, improved reporting, and support to grantees via technical assistance on housing, evidence based practices and other relevant topics.

Underage drinking has been linked to a number of mental and physical health problems. The Strategic Prevention Framework State Incentive Grant (SPF SIG) program, managed by SAMHSA, provides funding to States, Federally recognized tribes and U.S. territories to support local communities in preventing the onset and progression of substance abuse and substance abuse-related problems including underage drinking. Targets have been exceeded each year. For FY 2012, the most recent year for which State level estimates are available, 88 percent of the States in the program reduced their rates of underage drinking.

As the leading cause of death for persons from ages five to 34, motor vehicle crashes account for more than 30,000 deaths per year in the United States. CDC reduces the rate of fatal motor vehicle crashes by identifying effective traffic safety interventions including the promotion of child restraint systems, primary seat belt laws, ignition interlocks for prevention of impaired driving, Graduated Drivers Licensing programs for new teen drivers, and traffic safety programs for tribal communities. CDC is engaged in identifying effective strategies for reducing motor vehicle crash injuries and deaths and providing technical assistance to States interested in implementing these strategies. Although reductions in traffic fatalities indicate motor vehicle safety efforts have been effective, the rate of decline experienced between 2005 and 2009 (21 percent reduction) slowed from 2010 to 2011 (one percent reduction) and then slightly increased in 2012. However, this is consistent with historical trends that show repeated instances of large declines followed by a multi-year leveling off period

HHS manages a number of programs to reduce health disparities for minorities, including prevention and wellness. Unlike other racial and ethnic groups, American Indians appear to have an increasing incidence of cardiovascular disease (CVD). Modifying the following risk factors offers the greatest potential for reducing CVD morbidity, disability, and mortality: high blood pressure, high cholesterol, smoking tobacco, excessive body weight, and physical activity. IHS seeks to address these risk factors in patients 22 and older diagnosed with coronary heart disease by assessing all five of these risk factors. In FY 2013 the target was 32.3 percent of coronary heart disease patients receiving all 5 assessments and the result was 46.7 percent. Increasing the number of blood stem cell transplants facilitated for patients from racially and ethnically diverse backgrounds addresses the statutory aim of ensuring comparable access for patients from all populations. HRSA manages the C.W. Bill Young Cell Transplantation Program to increase the number of unrelated blood stem cell transplants facilitated for patients in need. In FY 2013, 3.05 million persons on the donor registry self-identified as belonging to racial/ethnic minority populations. This is an increase over the number in FY 2012, 2.88 million.

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

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

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

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

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

Objective 3.E Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	2.3 cases/100,000	2.2 cases/100,000	2.1 cases/100,000[46]
Result	3.5 cases/100,000	3.0 cases/100,000	2.6 cases/100,000	Jul 31, 2014
Status	Historical Actual	Target Not Met but Improved	Target Not Met but Improved	Pending

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

American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Lead Agency - IHS; Measure ID - 24)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	80%	74.6%	77.8%	Set Baseline
Result	79%[47]	75.9%[48]	76.8%	74.8%[49]
Status	Target Not Met	Target Exceeded	Target Not Met but Improved	Baseline

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	1.9	1.8	1.7	1.7
Result	1.6	1.5	1.5	Sep 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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 2010	FY 2011	FY 2012	FY 2013
Target		N/A	Set Baseline	47 %
Result		41 %	39 %	42 %
Status		Historical Actual	Baseline	Target Not Met but Improved

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	Set Baseline	13.53
Result	21.76	20.06	18.74	Nov 30, 2014
Status	Historical Actual	Historical Actual	Baseline	Pending

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

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

[49] Beginning in FY 2013 this measure will match the revised CDC Immunization Schedule and Healthy People 2020; therefore, results will differentiate the use of the 3 or 4 dose Hib vaccine for individual patients. CDC will identify the new measure as 4313*314 with the *3 representing the Hib vaccine. In previous years, CDC did not make a distinction between the 3 or 4 dose vaccine Individual sites will continue to use their choice of 3 doses or 4 doses of Hib. Until results are compiled, the agency does not know what the impact will be to the baseline result.

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		85% (median) in year 2006 countries	85% (median) in year 2007 countries	85% (median) in year 2008 countries
Result		42.8%	60.0%	Apr 30, 2014
Status		Target Not Met	Target Not Met but Improved	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline[50]	27.4 %	26.3 %	24.9 %
Result	25.4 %[51]	24.9 %	Jun 30, 2014	Jun 30, 2015
Status	Baseline	Target Exceeded	Pending	Pending

Proportion of persons served by the Ryan White HIV/AIDS program who are racial/ethnic minorities. (Lead Agency - HRSA; Measure ID - 16.I.A.1)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data
Result	72% (CDC = 66.5%)	72.2% (CDC= 66.7%)	72.6% CDC data not available for comparison at this time.	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	In Progress

Analysis of Results

Salmonella is the leading known cause of bacterial foodborne illness and death in the United States. Each year, food contaminated with Salmonella causes an estimated 1.2 million illnesses and between 400 and 500 deaths. Salmonella Enteritidis (SE), a subtype of Salmonella, is the second most common type of Salmonella and accounts for approximately 20 percent of all Salmonella cases in humans. The most significant sources of foodborne SE infections are shell eggs (FDA-regulated) and broiler chickens (USDA-regulated). To significantly reduce foodborne illness and death, the FDA and CDC have joined forces and made the reduction of SE infections attributable to shell eggs a Priority Goal for FY 2013. As of December 1, 2013, the illness rate from the 12-month period ending in September was 2.3 illnesses per 100,000. The rate has decreased over the last few years, but is still above the yearly targets. Eggs are not the only source of SE illnesses; chicken is also a major source, and there are other sources as well.

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

[51] CDC updates results as additional HIV surveillance data are received. Because state and local health departments rely on reports from doctors' offices and laboratories, as well as medical record abstracts and death records, incomplete or duplicate information is sometimes received, requiring additional follow up before the data can be considered complete. CDC routinely updates these data in published surveillance reports for up to four years as more information is reported to CDC.

In other areas related to decreasing infectious diseases, IHS is measuring the percentage of American Indian and Alaska Native infants receiving a combined series of immunizations consistent with the CDC's Advisory Committee on Immunization Practices standards and schedule that includes coverage for diphtheria, tetanus, whooping cough, polio, measles, mumps and rubella, Hepatitis B, influenza, chicken pox and pneumonia. Beginning in FY 2013 this measure matches the revised CDC Immunization Schedule and *Healthy People 2020*; therefore, results will differentiate the use of the 3 or 4 dose Hib vaccine for individual patients. As a result of this change in immunization schedule, the FY 2013 result sets a new baseline of 74.8 percent.

Other conditions the CDC is actively addressing in a collaborative manner include tuberculosis (TB), HIV infection, MRSA, and influenza. Due to the effectiveness of TB prevention and control programs, the U.S. consistently has one of the lowest TB incidence rates in the world, 9,945 cases in 2012 or 1.5 per 100,000 U.S. born population since national reporting began in 1953. CDC monitors key aspects of TB control including completion of treatment within one year, timely laboratory reporting, and testing.

Influenza is another major public health problem in the United States and globally. In the United States, on average 5-20 percent of the population contracts the flu, more than 200,000 people are hospitalized, and approximately 36,000 people die from seasonal flu-related causes. In 2010, CDC's Advisory Committee on Immunization Practices (ACIP) recommended the seasonal influenza vaccine for everyone 6 months of age and older. In FY 2012 CDC revised its flu measure to reflect the CDC's priorities to meet the new standards of vaccinations for everyone 6 months and older. In FY 2013 the number of adults that received a flu vaccination increased to 42 percent over the 2012 baseline, however CDC did not meet its goal.

In alignment with HHS Action Plan to Prevent Healthcare Associated Infections, CDC has developed guidelines and plans to reduce infections associated with healthcare settings, including but not limited to invasive Methicillin-resistant Staphylococcus Aureayus (MRSA) infections. The national incidence of healthcare-associated invasive MRSA infections continued to decline from CY 2008 baseline, decreasing from 21.76 infections per 100,000 population in CY 2010 to 20.06 in CY 2011 and to 18.74 in CY 2012.

Through the President's Malaria Initiative (PMI), CDC procured more than 17 million long-lasting, insecticide-treated mosquito nets (ITNs) in 2010. Scale-up of ITN distribution and other interventions through PMI and other program efforts have already led to reductions in all case mortality in children less than five years of age by 23–36 percent in PMI countries surveyed and contributed to saving more than 200,000 lives over the past nine years.[52] Although the FY 2012 target was not met due to delays in improvements of national distribution systems and delays in procurement, progress has been made.

More than 1.1 million people in the United States are living with HIV infection, and almost 1 in 6 (15.8 percent) are unaware of their infection. The CDC and HRSA are both striving to improve prevention and treatment results. Prior to 2012, CDC tracked the percentage of people diagnosed with HIV infection at earlier stages of disease (not CDC stage 3: AIDS). From 2007-2010, the percentage of people identified at earlier stages of disease steadily improved to almost 56 percent. Per the HHS Secretary's memo (April 2012) on implementing a common set of core indicators across federal agencies, CDC has revised this indicator definition to conform to a new cross–agency definition. FY 2011 data indicates that 24.9 percent of persons were diagnosed at later stages of disease within three months of diagnosis, a

[52] 2010 World Malaria Report

decrease of 2.8 percentage points from the baseline of 27.7 (2010), exceeding the FY 11 target of 27.4 percent. Though new HIV infections among racial/ethnic minorities overall have been roughly stable, compared with non-racial/ethnic minorities they continue to account for a higher proportion of cases at all stages of HIV – from new infections to death. The proportion of the Ryan White program's service population that comprises racial/ethnic minorities is an indicator of access to treatment for populations disproportionately impacted by HIV/AIDS. In FY 2012, 72.6 percent of Ryan White program clients were racial/ethnic minorities. FY 2012 CDC data is not yet available for comparison.

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

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

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

Within HHS, improving health security is a shared responsibility. ASPR serves as the Secretary's principal advisor on matters related to bioterrorism, public health emergencies, and also coordinates interagency activities between HHS, other Federal partners, State, local, and tribal officials responsible for emergency preparedness and protection of the civilian population. Other components and offices supporting emergency preparedness include ACF, CDC, and FDA. The table below includes performance measures that are indicative of HHS activities to improve the health and safety of Americans during emergencies.

Goal 3.F: Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	75 %	83 %	91 %	94 %
Result	89 %[53]	87 %	89 %	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending

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

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Result	Baseline	Awarded contract for Recombinant-based flu vaccines. Started large clinical studies to evaluate safety H5N1 vaccines. Issued RFP to establish Centers of Innovation for Advanced Development and Manufacturing. Proposals received and are under evaluation. Issued RFI to discern the capabilities of US vaccines and biologics manufacturing, which will inform the subsequent RFP.	**Target: EUAs= +1;** CBRN EUA= 1 anti-neutropenia cytokine drug for acute radiation treatment (Neupogen) Flu EUA = 4 Pre-EUA packages submitted to FDA by BARDA on H5N1 vaccines BLA Submissions= 3: (cell-based seasonal and H5N1 influenza vaccines – 2 and botulinum antitoxin - 1) **Pan Flu/EID Licensed= +1;** Licensures = 1: Influenza point-of-care diagnostic device (Simplexa) Awarded 3 contracts establishing the Centers for Innovation in Advanced Development and Manufacturing (CIADM) Issued RFP to establish domestic network of fill finish manufacturers for pandemic influenza and drug shortages.	CBRN EUA= 2; ST-246 antiviral for smallpox approved by FDA for EUA and Neupogen an anti-neutropenia cytokine for radiation treatment. 2 other packages were submitted but not acted on during the performance period. Pan Flu licensed=3; Licensed by FDA are: 1) Flucelvax, the first cell0based seasonal influenza vaccine, 2) FluBlØk, the first recombinant-based seasonal influenza vaccine, and 3) Aura, a next generation portable ventilator for adults. While not part of the goal, BARDA saw the first anthrax antitoxin and the first botulinum antitoxin licensed by FDA. Both projects were supported by Project BioShield and approved under the FDA's Animal Efficacy Rule.
Status	Target Met	Target Met	Target Met	Target Not Met but Improved

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem
Result	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem
Status	Target Met	Target Met	Target Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	46	46	41	46
Result	41	41	41	0[54]
Status	Target Not Met	Target Not Met	Target Met	Data Not Available

[54] Performance data for this measure is not available. Funding for response activities by the Commissioned Corps ended in FY 2012 as a result of a change in the Corps mission. OASH has requested to retire this measure effective FY 2014.

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Complete and evaluate the pilot vaccine adverse-effects program and participate in at least one international workshop or conference.	Apply novel technologies, including mass spectrometry, to quantify the absolute amount of hemagglutinin in the reference standards that are used to determine influenza vaccine potency.	Evaluate and compare new methods to determine the potency of influenza vaccines.	Develop and evaluate new methods to produce high-yield influenza vaccine reference strains
Result	Nov 30, 2010	The studies were delayed in FY 2011 awaiting the delivery of required equipment. In FY 2011, CBER did complete preliminary studies to evaluate the use of mass spectrometry to determine the absolute amount of hemagglutinin in reference standards and define initial sample conditions. (Target not met but improved)	In FY 2012 CBER met the goal by evaluating three new methods for the determination of influenza vaccine potency. These methods (ELISA using monoclonal antibodies to capture antigen, Surface Plasmon Resonance, and label-free, antibody-free mass spectrometry) were used to measure the potency of inactivated influenza vaccines from several manufacturers. In each case, the results demonstrated the potential of each method and indicated that further development and evaluation was warranted.	In FY 2013, CBER met the target to develop and evaluate new methods to produce high-yield influenza vaccine reference strains. Activities to meet this target include: • Multiple assays were evaluated to determine the best methods for assessing vaccine reference strain yield. • Further modifications were made to previously developed influenza vaccine reference strains for the 2009 H1N1 pandemic strain, which is now included in the seasonal vaccine. • One new influenza reference strain was developed as a possible vaccine candidate for the H7N9 influenza virus that emerged in China during 2013.
Status	Target Met	Target Not Met but Improved	Target Met	Target Met

Analysis of Results

To prepare for emergencies, HHS is undertaking a number of initiatives. For example, the CDC is helping public health agencies rapidly convene key management staff (within 60 minutes of being notified of an emergency) so that they can integrate information, prioritize resources, and effectively coordinate with

key response partners. Since FY 2009, the CDC's 62 grantees (which include States, territories and four major metropolitan U.S. cities) that successfully convened key staff within 60 minutes of notification increased from 68 percent to 89 percent, however the FY 2012 target was not met. CDC will continue to work with grantees to improve results and achieve future targets.

HHS is expanding diagnostic, preparation, response, and treatment options to deal with both natural and man-made disasters. To do this, both the FDA and ASPR are striving to have more options available to handle a crisis. For example, through the Office of Biomedical Advanced Research and Development Authority (BARDA), ASPR is working to increase the development of medical countermeasures for pandemic influenza as well as chemical, biological, radiological, and nuclear agents through public-private partnerships. The intent is to develop countermeasures, facilitate licensure of these producers, and build domestic countermeasure manufacturing capacity to address these threats. With the establishment of three Centers for Innovation in Advanced Development and Manufacturing in the U.S. in 2012, nearly 90 percent of the U.S. pandemic influenza vaccine supply will be produced domestically as compared to less than 50 percent in 2009. In FY 2013, the program fell just short of its target, producing 2 of 3 EUA and 3 of 3 Pan Flu/EID Licensed, however this represents substantial improvement over the previous year.

In March 2013, the first human cases of the novel avian influenza strain, H7N9, were reported in China. As of January 2014, 237 cases have been identified, including 58 deaths. Although H7N9 has not yet reached the United States, scientists have indicated that this strain poses a significant threat. Fortunately, lessons learned from the 2009 H1N1 pandemic have brought about improvements in response and coordination between agencies across the Department, including ASPR/BARDA, CDC, NIH, and FDA. Since the onset of the virus, HHS has taken steps to research and develop H7N9 vaccine candidates with the goal of producing a domestic stockpile. These candidates are currently at various stages of clinical trials testing. BARDA has also established the Fill-Finish Network, which is intended to boost the nation's ability to provide influenza vaccine domestically. Should large-scale distribution of a H7N9 vaccine be necessary, BARDA will be able to engage this network, which is anticipated to increase existing capacity by 20 percent.

The FDA is diversifying flu vaccine production and increasing laboratory surge capacity for testing potentially contaminated foods. The FDA seeks to ensure continued progress in preparation for new influenza strains, to strengthen vaccine safety monitoring, and to advance the detection of possible adverse events of new licensed vaccines through the use of large population databases. As a result, the FDA achieved its 2013 goal of developing and evaluating new methods to produce high-yield influenza vaccine reference strains. Evaluating multiple assays to determine the best methods for assessing vaccine reference strain yield is a critical issue for comparing different virus reference strains that might be available to manufacturers for vaccine production. The results indicated that a single method was insufficient for an accurate assessment of a candidate vaccine's potential for vaccine manufacturing and that multiple methods should be utilized. Modifications to the 2009 H1N1 influenza vaccine increased hemagglutinin (HA) content of the reference virus. HA yield is important to produce the needed quantity of vaccine and helps to ensure rapid availability of vaccines. The H7N9 influenza virus that emerged in China during 2013 is a new potential worldwide health hazard. The new influenza reference strain is a possible vaccine candidate for this virus, has passed all tests for attenuation and has been shared with the WHO collaborating centers. Also, in the event of a terrorist attack on the food supply, the FDA seeks to increase its ability to rapidly test large numbers of samples of potentially contaminated foods through a focus of laboratory capacity, achieving its target every year since 2010.

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

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

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

Objective 4.A Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	7,742	8,350	8,600	8,700
Result	8,438	8,881	9,206	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	19%	19%	17%	16%
Result	16.04%	16.23%	16.07%	Oct 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	0.8%	0.6%	0.7%	0.7%
Result	0.7%	0.8%	0.8%	0.7%
Status	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	3.2	3.4	3.6	3.6
Result	4.3	4.2	4.1	4
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

Analysis of Results

ACL has improved performance by more than 50 percent in the 10 years since FY 2002, when the baseline for the Home and Community-based Services measure was 6,103 senior citizens served for each million dollars of Older American's Act funds. This reflects the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers and increased commitments and partnerships at the State and local levels have all had a positive impact on program efficiency.

ACF strives to provide services to low income individuals and families through an efficient and cost effective delivery system through the Community Service Block Grant network. While States have an administrative cap of 5 percent, which limits the amount of funds that the State may retain for expenses, this ACF measure focuses on the administrative spending by sub-grantees. In FY 2012, approximately 16 percent of funds were spent for administrative purposes. The goal is to ensure the majority of CSBG funds are being spent on direct services to support low income individuals and families. ACF also saw improvement in reducing Head Start under-enrollment. Though each Head Start program is required to keep a wait list to fill vacancies as they occur, there are a number of reasons that it may be difficult to fill vacancies quickly. Low-income families are often mobile and eligible families on the waiting list may have moved out of the service area. In addition, as State pre-kindergarten programs have grown, parents may choose to send their children to those programs. Head Start has succeeded in substantially reducing vacancies from 4.4 percent in FY 2004 to 0.7 percent in FY 2013.

OMHA exceeded its target indicating the vast majority of appellants were somewhat or very satisfied with OMHA services from initiation through to case closure. These results were obtained through a third party contractor who used a stratified random sample of appellants to obtain results. OMHA looks at a range of appellant experiences including being informed of the status of their case, feeling there was a full opportunity to be heard and present their position, and believing their decision was fair.

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

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

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

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

Objective 4.B Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	14.3%	13.7%	10.4%	10.9%
Result	14.1%	11%	11.4%	9.5%
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target			N/A	31%
Result			27%[55]	31.8%
Status			Target Not In Place	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	9.5%	8.5%	5.4%	8.3%
Result	9.1%	8.6%[56]	8.5%[57]	10.1%
Status	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Target Not Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Further develop component measures of payment error for the Part D program	Report Baseline Composite Error Rate for the Part D program	3.2%	3.1%
Result	Additional component measure reported	Baseline 3.2%	3.1%	3.7%
Status	Target Met	Target Met	Target Exceeded	Target Not Met

[55] 27% is the FY 2012 baseline for this goal calculated based on the result of leads at the end of the first year of the Fraud Prevention System (FPS) (July 2012). The targets for 2013 and 2014 are calculated by increasing the baseline by 15% each year.

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

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target			Report national error rates in the 2012 Agency Financial Report based on 17 CHIP States	Report rolling average error rate in the 2013 Agency Financial Report based on States reported in 2012-2013
Result			8.2%	7.1%
Status			Target Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline[58]	8.4%[59]	7.4%[60]	6.4%[61]
Result	9.4%	8.1%	7.1%	5.8%
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	4.5%	4.7%	4.5%	6%[62]
Result	4.9%	5.25%	6.2%	5.3%
Status	Target Not Met	Target Not Met	Target Not Met	Target Exceeded

Analysis of Results

HHS employs a number of measures to track the performance of efforts to fight fraud and reduce improper payments. CMS's Fraud Prevention System (FPS) uses sophisticated algorithms and computer modeling to identify providers whose behavior is aberrant and potentially fraudulent. This program seeks to increase the percentage of Medicare providers and suppliers identified as high risk that receive administrative action. CMS measures performance in this area by instances where a high risk provider had at least one administrative action (numerator) compared to the universe of high risk providers and suppliers (denominator). In FY 2013 the FPS exceeded its target, with 31.8 percent of high risk Medicare

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

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

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

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

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

providers and suppliers receiving an administrative action. This approach reduces the burden on legitimate providers, while focusing the majority of the resources on those posing a high risk of fraud.

Medicare Advantage plans (Medicare Part C) are managed care plans that provide Medicare-covered services for beneficiaries who select to participate in the program. All Part C plans are paid a monthly per capita premium, and errors can occur in the transfer and interpretation of source data and in payment calculations. In FY 2009 the baseline error rate was 15.4 percent; FY 2013 results show that CMS has driven the error rate down to 9.5 percent, exceeding the measure target. The Medicare Fee-for-Service improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) Program. The FY 2013 result, an error rate of 10.1 percent, was above the targeted level of 8.3 percent. One of CMS's key goals is to pay claims properly the first time. The primary cause of improper payments is administrative and documentation errors, in large part due to insufficient documentation. CMS continues to develop new data analysis strategies and engage in provider and supplier education to prevent improper payments in Medicare Fee-for-Service. The payment error rate for the Medicare Part D Prescription Drug Program was 3.7 percent in FY 2013, higher than the FY 2012 result and the FY 2013 target. CMS continues to pursue enhancements to address this issue and has national training sessions for Part D plan sponsors covering comprehensive information for Part D payment and data submission requirements.

Medicaid and CHIP also have systems developed to identify, examine, track, and reduce the Medicaid and CHIP payment error rates. The Payment Error Rate Measurement (PERM) program measures improper payments in the fee-for service, managed care, and eligibility components of both Medicaid and the Children's Health Insurance Program (CHIP). In FY 2013 CMS made enhancements to the rate calculation methodology to improve the accuracy of the Medicaid improper payment rate estimate. These improvements included replacing the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate and incorporating prior year state-level improper payment rate recalculations. CMS met its target for the CHIP performance indicator, with 7.1 percent estimate of payment errors, below the 8.2 percent reported the previous year. The Medicaid Program exceeded its performance target with 5.8 percent payment error rate estimated, below the 7.1 percent from the previous year.

ACF seeks to reduce erroneous payments in the Title IV-E foster care program by estimating the national payment error rate and developing an improvement plan to strategically reduce, or eliminate where possible, improper payments. In FY 2013, ACF exceeded its target to decrease improper payments for foster care with an actual result of 5.3 percent of the Title IV-E foster care payments were determined to be improper, down 6.2 percent the previous year. The national error rate is estimated using data collected in the most recent foster care eligibility review for each State.

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

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

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

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

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

Objective 4.C Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	10.8 months	10 months	10 months	10 months
Result	10.8 months	10 months	10 months	10 months
Status	Target Met	Target Met	Target Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	350,000	1,169,208	1,215,976
Result	256,243	1,113,531	1,829,111	2,924,842
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded

Analysis of Results

HHS is committed to making high-quality and useful health-related data easily accessible in a timely manner. The Medical Expenditure Panel Survey (MEPS) Household Component fields questionnaires to individual household members to collect nationally representative data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. MEPS data is being used to increase the awareness of health and human service issues and generate insights into how to improve health and well-being. Through their efforts from 2006 (baseline) to 2012, AHRQ has reduced the number of months to public release of data from 12 to 10, meeting its target. It achieved the accelerated data release schedule for all the targeted MEPS public files during FY 2013.

The CDC created the Vital Signs Program late in 2009 to provide the latest data and information on key health indicators concerning major public health problems in the United States to a general audience. The first issue was published in July 2010 and since then Vital Signs has used a variety of communication channels. They include page views at CDC.gov, social media including Facebook and Twitter, email subscriptions and texting services. Significant increases in reach have been achieved each year and in FY 2013 12 issues were transmitted through over 2.9 million individual communications channels, substantially exceeding the target.

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

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

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

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

Objective 4.D Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target		12.0%	14.0%	16.0%
Result		13.0%	22.0%	38.0%
Status		Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	13,232 $MTCO_2e$	12,968 $MTCO_2e$	12,708 $MTCO_2e$	12,454 $MTCO_2e$
Result	11,750 $MTCO_2e$	13,404 $MTCO_2e$[63]	13,448 $MTCO_2e$	11,129 $MTCO_2e$
Status	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded

[63] Due to an error in calculation, HHS initially reported a result of 9,375 $MTCO_2e$ for FY 2011. However, after correcting this significant error, the accurate number has been calculated at 13,404 $MTCO_2e$. Measures are now in place to prevent similar miscalculations in the future.

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	100.0%	100.0%	100.0%
Result	32.0%	85.0%	94.0%	Dec 1, 2013
Status	Historical Actual	Target Not Met but Improved	Target Not Met but Improved	Pending[64]

Analysis of Results

In support of the HHS Sustainability Performance Plan, HHS has committed to reduce greenhouse gas emissions by technological, programmatic and behavior changes. Increasing the percentage of employees who telework or who are on an Alternate Work Schedule reduces vehicle miles traveled, greenhouse gas emissions and other pollutants. Commuting typically causes employee stress and decreases the amount of time that employees can devote to other healthy activities including physical activity, preparing healthy meals, and developing social capital by spending time with family or community events. Widespread telework and Alternate Work Scheduling coupled with office sharing and swing space can reduce overall facilities costs, waste-water treatment, and energy use. HHS far exceeded the expected target, with 38 percent of employees either teleworking or using Alternate Work Schedules to reduce their commute times and their carbon footprint.

HHS is committed to replacing gasoline-powered vehicles with alternative fuel vehicles (AFV) in accordance with GSA acquisition guidelines and in alignment with HHS Sustainability Plan and the Presidential Order to reduce greenhouse gases. In terms of HHS fleet emissions HHS has had a substantial decline from the 2012 high of 13,442 million metric tons of carbon dioxide equivalents ($MTCO_2e$). The rise in tons of CO_2 was due primarily by vehicles being added to the HHS fleet. The FY 2013 decline is related to reduced gasoline fuel use. Vehicles that are used by HHS law enforcement, protective, and emergency response are excluded from the calculation.

[64] Result is pending due to internal review of data.

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

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

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

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

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

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

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

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

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

HHS supports health workforce training efforts across the educational spectrum. CMS makes substantial financial investment in the health professions workforce by supporting the graduate medical education

of physicians. CMS also uses various payment incentives to help encourage providers to practice in underserved areas. NIH is committed to meeting the Nation's needs for biomedical, behavioral, and clinical investigators by providing research training for pre- and post-doctoral trainees and fellows. HRSA and IHS offer programs that provide scholarships and loan repayment in exchange for service in underserved areas. IHS provides loan repayment support for a broad range of health professionals who provide health care services in the Indian health care system of health care settings. HRSA provides support to medical, nursing, and other health professional schools to improve the supply, diversity, quality, and specialty and geographic distribution of health care providers. IHS supports programs to increase the numbers of AI/AN health professionals through a scholarship program and grants to educational institutions. CDC works to ensure a prepared, diverse, sustainable public health workforce through experiential fellowships and high-quality training programs, which fill critical gaps in key areas such as epidemiology, informatics, prevention effectiveness (health economics and decision sciences), preventive medicine, program management, and policy analysis. Routine placement of fellows in the field also strengthens the ability of State and local health departments to respond to public health problems and emergencies. IHS provides loan repayment support for a broad range of health and allied health professionals required to provide health care services in the Indian health care system of hospitals, clinics, health centers and stations. HHS components are committed to investing and strengthening the health and human service workforce and improving the quality of training and technical assistance; strategic use of data, monitoring, and evaluation efforts; collaboration with other agencies; and the promotion of evidence-based practices. Below are examples of performance measures from selected components designed to meet the demands for a well-trained health and human service workforce.

Objective 5 Table of Related Performance Measures

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 10%
Result	Award rate to comparison group reached 12%.	Award rate to comparison group reached 12%.	Award rate to comparison group reached 11%.	Award rate to comparison group reached 11%.
Status	Target Met	Target Met	Target Not Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 10%
Result	Award rate to comparison group reached 14% and exceeded the target by at least 2%.	Award rate to comparison group reached 13% and exceeded the target by 1%.	Award rate to comparison group reached 13% and exceeded the target by 1%.	Award rate to comparison group reached 13% and exceeded the target by 3%.
Status	Target Met	Target Met	Target Met	Target Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	7,358	9,203	9,193	8,068[65]
Result	7,530	10,279	9,908	8,899
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded

Percentage of individuals supported by the Bureau of Health Professions who completed a primary care training program and are currently employed in underserved areas. (Lead Agency - HRSA; Measure ID - 6.I.C.2)

	FY 2010	FY 2011	FY 2012	FY 2013
Target	35%	43%	43%[66]	43%
Result	31%[67]	33%[68]	43%	Dec 31, 2014
Status	Target Not Met	Target Not Met	Target Met	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target				166
Result				Dec 31, 2014[69]
Status				Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target			140	280[70]
Result			37[71]	Dec 31, 2014
Status			Target Not Met	Pending

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

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

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

[68] Service location data are collected on students who have been out of the HRSA program for 1 year. The results are from programs that have ability to produce clinicians with one–year post program graduation. Results are from academic year 2010–2011.

[69] Outputs based on forward–funded grants.

[70] Cumulative

[71] Outputs based on forward–funded grants.

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target			110[72]	260[73]
Result			249[74]	Dec 31, 2014
Status			Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	85%	100%[75]	100%[76]	100%
Result	85%	88.2%[77]	93.2%	94.6%
Status	Target Met	Target Not Met but Improved	Target Not Met but Improved	Target Not Met but Improved

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	80 Average Number of Days	61 Average Number of Days	60 Average Number of Days
Result	65 Average Number of Days	61 Average Number of Days	65 Average Number of Days	68 Average Number of Days
Status	Historical Actual	Target Exceeded	Target Not Met	Target Not Met

[72] Targets in the FY 2014 Congressional Justification were misreported for FY 2012. The ANEE program will support 1 cohort of nurse practitioners (NPs) in Academic Year 2011–2012 (FY 2011); 1 cohort of NPs in Academic Year 2012–2013 (FY 2012); 1 cohort of NPs in Academic Year 2013–2014 (FY 2013); and 1 cohort of NPs in Academic Year 2014–2015 (FY 2014). Each cohort will complete the program after 2 years of training. 1st cohort will graduate in Academic Year 2012–2013 (FY 2012); 2nd cohort will graduate in Academic Year 2013–2014 (FY 2013); 3rd cohort will graduate in Academic Year 2014–2015 (FY 2014); and the final cohort will graduate in Academic Year 2015–2016 (FY 2015). 260 NPs are expected by FY 2013.

[73] Includes nurse midwives; cumulative

[74] Outputs are based on forward–funded grants. Includes 101 graduates from Academic Year 2011–2012.

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

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

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

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	37,896	110,000[78]
Result	51,415[79]	104,416[80]	77,074[81]	67,944[82]
Status	Historical Actual	Historical Actual	Target Exceeded	Target Not Met

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	185	176	176
Result	212[83]	197	243	266
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	198	237	248
Result	182	309	335	401
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	26	31	33
Result	25	26[84]	33	36[85]
Status	Baseline	Target Met	Target Exceeded	Target Exceeded

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[78] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY 2013 performance targets reflect FY 2012 funding levels.

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

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

[81] Changed from previously reported due to updated data.

[82] Results are preliminary and will be updated in 2014.

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

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

[85] 36 Plus DC

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	149	164	179	255
Result	192	351	280	Jun 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013
Target	2,316	2,486	2,660	2,846
Result	2,351	2,658	2,881	Jun 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending

Analysis of Results

HHS recognizes that a high-quality workforce is crucial to the effective delivery of health and human services. The Department has a number of activities that focus on addressing current workforce issues and the strategic development of workforce capacity. For example, HHS seeks to ensure that our country not only maintains, but enhances its capacity for innovative health-related research. A critical part of the NIH mission is the education and training of the next generation of biomedical, behavioral, and clinical scientists. In FY 2013, NIH pre-doctoral trainees and fellows were 11 percent more likely to remain active in biomedical research than non-NIH trainees and fellows; this result exceeded the annual target of 10 percent. To assess its performance, NIH also routinely monitors the career outcomes of former postdoctoral fellows. In FY 2013, NIH postdoctoral fellows were 13 percent more likely to remain active in biomedical research than non-NIH fellows; this result exceeded the annual target of 10 percent.

The Nation's healthcare workforce is facing a number of significant challenges that are increasing demand, including changing population demographics, demand for health care services arising from increased health insurance coverage, and the imminent retirement of many Baby Boomer health professionals. HRSA's Bureau of Health Professions Programs are designed to improve the health of the Nation's communities, especially vulnerable populations, by supporting programs to augment the supply of health care providers who enter practice in underserved areas and increase access to quality health care. The overall percentage of graduates and completers who were directly supported by a Title VII or Title VIII program and went on to practice in a medically underserved community or health professional shortage area increased significantly in FY 2012, meeting its goal. HHS made initial Prevention and Public Health Fund-supported grants for education of primary care physicians, physician assistants, and nurse practitioners in late September 2010. The first groups of physician assistants and nurse practitioners completed the programs in FY 2012. In the first year, the number of nurse practitioners completing was more than double the target; the number of physician assistants was substantially less than the target. These results are a consequence of the newness of the program and will stabilize as maturity is reached.

The National Health Service Corps addresses the nationwide shortage of health care providers in areas of need 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. In FY 2013, the Corps field strength was 8,899, exceeding the target but below the FY 2012 level. Field strength is generally dependent upon variables such as the level of available funding, the number of qualified applicants, and the mix of scholarship and loan repayment support provided.

Head Start is a federal program that promotes the school readiness of children ages birth to five from low-income families by enhancing their cognitive, social, and emotional development. Head Start grantees are required to develop plans to improve the qualifications of staff. The 2007 Head Start reauthorization requires that all Head Start preschool center-based teachers have at least an early childhood education related AA degree or higher by October 1, 2011. In FY 2013, 94.6 percent of Head Start teachers had an AA degree or higher, missing the target of 100 percent, but improving over the FY 2012 result.

Within HHS, prompt turnaround for recruitment requests is necessary for hiring highly qualified candidates and is also required under several OPM directives that oblige agencies to streamline processes and decrease timelines. ASA has set goals that exceed the OPM federal targets for hiring timelines. To optimize performance, the Office of Human Resources has implemented a number of process and systems improvements to support hiring managers in their recruitment efforts. In FY 2013, the average days to hire was 68 days, missing the target of 60 days. A potential cause for this increase relative to FY 2012 is adaptation to the decentralization of HR offices; HHS transitioned from having 3 HR centers to an HR center at each operations division, which resulted in staff changes and the need to train new staff.

The detection and monitoring of pathogens and infections is a key component of HHS's strategic plan to enhance public health. State health departments report shortages of critical disciplines such as epidemiologists, public health nurses, managers, disease investigation specialists, laboratorians, environmental scientists, sanitarians, and informaticians. CDC's fellowship programs promote service while learning; fellows fill critical workforce needs at CDC and in the field while they are in-training for careers in the field of public health. Targets are set based on the typical, annual class size for each of the fellowship programs included in the measure. In FY 2013, 83 percent of CDC's fellowship program graduates pursued careers in public health practice, while less than 25 percent of school of public health did so. Over the past three years, CDC exceeded its targets for training up the next generation of the public health workforce, including 266 new trainees in FY 2013. As of September 30, 2013, CDC supported 614 fellows, 401 (65 percent) of whom were placed in State, tribal, local and territorial field assignments in 46 States, Washington D.C., American Samoa, Guam, Puerto Rico, and six tribal locations, exceeding the target.

The spread of infectious diseases continue to be a national and international concern, requiring a robust system of detection, monitoring, and prevention. CD4 and viral load reporting provide the fundamental data for four of the National HIV/AIDS Strategy Goals. These goals are to increase the proportion of newly diagnosed persons linked to clinical care, and reduce the proportion of three populations diagnosed with HIV who have undetectable viral loads. Routine reporting of CD4 and Viral Load data to surveillance programs facilitates case finding and follow-up on new cases. These data help to ensure the timeliness, accuracy, and completeness of the national HIV surveillance system. As of FY 2013, 36 States and the District of Columbia reported all CD4 and viral load values for surveillance purposes, exceeding CDC's target of 33 States. The current ease and frequency of long-range travel can make previously

regional diseases and infections local risks. Therefore, HHS supports a number of initiatives to develop local and international workforce to improve public health both at home and abroad. Since 1980, CDC developed 50 international Field Epidemiology Training Programs (FETPs) serving 94 countries and graduated over 2,800 epidemiologists. On average, 80 percent of FETP graduates work within their Ministry of Health after graduation and many assume key leadership positions. Their presence enhances sustainable public health capacity in these countries, which is critical in transitioning U.S. government global health investments to long-term host-country ownership. In FY 2012, CDC exceeded targets for new residents and total graduates.

HHS works to strengthen this crucial group that addresses some of society's most basic needs. SAMHSA is seeking to increase the total number of individuals trained as a result of its Science and Services programs. This measure reflects the total number of participants who attended a SAMHSA-funded training, meeting, or received technical assistance from the Center for Substance Abuse Treatment, the Center for Mental Health Services, and the Center for Substance Abuse Prevention. The FY 2013 data is preliminary and will be updated during 2014.

Annual Performance Plan - FY 2014 – 2018 Strategic Plan

This performance plan contains the strategic objectives and performance goals HHS plans to achieve during this and the next fiscal year. The measures below make up the representative set of performance indicators aligned to the FY 2014–2018 Strategic Plan. These will serve as the primary indicators of Departmental performance for the duration of this Strategic Plan.

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

Maintain the number of months to produce the Insurance Component tables following data collection (MEPS-IC) (Lead Agency - AHRQ; Measure ID - 1.3.16)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	6 months	6 months	6 months	6 months	6 months	6 months
Result	6 months	6 months	6 months	6 months	Oct 31, 2014	Oct 30, 2015
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	N/A	43,212,512 children	45,592,385 children	46,617,385 children	47,642,385 children
Result	42,146,940 children	43,542,385 children	44,453,639 children	Mar 31, 2014	Mar 31, 2015	Mar 31, 2016
Status	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	90%	90%	90%	90%	90%	90%
Result	90%	92%	90%	91%	Dec 31, 2014	Dec 31, 2015
Status	Target Met	Target Exceeded	Target Met	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	90%	90%	90%	90%	90%	90%
Result	91%	92%	91%	91%	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	N/A	58.0%	55.0%	53.0%	48.0%
Result	100.0%	57.0%	57.0%	Feb 28, 2015	Feb 28, 2016	Feb 28, 2017
Status	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending	Pending

Increase the number of individuals referred to mental health or related services (Lead Agency - SAMHSA; Measure ID - 3.2.37)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		N/A	N/A	Set Baseline	5,911	5,911
Result		4,304	3,760	7,389	Dec 31, 2014	Dec 31, 2015
Status		Historical Actual	Historical Actual	Baseline	Pending	Pending

Increase the percentage of enrolled homeless persons in the Projects for Assistance in Transition from Homelessness (PATH) program who receive community mental health services (Lead Agency - SAMHSA; Measure ID - 3.4.15)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	47	47	47	50	47	66
Result	60	40	66	Jul 31, 2014	Jul 31, 2014	Jul 31, 2015
Status	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending	Pending

Plans for the Future

HHS is committed to increasing the number of individuals and families that have access to health care and are covered by insurance who receive the health care that they need. CMS plans to increase by nearly 28 percent the number of children who are covered under either CHIP or Medicaid over the FY 2008 levels. Children who have health insurance generally have better health throughout their childhood and into their teens. They're more likely to get the preventative care to keep them well, get the treatment they need when sick or injured, and better able to concentrate and achieve in school. In FY 2012 44.5 million children were covered through CHIP or Medicaid, and by 2015 CMS expects that 47.6 million children will be covered. The ACA has provided HHS with the opportunity to have a complete source of data on the cost and use of health care and health insurance coverage, which will be important to tracking trends and identifying areas for health care improvement.

AHRQ plans to continue producing insurance component tables from the Medical Expenditure Panel Survey (MEPS) and be able to produce searchable tables within 6 months of the data collection. The MEPS-Insurance Component provides annual National and State estimates of aggregate spending on employer-sponsored health insurance for the National Health Expenditure Accounts (NHEA) that are maintained by CMS and for the Gross Domestic Product produced by the Bureau of Economic Analysis. In support of the ACA, MEPS-IC State-level premium estimates are the basis for determining the average limits for the federal tax credit available to small businesses that provide health insurance to their employees.

With the focus on expanding health care coverage some experts have been concerned that currently covered individuals may see a decline in the quality of service that they receive. The Department is focused not just on expanding care, but also on maintaining high quality care. For this reason, CMS has committed to continuing to track the percent of beneficiaries in MFFS and in MA who report access to care. Historically, these measures have had high rates of beneficiary satisfaction. CMS plans to continue these high rates of client access through FY 2015. Between 2011 and 2020, CMS will work to reduce out of pocket costs for Medicare coverage for prescription drugs. Prior to the passage of ACA, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and

the catastrophic limit. By 2015, CMS will aim to reduce the coverage gap to 48 percent, using a combination of rebate checks, manufacturers' discounts and enhanced Medicare benefits.

Mental health related services are handled more equitably in the implementation of the ACA. SAMHSA recognizes that some populations have different needs for mental health services. SAMHSA has committed to increase the percentage of enrolled homeless people who receive community mental health services. These community services include substance abuse and alcohol counseling, group supports, and treatments to reduce anxiety. In FY 2012, the most current data available, there were more than 103,000 homeless people enrolled in the Projects to Assist in the Transition from Homelessness (PATH), with 66 percent of them receiving mental health services. SAMHSA expects to maintain or increase the current target levels through FY 2015. In the State-Sponsored Youth Suicide Prevention and Early Intervention program services are focused on individuals 10 to 24 years old who are at especially high risk of suicide. In FY 2015 SAMHSA plans to have at least 5,911 individuals receive direct treatment including outpatient, day treatment, intensive outpatient or residential programs in an effort to prevent suicide. Additional services are also available to participants including support service, wrap-around services, and outreach services. For FY 2013, the program screened more than 79,000 youth for mental health services. From those screened, 7,389 youth were referred for mental health services. This represents a nine percent rate of referral.

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

Reduce by 10 percent hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2015. (Lead Agency - CMS; Measure ID - MCR28.2)[86]

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target			10%[87]	20%[88]	5%[89]	10%[90]
Result			-17%	Mar 31, 2014[91]	Mar 31, 2015	Mar 31, 2016
Status			Target Not Met	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	580 users of research	900 users of research	1032 users of research	1300 users of research	1350 users of research	1750 users of research
Result	885 users of research	1032 users of research	1128 users of research	1627 users of research	Sep 30, 2014	Oct 30, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Reduce the central line-associated bloodstream infection (CLABSI) standardized infection ratio (SIR) (Lead Agency - CDC; Measure ID - 3.3.3)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	0.7	0.6	0.5	0.4	0.35
Result	0.68	0.59	0.56	Nov 30, 2014	Nov 30, 2015	Nov 30, 2016
Status	Historical Actual	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Set Baseline	5,000	6,500	12,000	13,500	17,000
Result	2,619	5,000	10,900	12,400	Jan 1, 2015	Jan 1, 2016
Status	Baseline	Target Met	Target Exceeded	Target Exceeded	Pending	Pending

[86] Targets and results in this table reflect a reduction from a baseline with positive numbers. Consequently, a negative number indicates an increase from the baseline (the opposite of the desired result).

[87,88] The Standardized Infection Ratio (SIR) for FY 2010 is 0.94. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.94 x 0.9). Projected FY 2013 calculation (0.94 x 0.8).

[89] The midway CAUTI target for FY 2014–15 is a 5% reduction in the CAUTI SIR from its baseline (1.02) or target SIR 0.97. The midway point is September 2014 and the midpoint data will be reported in March of 2015.

[90] The final FY 2014–15 CAUTI target will be 10% reduction in the national CAUTI SIR from baseline or a target SIR 0.92. The end period for this goal is September 2015 and the final goal data will be reported in March of 2016.

[91] NHSN CAUTI data through March 2013 (FY 2013 midpoint) was calculated at 1.02 SIR or a 9 percent increase (opposite of desired outcome) in the SIR over the baseline of 0.94 SIR, and is behind the midway goal of 0.85 SIR or a 10 percent reduction.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		Work with States to ensure that 70 percent of States report on at least one quality measure in the CHIPRA core set of quality measures.	Work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 85 percent of States report on at least seven quality measures in the CHIPRA core set of quality measures.	Work with States to ensure that 90 percent of States report on at least eight quality measures in the CHIPRA core set of quality measures.	Work with States to ensure that 90 percent of States report on at least nine quality measures in the CHIPRA core set of quality measures
Result		84 percent of States reported on at least one quality measure.	92% of States reported on at least five quality measures	Mar 31, 2014	Mar 31, 2015	Mar 31, 2016
Status		Target Exceeded	Target Exceeded	In Progress	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		Publish recommended core set of adult quality measures in the Federal Register.	Publish initial core set of adult quality measures in the Federal Register.	Work with States to ensure that 60 percent of States report on at least three quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	Work with States to ensure that 65 percent of States report on at least five quality measures in the Affordable Care Act Adult Medicare core set of quality measures.	Work with States to ensure that 70 percent of States report on at least seven quality measures in the Affordable Care Act Adult Medicaid core set of quality measures
Result		Target Met	Target Met	Mar 31, 2014	Mar 31, 2015	Mar 31, 2016
Status		Target Met	Target Met	In Progress	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	8.1%	Set Baseline	6.9%	6.9%	6.7%[92]	6.6%
Result	7.4%	7.1%	6.5%	Feb 28, 2014	Feb 28, 2015	Feb 28, 2016
Status	Target Exceeded	Baseline	Target Exceeded	Pending	Pending	Pending

[92] FY 2014 Target was originally 6.9% in the CMS CJ. The target was reduced to 6.7% when 2012 results were received.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	1900	2000	2000	2000	1350	1450
Result	2079	2276	2313	1302	Nov 30, 2014	Nov 30, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	100%	100%	100%	100%	100%	100%
Result	100%	100%	100%	100%	Dec 31, 2014	Dec 31, 2015
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

Plans for the Future

A concerted effort among CMS, AHRQ, CDC, and OASH will continue to be crucial in achieving HHS's FY 2014-2015 Priority Goal targets to reduce catheter-associated urinary tract infections in hospitals. HHS will continue to use a combination of programmatic levers and evidence-based infection control interventions in order to show substantial reductions in catheter-associated urinary tract infections. This includes aligning strategy and metrics, providing consistent messaging to its audiences, using data to target those facilities in most need of improvement, and creating synergy to achieve catheter-associated urinary tract infections reduction outcomes. The key strategic elements of this goal necessary to produce successful outcomes include: collaboration among multiple stakeholders in the healthcare community; tracking and monitoring data that drives improvement; linking higher quality, safer and more efficient care to payment; and research and testing that refine evolving HAI prevention guidelines, optimize implementation strategies and tools, and integrate health information technology.

HHS uses a variety of approaches to improve healthcare quality and patient safety. AHRQ produces patient safety culture assessment tools for hospitals, medical offices, nursing homes, and pharmacies. One of these tools is a comparative database that healthcare providers can use as a benchmark for comparison on patient safety approaches. Information for this database report comes from the four patient safety culture survey tools: Hospital Survey on Patient Safety Culture (HSOPS), Medical Office Survey on Patient Safety Culture, Nursing Home Survey on Patient Safety Culture, and Pharmacy Survey on Patient Safety Culture. In FY 2013 data from 653 hospitals, 934 medical offices and 40 nursing homes was available and used by more than 1,627 researchers to establish, improve and maintain a culture of patient safety. AHRQ is taking steps to update portfolio research topic areas and plans to continue to expand the number of research users through FY 2015. CDC has the National Healthcare Safety Network which tracks healthcare associated infections and is a vital resource for tracking progress on preventing infections across healthcare settings. CDC plans to increase the number of health care organizations reporting into the National Healthcare Safety Network to 17,000 facilities by FY 2015. That would be a nearly a 550 percent increase from FY 2010 when only 2,619 hospitals were reporting. IHS has taken a different approach to improving healthcare quality; it has committed to maintaining 100 percent accreditation of IHS-operated hospitals and clinics, using the standards and practices recommended by the Joint Commission on Hospital Accreditation and the American Association of Ambulatory Health Centers. The Commission and the Association continue to revise standards and have been increasing clinical quality of care assessments, which IHS plans to adapt to and continue to meet.

Medicaid and CHIP are Federal/State partnerships, which allow States flexibility to develop systems of care that reflect their unique circumstances. CMS has goals to improve quality in both Medicaid and CHIP and has a phased in approach that allows States to take an iterative approach to quality improvement. CMS will continue to work closely with States to improve children's health care quality across Medicaid and CHIP, as required by the CHIP Reauthorization Act of 2009 (CHIPRA). In collaboration with States, CMS developed and published a Child Core Set of quality measures. CMS is encouraging all States to use and report on the Child Core Set to collect data that will lead to improved health outcomes and to enhance the accuracy and applicability of the pediatric quality measures program specific to the Medicaid and CHIP programs. In FY 2015 CMS will focus technical assistance efforts to ensure that 90 percent of States report on at least nine quality measures in the Child Core Set. In addition, as required by ACA, HHS will encourage States to report on a core set of adult quality performance measures for Medicaid. Although State reporting is voluntary, CMS will use State reporting to assess the care received by adults in the Medicaid program. By encouraging States to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting and improvement for adults in Medicaid. CMS will aim to have 70 percent of States report on at least seven adult quality measures in FY 2015.

New drugs are another way that healthcare quality and patient safety can be improved. FDA, has the responsibility to protect public health by assuring the safety, effectiveness, quality and security of human and veterinary drugs and other biological products. Though actions taken on abbreviated new drug applications results seemed to have declined, this result also reflects recent new legislation which changes the methodology for counting these actions. Previously, deficiency letters were communicated to the sponsor from multiple disciplines. Beginning in FY 2013, a single complete response letter as opposed to multiple deficiency letters was required. While this process improvement caused FDA to miss its target it does not reflect a drop in program performance. The FY 2015 target was adjusted to reflect the new methodology.

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Set Baseline	64.2 %	68 %	68.3 %	71 %	71.4 %
Result	67.4 %	68.3 %	70.2 %	Dec 30, 2014	Dec 30, 2015	Dec 30, 2016
Status	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Percentage of pregnant Health Center patients beginning prenatal care in the first trimester (Lead Agency - HRSA; Measure ID - 1.II.B.1)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	61.3%	61.3%	64%	64.3%	65%	66%
Result	69%	70%	70%	Aug 31, 2014	Aug 31, 2015	Aug 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Plans for the Future

CDC is working with communities, businesses, early child and education centers, and schools to increase the number of people 18 and older who are physically active. Creating more safe spaces to exercise in communities can improve individuals' overall health. CDC estimates 71 percent of adults will be participating in at least 150 minutes of physical activity a week by FY 2015 through its efforts to increase the availability of safe environments for physical activity.

Prenatal care is one of the most important interventions for ensuring the health of pregnant women and their newborn babies. Early high-quality prenatal care is critical to improving pregnancy outcomes. Monitoring timely entry into prenatal care assesses both quality of care as well as Health Center outreach efforts that are associated with improving birth outcomes. In FY 2012 70 percent of pregnant health center patients began prenatal care in the first trimester. HRSA projects that over the next few years an average of 65 percent will begin prenatal care in the first trimester, given the changing mix of the pool of health centers. Health Centers serve a higher risk prenatal population than seen nationally. HRSA will continue work to improve the percentage of pregnant Health Center patients that begin prenatal care in their first trimester.

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

Increase the number of Medicare beneficiaries who have been aligned with Accountable Care Organizations (Lead Agency - CMS; Measure ID - ACO1.1)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target				Set Baseline	5,600,000	7,000,000
Result				4,200,000	Apr 30, 2014	Apr 30, 2015
Status				Baseline	Pending	Pending

Increase the number of physicians participating in an Accountable Care Organization (Lead Agency - CMS; Measure ID - ACO1.2)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target				Set Baseline	131,000	161,000
Result				100,000	Apr 30, 2014	Apr 30, 2015
Status				Baseline	Pending	Pending

Increase the percentage of Accountable Care Organizations that share in savings (Lead Agency - CMS; Measure ID - ACO1.3)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target					Set Baseline[93]	TBD[94]
Result					Sep 30, 2014	Sep 30, 2015
Status					Pending	Target Set When Baseline Available

Reduce all-cause hospital readmission rates for Medicare beneficiaries by one percent over the previous year's target rate (Lead Agency - CMS; Measure ID - MCR26)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target			N/A	18.5% Percent[95]	18.3% Percent[96]	18.1% Percent[97]
Result			18.7% Percent[98]	18.6% Percent[99]	Mar 31, 2014	Mar 31, 2015
Status			Historical Actual	Target Not Met but Improved	Pending	Pending

[93] Collect CY 2012 and CY 2013 data on savings and measures of quality to determine shared savings to develop baseline

[94] TBD: Collect CY 2012 and CY 2013 data on savings and measures of quality to determine shared savings to develop baseline

[95] Based on CY 2011 data.

[96] Based on CY 2012 data.

[97] Based on CY 2013 data.

[98] Based on CY 2010 data.

[99] Based on CY 2011 data.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	$487.3 M	$551.3 M	$616.1 M	Prior Result +0	Prior Result +0	Prior Result +0
Result	$551.2 M	$616.1 M	Apr 30, 2014	Apr 30, 2015	Apr 30, 2016	Apr 30, 2017
Status	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

Plans for the Future

Leveraging the innovative model of Accountable Care Organizations (ACO) is a key part of promoting healthcare cost savings through the Affordable Care Act. As part of the delivery system reform process, CMS will aim to increase the number of Medicare beneficiaries who have been aligned with ACOs and increase the number of physicians participating in ACOs. In CY 2013, the baseline year, 4,200,000 Medicare beneficiaries and 100,000 physicians were aligned with an ACO. CY 2014 and CY 2015 targets for other the beneficiaries and physicians show ambitious increases.

CMS uses a number of programs to reduce hospital readmissions, including the Hospital Readmissions Reduction Program, which would reduce a portion of Medicare's payment amounts to certain hospitals. This reduction is based on the hospital's excess Medicare readmissions in the conditions included in the program. Other programs are the Partnership for Patients to reduce preventable complications during a transition from one care setting to another, as well as partnerships with the Community-Based Care Transitions Program and Quality Improvement Organizations. CMS's efforts to reduce readmissions also extend to ACOs, which must report on 33 quality measures if they wish to receive incentives under the Medicare FFS Shared Savings Program. Although CMS technically CMS missed its 2013 target, CMS expects to meet or exceed the 2014 target for this goal. Data used to assess future targets will include admissions data that reflects hospitals' experiences under and resulting from CMS's efforts aimed at reducing hospital readmissions.

State AIDS Drug Assistance Programs (ADAPs) are supported by the Ryan White HIV/AIDS program to provide assistance to low-income persons living with HIV/AIDS who have limited or no access to needed medications. State ADAPs will continue to use a variety of strategies to contain medication costs, potentially enabling ADAPs to serve more people. Moving forward, HRSA plans to use the previous year's result as the subsequent year's target.

Goal 1. Objective E: Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	33%	30.2%	32.7%	Set Baseline	48.3%	47.7%
Result	32%	31.9%	33.2%	48.3%[100]	Oct 31, 2014	Oct 31, 2015
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Baseline	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	53%	51.9%	56.5%	58.6%	66.9%	64.3%
Result	52%	56.5%	61.9%	65.1%	Oct 31, 2014	Oct 31, 2015
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		3 recommendations	3 recommendations	3 recommendations	3 recommendations	3 recommendations
Result		7 recommendations	4 recommendations	4 recommendations	Sep 30, 2014	Sep 30, 2015
Status		Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	61	61	62	63	62	62.5
Result	60.5	62.8	63	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[100] In FY 2013 this measure changes from Ideal Glycemic Control to Good Glycemic Control with an A1c (blood sugar) value of less than 8.0% to align with new diabetes standards of care. More patients will meet this goal; therefore, annual targets and results will increase. Prior to 2013, the A1c value for Ideal Glycemic control was set at less than 7.0%

Increase the number of program participants exposed to substance abuse prevention education services (Lead Agency - SAMHSA; Measure ID - 2.3.56)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	2,327	1,535[101]	1,535	5,734[102]	3,891[103]	3,000[104]
Result	4,552	4,283[105]	6,593	Aug 31, 2014	Aug 31, 2015	Aug 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	62.9 %	66.1 %	63.1 %	64.2 %[106]	64.2 %	62.7 %
Result	66.1 %[107]	63.1 %[108]	64.2 %	62.7 %	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Not Met	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	20.15 million	19.7 million	20.6 million	21.6 million	28.6 million	31 million
Result	19.5 million	20.2 million	21.1 million	Aug 31, 2014	Aug 31, 2015	Aug 31, 2016
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	7,358	9,203	9,193	8,068[109]	7,520	15,438
Result	7,530	10,279	9,908	8,899	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

[101] Target reflects close–out of Cohort 6 and start–up of Cohort 7 and Cohort 8.

[102] Target has been revised from previously reported. Target has been changed to include Cohorts VII, VIII, IX, and X.

[103] Decrease in target is due to cohort effects and includes Cohorts VIII, IX, and X.

[104] Decrease in target from previous year is due to cohort effects and includes Cohorts IX and X.

[105] The decline in number of participants receiving services reflects the closeout of cohort 6 grantees.

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

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

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

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

Percentage of individuals supported by the Bureau of Health Professions who completed a primary care training program and are currently employed in underserved areas. (Lead Agency - HRSA; Measure ID - 6.I.C.2)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	35%	43%	43%[110]	43%	33%	33%
Result	31%[111]	33%[112]	43%	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Target Not Met	Target Not Met	Target Met	Pending	Pending	Pending

Proportion of persons served by the Ryan White HIV/AIDS Programs who are racial/ethnic minorities. (Lead Agency - HRSA; Measure ID - 16.I.A.1)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data
Result	72% (CDC = 66.5%)	72.2% (CDC= 66.7%)	72.6% CDC data not available for comparison at this time.	Oct 31, 2014	Oct 31, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	2.35 Million	2.48 Million	2.66 Million	2.85 Million	3.05 Million	3.26 Million
Result	2.46 Million	2.67 Million	2.88 Million	3.05 Million	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	380,000	385,000	390,000	395,000	400,000	405,000
Result	383,776	615,849	747,952	Oct 31, 2014	Oct 31, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

[111] FY 2010 Actuals reported for this measure in the FY 2013 Congressional Justification were misreported as 43%. Based on available performance data, the proportion of graduates and program completers entering practice in a MUC or HPSA for FY 2010 was 31%.

[112] Service location data are collected on students who have been out of the HRSA program for 1 year. The results are from programs that have ability to produce clinicians with one–year post program graduation. Results are from academic year 2010–2011.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	1,413,000	1,324,000	1,296,300	1,340,300	1,196,600	1,155,500
Result	1,417,219	1,333,149	1,247,525	Oct 31, 2014	Oct 31, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

Plans for the Future

IHS will strive to maintain the FY 2013 baseline of patients with good glycemic control in FY 2014 and 2015. Major national diabetes guidelines now recommend individualizing glycemic control targets. Because of the importance of individualizing glycemic control targets, the future of performance measures will be to allow providers to document the target agreed upon with the patient/family in the electronic medical record. This individualized target will be compared to the actual measure for that patient during the performance period. Until this future is realized, selecting an A1c (A1c reflects the average blood sugar over a three month period) of 8% as representative of good glycemic control allows IHS to continue to emphasize the importance of diabetes control without promoting universal targets which could unintentionally lead to harmful episodes of hypoglycemia in vulnerable patients. Another ongoing goal is to maintain an open, continuous, and meaningful Tribal consultation between American Indian and Alaska Native Tribes and IHS by implementing at least three process improvement recommendations per year. IHS will also meet depression screening goals through promoting increased accountability for achieving targets at the regional and local levels for IHS operated programs, and a more focused educational campaign will be undertaken for Tribally operated programs to convey the benefits of depression screening. The screening tools and results are incorporated into the IHS Electronic Health Record. The system is now deployed and in operation in more than 250 clinical sites across the country.

ACL believes the composite measure of nursing home predictors, which gauges the prevalence of select characteristics of the service population, predictive of nursing home placement, will remain relatively stable over the next few years due to effective service delivery for caregivers and home and community-based services that are instrumental in the delay or deferral of nursing home placement of elderly and disabled clients.

SAMHSA supports a "system of care" organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families. The level of positive functioning of the children receiving systems of care mental health services at six month follow-up shows the benefits associated with this initiative. Positive functioning relates to psychological, social, and emotional well-being of the subject as well as a general ability to perform the tasks associated with routine life activities. Additional technical assistance is now being provided to improve performance in this program and under the new implementation grant, the new grantees have started using a new automated system for reporting.

Increased awareness of the consequences of substance abuse and risky sexual behaviors reduces the likelihood of engaging in these behaviors. SAMHSA monitors the numbers of individuals receiving

education in the areas of substance abuse prevention and health promotion, thus enhancing protective factors against substance abuse, and transmission of HIV and other sexually transmitted diseases. Evidence-based substance abuse and HIV prevention interventions are integrated, including HIV testing for those at high risk, such as persons released from prisons and jails within the past two years. SAMHSA expect the targets for FY 2014 and 2015 to decline due to the exit of cohorts from the program.

HRSA expects the number of patients served by health centers will increase in the coming years. This is because success in increasing the number of patients served has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics. The field strength of the NHSC fluctuates as it is dependent upon variables such as the level of available funding, the number of qualified applicants, and the mix of scholarship and loan repayment support provided. However, the NHSC field strength is expected to reach a historic high of 15,438 in FY 2015. Estimates of the percentage of individuals trained by Bureau of Health Professions (BHPr) Programs working in underserved areas will remain static for the forthcoming years until new data become available that can help in refining targets to better reflect program performance in this area. The Ryan White HIV/AIDS Program will continue its efforts to ensure that the proportion of racial and ethnic minorities served by Ryan White-funded programs exceeds their representation in national AIDS prevalence data. The C.W. Bill Young Cell Transplantation Program will have an increasing number of racial/ethnic minorities on the donor registry. The target for the number of people receiving direct services through Office of Rural Health Policy Outreach Grants will increase gradually, given changes in the cohort of grantees. To maintain the quality of services provided, HRSA works with Outreach grantees to ensure they maintain the minimum required number of consortium members. The number of young women screened for Chlamydia is projected to decline over the coming years, primarily due to funding assumptions.

Goal 1. Objective F: Improve health care and population health through the meaningful use of health information technology

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		N/A	80,000 eligible professionals and hospitals	230,000 eligible professionals and hospitals	375,000 eligible professionals and hospitals	425,000 eligible professionals and hospitals
Result		10,700 eligible professionals and hospitals	15,6758 eligible professionals and hospitals	32,5124 eligible professionals and hospitals	Dec 31, 2014	Dec 31, 2015
Status		Historical Actual	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2015	FY 2014
Target	23% of office-based primary care physicians	35% of office-based primary care physicians	45% of office-based primary care physicians	55% of office-based primary care physicians	65% of office-based primary care physicians	TBD
Result	30% of office-based primary care physicians	39% of office-based primary care physicians	49% of office-based primary care physicians	53% of office-based primary care physicians	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met but Improved	Pending	Target Not In Place

Increase the percentage of public health agencies that can receive production Electronic Laboratory Reporting (ELR) Meaningful Use compliant messages from certified Electronic Health Record (EHR) technology used by eligible hospitals (Lead Agency - CDC; Measure ID - 8.B.1.3a)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	N/A	Set Baseline	33 %	54 %	54 %
Result	0 %	9 %	18 %	46 %	Dec 31, 2014	Dec 31, 2015
Status	Historical Actual	Historical Actual	Baseline	Target Exceeded	Pending	Pending

Identify three key design principles that can be used by health IT designers to improve Personal Health Information Management (PHIM) (Lead Agency - AHRQ; Measure ID - 1.3.60)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		Develop and issue FOA	Award research grants to identify key design principles	Gather first year report from grantees	Gather second year report from grantees.	Continue gathering reports from grantees.
Result		Developed and issued FOA	Awarded research grants to identify key design principles.	Gathered first year reports from grantees.	Oct 31, 2014	Oct 30, 2015
Status		Target Met	Target Met	Target Met	In Progress	In Progress
Target				Report preliminary results of grantees in Health IT's Annual Report	Report preliminary results of grantees in Health IT's Annual Report and summarize any early findings from PA-11-99 identifying key design principles for PHIM.	Report preliminary results of grantees in Health IT's Annual Report and summarize any ongoing findings from PA-11-99 identifying key design principles for PHIM in preparation for final report in FY 2016.
Result				Preliminary results will be posted on healthit.ahrq.gov and in Health IT's Annual report (under development).	Oct 31, 2014	Oct 30, 2015
Status				Target Met	In Progress	In Progress

Plans for the Future

ONC, CMS, CDC, AHRQ and their partners will to promote the meaningful use of technology and the development of health IT standards designed to improve quality and lower health care costs. This will represent a HHS Priority Goal for FY 2014 – 2015. More specifically, ONC and its partners will continue to analyze EHR Incentive Program registration, attestation, and payment data to evaluate the characteristics of providers at each of the different program milestones. Analysis of the program data will enable States and Health Information Technology for Economic and Clinical Health (HITECH) Act grantees to establish goals and accelerate progress to meaningful use of electronic health records and health IT.

AHRQ is conducting a study to identify three key design principles that can be used by health IT designers to improve Personal Health Information Management (PHIM). Progress in this study will be tracked by yearly milestones.

CDC is working to assess and ensure readiness of three key systems in each State: Electronic Laboratory Reporting, Immunization Information Systems, and Syndromic Surveillance. In 2013, 46 percent of public health agencies received production electronic laboratory reporting (ELR) Meaningful Use compliant messages from certified EHR technology used by eligible hospitals. CDC expects significant capability gains in the percentage of public health agencies that can receive these messages, as healthcare and public health agencies strive to meet meaningful use stage one and two requirements.

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 10%	N ≥ 10%	N > 10%
Result	Award rate to comparison group reached 12%.	Award rate to comparison group reached 12%.	Award rate to comparison group reached 11%.	Award rate to comparison group reached 11%.	Dec 31, 2014	Dec 31, 2015
Status	Target Met	Target Met	Target Not Met	Target Met	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 10%	N ≥ 10%	N > 10%
Result	Award rate to comparison group reached 14% and exceeded the target by at least 2%.	Award rate to comparison group reached 13% and exceeded the target by 1%.	Award rate to comparison group reached 13% and exceeded the target by 1%.	Award rate to comparison group reached 13% and exceeded the target by 3%.	Dec 31, 2014	Dec 31, 2015
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Establish 35 new assays in the Molecular Libraries Program (MLP) Portfolio.	Increase depositions of bioassays in PubChem to a rate of five (5) per month.	Deposit chemical structure and biological data for 200 new small molecule probes in PubChem.	Establish 400 primary biochemical, cell-based or protein-protein interaction assays that can be miniaturized and automated as high throughput screens in the Molecular Libraries Program (MLP) Portfolio.	Increase the Molecular Libraries Program (MLP) inventory to 375 small molecule probes that can be used in biological research to interrogate basic biological processes or disease.	Make freely available to researchers the results of 400 high-throughput biological assays screened against a library of 300,000 unique compounds, and the detailed information on the molecular probes that are developed through that screening process.
Result	98 new high-throughput assays were added to the MLP Portfolio.	NIH increased the assay deposition into PubMed to a rate greater than eight HTS assays per month, resulting in a total deposit of 103 assays.	The Molecular Libraries Program deposited chemical structure and biological data for 294 new small molecule probes in PubChem since the program began.	Established 570 primary biochemical, cell-based or protein-protein interaction assays that were miniaturized and automated as high throughput screens in the Molecular Libraries Program (MLP) Portfolio.	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Begin accrual of two patient cohorts presenting in childhood, one with a monogenic autoinflammatory disorder and one with a genetically complex autoinflammatory disorder.	Complete phenotypic characterization of a patient cohort.	Complete genetic, biochemical, or cellular studies aimed at identifying a molecular pathway underlying the disease in the patient cohort.	Identify at least one molecular pathway suitable for targeting in the patient cohort by performing detailed genetic mapping and confirmatory analyses for markers and pathways identified through genome-wide association.	Design a clinical trial testing an agent for a disorder of the immune system in children (e.g., Still's disease).	Complete a clinical pilot study in patients with a pediatric cohort of patients with a disorder of the immune system in children.
Result	Two cohorts are being accrued by NIH investigators – one with neonatal-onset multisystem inflammatory disease and another with systemic-onset juvenile idiopathic arthritis.	NIH researchers completed recruitment of a cohort of well-characterized patients with systemic-onset juvenile idiopathic arthritis through an international consortium of investigators.	A genome-wide association study has been performed on the cohort of 982 systemic-onset juvenile idiopathic arthritis patients and over 7000 healthy controls for 1.4 million genetic markers.	Researchers have identified a genetic variant that confers an increased risk of developing systemic juvenile idiopathic arthritis (sJIA) and that indicates the CD4+ T cell activation pathway as a therapeutic target.	Dec 31, 2014	Dec 31, 2015
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Establish a >7000 compound library for testing in quantitative high throughput screens (qHTS) and test in >20 qHTS, test >50 compounds (a subset of the main library) in at least 50 mid-throughput assays.	Identify an additional 3,000 compounds to the library for testing, complete compound analytical analysis, and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 50 qHTS and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 25 qHTS and test 180 compounds in densely sequenced human lymphoblastoid cell lines to assess genetic diversity in response to toxicants.	Test 10,000 compound main library in an additional 15 qHTS and test 20 subsets of possible high risk chemicals in high-content screens.	A formal process of prioritizing compounds for more extensive toxicological testing will be evaluated and used
Result	7,000 compounds were selected and collected as an establishment of the compound library. A subset of this library, "the 1408 compound library," has screened an additional 20 qHTS assays. 50 compounds were identified for testing in 50 mid-throughput assays but testing was not conducted and was rescheduled for 2011.	The 10K library was completed. Performance on mid- throughput assays surpassed the target. Analytical or chemical analysis is in progress but not yet completed.	The library containing 10,000 compounds was screened in 65 quantitative high throughput screens (qHTS) or assays. Fifty compounds were screened in approximately 600 mid-throughput assays.	The 10,000 compound library was screened in 33 qHTS assays and data was analyzed on 179 compounds screened for cytotoxicity across 1086 human lymphoblastoid cell lines representing 9 racial groups to assess genetic diversity in response to toxicants.	Dec 31, 2014	Dec 31, 2015
Status	Target Not Met	Target Not Met	Target Met	Target Met	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Describe phenotypic characteristics of a group of asthma patients prone to exacerbations.	Characterize cellular and molecular inflammation in the distal lung that may contribute to severe disease with frequent exacerbations.	Investigate the role of mucus gel formation in healthy controls and asthma patients.	Conduct investigations to elucidate the dynamic, pathophysiologic phenotypes of severe asthma.	Investigate the disease processes involved in asthma exacerbations and/or severe asthma using state-of-the-art pulmonary imaging techniques.	Identify and characterize two molecular pathways of potential clinical significance that may serve as the basis for discovering new medications for preventing and treating asthma exacerbations.
Result	Histoblood group antigens were explored as susceptibility factors for asthma exacerbations. O-secretor mucin glycan phenotype was identified as a risk factor for asthma exacerbations.	Scientists characterized the molecular pathways in fibroblasts (the principal active cells of connective tissue) from two regions of the lung. Their findings suggest that fibroblasts from the distal lung may be the more important fibroblast cell type in processes that contribute to disease progression and severity in asthma.	Researchers investigated two proteins associated with mucus formation, CLCA1 and TMEM16A, that may serve as potential targets for treating asthma.	The Severe Asthma Research Program is conducting investigations	Dec 31, 2014	Dec 31, 2015
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

Plans for the Future

NIH expects to maintain the retention and long-term success of both pre- and post-doctoral trainees and fellows in FY 2014 and 2015. It is taking a number of steps to bring this about, including encouraging the routine use of individual development plans to guide the career development of graduate students and post-doctorates supported by NIH, and establishing a new office to address biomedical workforce issues. To assess its performance, NIH routinely monitors degree completion by its pre-doctoral Kirschstein-

NRSA trainees and fellows and tracks the extent to which the graduate students and post-doctorates it supports are subsequently involved in research, using data from the national Survey of Earned Doctorates and the NIH IMPAC II administrative database.

For its various milestone-based research goals, NIH expects to achieve each during the next few years. This includes: making more chemical biology information available to researchers; further examining immune disorders; examining more compounds for toxicological effects; and exploring molecular pathways that may lead to promising avenues for preventing and treating asthma.

Goal 2. Objective B: Foster and apply innovative solutions to health, public health, and human services challenges

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	311	317	340	346	500	510
Result	311	334	343	496	Oct 31, 2014	Oct 31, 2015
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	117	122	285	288	1,200	1,440
Result	179	282	366	1,025	Oct 31, 2014	Oct 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	7	8	10	12	13	14
Result	6	8	10	12	Oct 31, 2014	Oct 31, 2015
Status	Target Not Met	Target Met	Target Met	Target Met	Pending	Pending

Plans for the Future

HHS has accelerated the development of tools to further foster collaboration and participation. In FY 2014, HHS plans more work developing engagement opportunities and collaboration initiatives. Additionally, under the guidance of the Chief Technology Officer, HHS will focus increasingly on data education and stakeholder engagement, developing new mediums of educating our data communities on the content of HHS data, such as codeathons and on-line chat sessions. HHS will also continue to increase the number of high value data sets and tools made available to the public.

Goal 2. Objective C: Advance the regulatory sciences to enhance food safety, improve medical product development, and support tobacco regulation

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Identify patterns in serum biomarkers to use in monitoring dietary intervention protocols to reduce obesity	Identify target genes that can predict potential for obesity and type 2 diabetes to provide individually tailored therapeutic treatment and dietary guidelines for use in improving health	1) Develop analytical methods to assess drug-induced heart damage 2) Identify target genes for obesity and the consequent development of metabolic syndrome diseases and heart disease	1) Analyze urine, blood , and tumor tissues samples to identity biomarkers that will facilitate early detection in new cases and in the reemergence of pancreatic cancer. 2) Develop a new targeted therapeutic approach to improve clinical management of breast cancer.	Determine if some drugs cause a higher incidence of liver toxicity in women than men	1) Complete pilot project that will promote women's health by facilitating the development of personalized approaches to treat breast cancer 2) Evaluate serum metabolic biomarkers to determine whether they are correlated to acute kidney illness diagnosis and prognosis
Result	Patterns were identified from analysis of 2009 CBPR data and preliminary analysis of 2010 CBPR data in serum biomarkers that can be used to monitor dietary intervention protocols to reduce obesity. (Target Met)	Statistical analyses of gene-phenotype interactions and nutrient levels were conducted and target genes identified, further results are pending a final analysis and publication (Target Met)	1) A model of drug-induced heart damage was developed and is being used to identify new predictive biomarkers of early stages of drug-induced cardiac tissue injury. (Target Met) 2) Research experiments have been completed and preliminary results suggest the involvement of a number of genes involved in lipid metabolism and sugar transporters. (Target Met)	Published results that found potential for new breast cancer therapy using epigenetic approach (Target Met)	Dec 31, 2015	Dec 31, 2016

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	9.0 working days	6.0 working days	5.0 working days	4.0 working days	4.0 working days
Result	10.0 working days	7.0 working days	6.0 working days	5.0 working days	Dec 31, 2014	Dec 31, 2015
Status	Historical Actual	Target Exceeded	Target Met	Target Met	Pending	Pending

Complete review and action on original New Animal Drug Applications (NADAs) and reactivations of such application received during the fiscal year. (Lead Agency - FDA; Measure ID - 243201)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	90% w/in 180 days	90% w/in 180 days	90% w/in 180 days	90% w/in 180 days	90% w/in 180 days	90% w/in 180 days
Result	100% w/in 180 days	Jan 31, 2013	100% w/in 180 days	Jan 31, 2015	Jan 31, 2016	Jan 31, 2017
Status	Target Exceeded	In Progress	Target Exceeded	In Progress	In Progress	In Progress

Plans for the Future

The FDA plans to continue to coordinate testing and refinement of the technology to reduce the average number of days to identify pathogens in food. This technology has already reduced the time to conduct these analyses from 14 days to less than a week, with future targets indicating even less time. The FDA intends to maintain its goal of review and action on 90 percent of original New Animal Drug Applications within 180 days. In addition, the FDA plans to study if some drugs cause a higher incidence of liver toxicity in women than men.

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

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 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	52%	60%	65.3%	76.7%	Prior Result +3PP	Prior Result +3PP
Result	57%	62.3%	73.7%	Oct 31, 2014	Oct 30, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		Set Baseline	973,724	1,032,147	1,400,000	1,400,000
Result		927,357	1,220,956	1,359,772	Oct 31, 2014	Oct 31, 2015
Status		Baseline	Target Exceeded	Target Exceeded	Pending	Pending

By 2018, identify three effective system interventions generating the implementation, sustainability and ongoing improvement of research-tested interventions across health care systems. (Lead Agency - NIH; Measure ID - SRO-8.7)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Identify at least three systemic (or services) intervention studies which utilize implementation mechanisms, strategies or techniques to improve the uptake of effective interventions in healthcare settings	Identify at least 3 mechanisms for tracking successful implementation within studies to improve the uptake of research-tested interventions in health care settings.	Complete target by identifying three effective implementation strategies that enhance the uptake of research-tested interventions in service systems such as primary care, specialty care and community practice.	Identify three key factors influencing the sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice.	Identify three effective implementation strategies that enhance the sustainability of research-tested interventions in service systems such as primary care, specialty care and community practice.	Identify three key factors influencing the scaling up of research-tested interventions across large networks of services systems such as primary care, specialty care and community practice. (Outcome)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Result	Three intervention studies that utilize implementation mechanisms, strategies, or techniques were identified to improve the uptake of effective interventions for mental health services, HIV and drug use disorders, and alcohol screening and treatment in healthcare or community settings.	Three mechanisms for tracking successful implementation within studies were identified to improve the uptake of research-tested interventions in health care settings.	NIH identified three approaches that enhance the uptake of research-tested interventions in service delivery systems addressing child mental health, attention deficit hyperactivity disorder, and depression.	NIH researchers identified three influences on sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice: Community Development Teams in child mental health service systems; barriers and facilitators to evidence-based interventions to control blood pressure in community practice; and a set of factors to enhance sustainability of health care interventions across multiple settings.	Dec 31, 2014	Dec 31, 2015
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

Plans for the Future

Over time, the Community-Based Child Abuse Prevention (CBCAP) program expects to increase the number of effective programs and practices that are implemented, maximizing the impact and efficiency of CBCAP funds. ACF is committed to continuing to work with CBCAP grantees to invest in known evidence-based practices, while continuing to promote evaluation and innovation. ACF will increase each year the funding going to evidence-based projects 3 percentage points greater than the previous year's result.

NIH has developed and will implement a series of process steps to identify three effective system interventions generating the implementation, sustainability and ongoing improvement of research-tested interventions across health care systems by 2018.

Goal 2. Objective E: Improve laboratory, surveillance, and epidemiology capacity

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Set Baseline	26	31	33	36	37[113]
Result	25	26[114]	33	36[115]	Feb 1, 2015	Feb 1, 2016
Status	Baseline	Target Met	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Set Baseline	198	237	248	298	298
Result	182	309	335	401	Dec 31, 2014	Dec 31, 2015
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	149	164	179	255	430	430
Result	192	351	280	Jun 30, 2014	Jun 30, 2015	Jun 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	2,316	2,486	2,660	2,846	3,101	3,256
Result	2,351	2,658	2,881	Jun 30, 2014	Jun 30, 2015	Jun 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Plans for the Future

CDC will hold steady the number of States (including the District of Columbia) that report for HIV surveillance purposes in FY 2014 and slightly increase in FY 2015. The CDC expects the number of

[113] 37 Plus DC

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

[115] 36 Plus DC

trainees in public health agencies to level off in FY 2015 as a result of changes to PPHF funding received by CDC. The CDC is also planning for increases in Field Epidemiology Training Program (FETP) new residents and graduates –through FY 2015 based on current participation. CDC will also work with the countries' ministries of health to implement basic and intermediate level FETPs, which will help accelerate progress.

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		Set Baseline	20 states	25 states	29 states[116]	32 states
Result		17 states	19 states	27 states	Jan 30, 2015	Jan 31, 2016
Status		Baseline	Target Not Met but Improved	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target			Set Baseline	23%	27%[117] (Avg. of FY12+FY13 results – 1PP)	26% (Avg. of FY12+FY13 results – 2PP)
Result			25%	31%	Jan 30, 2015	Jan 31, 2016
Status			Baseline	Target Not Met	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	N/A	N/A	76.1%[118]	76.1%	65.9%
Result	79%	73.5%	76.1%	65.9%	Dec 31, 2014	Dec 31, 2015
Status	Historical Actual	Historical Actual	Historical Actual	Target Not Met	Pending	Pending

Increase the number of children with severe emotional disturbance that are receiving services from the Children's Mental Health Initiative (Lead Agency - SAMHSA; Measure ID - 3.2.16)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	13,051	13,051	4,930	6,457	4,846[119]	6,610
Result	4,930	6,639	6,357	6,610	Dec 31, 2014	Dec 31, 2015
Status	Target Not Met	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Pending

[116] The FY 2014 target for this performance measure has been updated to maintain rigor given the latest data trend.

[117] The FY 2014 and FY 2015 targets for this performance measure have been updated in light of the most recent data.

[118] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY 2013 performance targets reflect FY 2012 funding levels.

[119] Target has been revised from previous reported.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	20.0 %	20.0 %	20.0 %	20.0 %[120]	20.0 %	18.1 %
Result	24.0 %	21.5 %	19.1 %	18.1 %	Dec 31, 2014	Dec 31, 2015
Status	Target Not Met	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	85%	85%	86%	86%	86%	86%
Result	87%	87%	89.4%	87.7%	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	N/A	91.9 %	91.7 %	Prior Result +0.2PP	Prior Result +0.2PP
Result	91.5 %	91.7 %	91.5 %	Oct 30, 2014	Oct 30, 2015	Oct 31, 2016
Status	Historical Actual	Historical Actual	Target Not Met	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	N/A	73.3 %	75.3 %	Prior Result +0.5PP	Prior Result +0.5PP
Result	72.5 %	72.8 %	74.8 %	Oct 30, 2014	Oct 30, 2015	Oct 31, 2016
Status	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending	Pending

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	80%	80%	80%	80%	80%	84%
Result	85.1%	84.6%	85.3%	Oct 30, 2014	Oct 30, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	30 M	31 M	33 M	30 M	31 M	32 M
Result	34.5 M	37.4 M	35.9 M	Nov 30, 2014	Nov 30, 2015	Nov 1, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Plans for the Future

ACF will continue to have aggressive targets and aim to improve results in order to lay a stronger foundation for each child's future through strengthening the quality of early childhood education programs. Progress in expanding the implementation of the Quality Rating and Improvement Systems (QRIS) was hampered in FY 2012 by tight budget environments and implementation challenges of statewide roll-outs. Given this most recent data, ACF has increased future year targets for FY 2014 – 2015 to maintain rigor. To date, ACF has invested in building its CLASS-related resources and making those resources available to grantees. In response to the data from the FY 2013 CLASS reviews, ACF plans to provide more intentional targeted assistance to those grantees that score in the low range on CLASS, using a case management approach. ACF will conduct more analysis on the specific dimensions that are particularly challenging for those grantees and develop a process for working more directly with those grantees on strategies for improvement. This will continue as an HHS Priority Goal for FY 2014 – 2015.

The National Child Traumatic Stress Initiative (NCTSI) represents a critical outlet for SAMHSA to develop, test, and implement evidence-based practices in trauma-related care for children. Positive functioning relates to psychological, social, and emotional well-being of the subject as well as a general ability to perform the tasks associated with routine life activities. The grantees implement Evidence Based Practices (EBPs). For many grantees their service providers were recently trained during FY 2013 and are becoming familiar with their new interventions in this first grant year. It is expected that as grantees continue to provide training and service providers continue to develop their capacity to provide trauma-informed services, that the rate of positive functioning at 6 month follow-up will increase.

SAMHSA supports the Children's Mental Health Initiative through grants to support States, political subdivisions within States, the District of Columbia, Territories, Native American Tribes and tribal organizations, in developing integrated home and community-based services and supports for children and youth with serious emotional disturbances and their families by encouraging the development and expansion of effective and enduring systems of care. SAMHSA expects a decline in performance in FY 2014 followed by an increase in performance in FY 2015.

SAMHSA also seeks to implement an enhanced, coordinated, and comprehensive plan of activities, programs, and services that promote healthy childhood development, prevent violence, and prevent alcohol and drug abuse. It measures the success of this program in part through the percentage of middle and high school students who report current substance abuse. SAMHSA expects this percentage to remain the same in FY 2014 and decline in FY 2015.

Improving the health of mothers, children, and their families is the mission of HRSA's Maternal and Child Health Block Grant program. HRSA has reduced targets for the number of children served in FY 2013 due to fewer children being served by the program in FY 2010 and the uncertainty around States being able to maintain or expand their existing level of services.

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	78	75	80	85	Prior Result +0[121]	Prior Result +0[122]
Result	74[123]	78	83	Nov 30, 2014	Nov 30, 2015	Nov 30, 2016
Status	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	110[124]	110	124	116	Prior Result +0%[125]	Prior Result +0%[126]
Result	118[127]	122[128]	114	Nov 30, 2014	Nov 30, 2015	Nov 30, 2016
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Set Baseline	89.4 %	89.7 %	90 %[129]	90 %	90 %
Result	89.3 %	90.7 %	90.3 %	May 30, 2014	May 30, 2015	May 31, 2016
Status	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

[122] The FY 2015 target is to maintain the prior year result.

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

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

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

[126] The FY 2015 target is to maintain the prior year result.

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

[128] The FY 2011 actual result for this performance measure was updated (previously reported as 121) due to additional data validation.

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	67.88%	68.79%	71.75%	71.77%	69.76%	Prior Result +1%
Result	68.11%	71.04%	71.06%[130]	69.07%	Nov 30, 2014	Nov 30, 2015
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Target Not Met	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	40.87%	42.97%	51.02%	52.5%[131]	54%[132]	54.5%
Result	42.13%	50.02%	52.91%	Dec 30, 2014	Dec 31, 2015	Dec 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	62%	61%	62%	62%	62%	63%
Result	62%	62%	63%	Nov 30, 2014	Nov 30, 2015	Nov 30, 2016
Status	Target Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	38.4%	27.5%[133]	30.4%	30.7%	Prior Result +0.1PP	Prior Result +0.1PP
Result	29%[134]	30.1%	30.4%[135]	Oct 30, 2014	Oct 31, 2015	Oct 30, 2016
Status	Target Not Met but Improved	Target Exceeded	Target Not Met but Improved	Pending	Pending	Pending

[130] The FY 2012 actual result for this performance measure has been updated as a result of revised data submissions from grantees.

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

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

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

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

[135] This data excludes territories, but includes the District of Columbia.

Increase the percentage of homeless clients receiving services who were currently employed or engaged in productive activities (Lead Agency - SAMHSA; Measure ID - 3.4.24)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	32.7 %	32.7 %	32.7 %	32.7 %	31.7 %	31.7 %
Result	32 %	32 %	32.7 %	29 %	Oct 31, 2014	Oct 31, 2015
Status	Target Not Met but Improved	Target Not Met	Target Met	Target Not Met	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	25.6 %	25.6 %	25.6 %	25.6 %[136]	24.6 %	33.0 %
Result	29.4 %	33 %	35.7 %	44.9 %	Oct 31, 2014	Oct 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	560,000	790,000	792,000	796,000	790,000	790,000
Result	761,000	819,598	867,546	Oct 31, 2014	Oct 31, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Plans for the Future

ACF plans to increase the recipiency index score each year for the Low Income Home Energy Assistance program in fiscal years 2013-2015 for households with older members and young children. Overall, the above targeting index scores indicate that elderly households faced increased difficulty in enrolling in LIHEAP as compared to families with young children. LIHEAP is one of five federal benefit programs for which the National Center for Outreach and Benefit Enrollment is seeking to develop innovative ways to increase enrollment of the elderly. In those households with young children, for FY 2013 the target goal is 116, which represents an increase of two percent over the previous year's actual result. ACF's targets for FY 2014 and FY 2015 is to maintain targeting performance at the FY 2013 level.

From FY 2013-2015, ACF aims to maintain the target rate of 90 percent of domestic violence program clients reporting improved knowledge of safety planning. This target rate is a realistic expectation of client assessment of their increase in knowledge due to services received. A higher number of clients responding that they increased their knowledge is unrealistic because many program participants receive short term crisis assistance and would not be expected to report significant change.

In the area of refugee self-sufficiency, ACF seeks to continue to make progress despite a challenging job market and a population of refugees who may face significant cultural and language barriers. By FY

[136] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY 2013 performance targets reflect FY 2012 funding levels.

2015, the goal is to improve by at least 1 percent over the prior year's actual result for measures of cash assistance dependency and by more than 1.5 percent in employment. ACF intends to increase its monitoring activities to enhance program performance.

ACF also aims to maintain the child support percent collection rate target at 62 percent for FY 2013-2014 and increase to 63 percent in FY 2015 in anticipation of more modest improvements in economic conditions in the near term.

Future targets related to the ACF Temporary Assistance for Needy Families (TANF) program include increasing the percentage of newly employed recipients by 0.3 percentage points in FY 2013 and by 0.1 percentage points above the prior year result in FY 2014 and FY 2015.

The Grants for the Benefits of Homeless Individuals (GBHI) programs include efforts to support innovative strategies and provide services that help integrate individuals who are experiencing or at risk of homelessness and who also have substance abuse and mental health disorders into the community, assist providers in strengthening the infrastructure for delivering and sustaining housing to support recovery, and other critical services. After missing a target in FY 2013, SAMHSA plans to increase the percentage of productively engaged homeless clients receiving services to 31.7 percent in FY 2014 and maintain that level in 2015. Homeless clients receiving services who had a permanent place to live in the community experienced consistent performance improvements, but the program has lowered target expectations for FY 2014–2015. External factors influenced performance in significant ways. When the percentage of those employed decreased nationally, fewer clients would be able to afford housing. SAMHSA will continue to provide targeted technical assistance to grantees and use strategies to improve the percentage of adult clients who have a permanent place to live in the community.

ACL believes that Home and Community-based and Caregiver Support Services performance will continue to remain relatively stable over the next few years. ACL will strive to maintain the improvements that have been realized over the past few years of serving a growing population of frail homebound seniors. Fluctuations are likely due to yearly variation in the mix of five services delivered to meet the needs of the caregivers in the program (i.e. if caregiver needs result in a service mix with more of the expensive services (e.g. respite versus caregiver training) then fewer caregivers can be served with a given amount of resources).

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	30%	30%	28%	28%	28%	27%
Result	29%	30%	26%	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Met	Target Exceeded	Pending	Pending	Pending

Maintain at 90% or higher the percentage of clients receiving home delivered meal who rate services good to excellent. (Lead Agency - ACL; Measure ID - 2.9a)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	90%	90%	90%	90%	90%	90%
Result	90.08%	90%	88%	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Met	Target Not Met	Pending	Pending	Pending

Maintain at 90% or higher the percentage of transportation clients who rate services good to excellent. (Lead Agency - ACL; Measure ID - 2.9b)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	90%	90%	90%	90%	90%	90%
Result	98%	97%	98.5%	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Maintain at 90% or higher the percentage of National Family Caregiver Support Program clients who rate services good to excellent. (Lead Agency - ACL; Measure ID - 2.9c)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	90%	90%	90%	90%	90%	90%
Result	94%	96%	93.8%	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the percentage of older persons with severe disabilities who receive home-delivered meals. (Lead Agency - ACL; Measure ID - 3.5)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	N/A	Set Baseline	39.0%[137]	44.3%	44.8%
Result	40.2%	41.8%	43.5%	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Historical Actual	Historical Actual	Baseline	Pending	Pending	Pending

[137] Beginning with FY 2013 results, this measure replaces ACL measure 3.2. It reports the same data as the previous measure, but as a percentage, rather than a number. Reporting as a percentage provides greater clarity regarding the performance impact of the program.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	4,927	5,420	5,420	5,420[138]	4,591[139]	4,360
Result	5,163[140]	4,459	4,781	4,360	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Not Met	Target Not Met but Improved	Target Not Met	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	87.0 %	87.0 %	87.0 %	87.0 %[141]	87.0 %	87.0 %
Result	90.0 %	92.0 %	87.0 %	Jul 31, 2014	Jul 31, 2015	Jul 31, 2016
Status	Target Exceeded	Target Exceeded	Target Met	Pending	Pending	Pending

Plans for the Future

HHS will continue its efforts to enhance support services for people with disabilities and older adults. Based on performance improvements, ACL plans to reduce the percentage of caregivers who report difficulty getting services to 28 percent for FY 2013-2015. Program performance has reduced caregivers reporting difficulty to such a low level that further reductions are expected to be more modest, if at all. ACL plans to maintain the current high performance for the measures of client satisfaction with Family Caregiver Support Services, transportation, and home delivered meals at current levels for FY 2013–2015. The percentage of older persons with severe disabilities receiving home-delivered meals has increased year by year, despite stable funding and increased cost related to food, fuel, and labor. States have increased their targeting of these clients at high risk of nursing home entry. Consequently, ACL increased the FY 2013-2015 performance targets.

SAMHSA has reduced its targets for the number of PATH providers trained in the SOAR process for FY 2014 and 2015 due to decreased State and local funds for their trainings.

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[138] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY 2013 performance targets reflect FY 2012 funding levels.

[139] Target has been revised from previously reported.

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

[141] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY 2013 performance targets reflect FY 2012 funding levels.

Protection and Advocacy for Individuals with Mental Illness (PAIMI) is a SAMHSA program that measures the percentage of complaints of alleged abuse, neglect and rights violations not withdrawn by the client that resulted in positive change for the client in the safety or welfare of their environment, as a result of involvement. SAMHSA plans to maintain its current performance levels for substantiated and not withdrawn complaints due to PAIMI involvement although business costs continue to rise.

Goal 3. Objective D: Promote prevention and wellness across the lifespan

Reduce the annual adult combustible tobacco consumption in the United States (cigarette equivalents per capita) (Lead Agency - OASH; Measure ID - 1.5)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target			1,342.0 per capita	1,259.0 per capita	1,212.0 per capita	1,174.0 per capita
Result			Jul 31, 2013	Jul 31, 2014	Jul 31, 2015	Jul 31, 2016
Status			Baseline	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		N/A	84,000	75,000	100,000	105,000
Result		24,419	87,455	109,908	Jan 31, 2015	Jan 31, 2016
Status		Historical Actual	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Set Baseline	20.5 %	20 %	19 %	18 %	17 %
Result	19.3 %[142]	19 %	18.1 %	Jun 30, 2014	Jun 30, 2015	Jun 30, 2016
Status	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		18.9 %	18.6 %	18.2 %	N/A[143]	17.6 %
Result		18.1 %	14 %[144]	Jun 30, 2014		Jun 30, 2016
Status		Target Exceeded	Target Exceeded	Pending		Pending

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

[143] The primary data source for setting and reporting targets is the Youth Risk Behavior Surveillance System (YRBSS), which monitors priority health–risk behaviors and is conducted every other year (odd years). Beginning in FY 2011, the National Youth Tobacco Survey (NYTS) was added as an additional data source, which tracked closely with YRBSS. Due to variance in results that developed between the two data sets after FY 2011, CDC began setting and reporting targets based only on YRBS as of FY 2014.

[144] NYTS data, which captures youth smoking prevalence in the interim years of YRBSS reporting. Targets are set per YRBSS data.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	50.4%	50.4%[145]	55.9%	50%	50%	50%
Result	58%[146]	85%[147]	88%	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	555,132	555,132	555,132	555,132[148]	765,638[149]	989,994
Result	664,932	765,638	884,536	1,061,204	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	66.0 %	62.3 %	68.4 %	63.1 %	63.1 %	66.1 %
Result	62.3 %[150]	67.4 %[151]	66.7 %	66.1 %	Dec 31, 2014	Dec 31, 2015
Status	Target Not Met	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending

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

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

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

[148] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY 2013 performance targets reflect FY 2012 funding levels.

[149] Target adjusted to reflect 2011 actual.

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

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

Increase the percentage of Early Head Start children completing all medical screenings to 91 percent by FY 2010. (Lead Agency - ACF; Measure ID - 3.6LT and 3B)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	91%	92%	93%	93%	93%[152]	93%
Result	84.9%[153]	85.7%	85.9%	Jan 31, 2014	Jan 31, 2015	Jan 31, 2016
Status	Target Not Met	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	N/A	N/A	32.3%	51%	47.3%
Result	29%	32.8%	37.5%	46.7%	Oct 31, 2014	Oct 31, 2015
Status	Historical Actual	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending

Plans for the Future

In FY 2014 and beyond the Department will continue its efforts coordinated across a number of agencies to reduce smoking among all ages and populations. The annual adult combustible tobacco consumption measure is a new Priority Goal for FY 2014–2015 and HHS continues its commitment to reducing tobacco consumption through 2015. The focus of this goal was changed from cigarettes to combustible tobacco due to consumer preferences shifting to other products such as cigars and cigarillos. The FDA contributes to this cause by contracting with 45 States and territories to conduct tobacco regulation compliance check inspections of retail establishments. Although the FY 2013 result was a much higher number than expected, it reflects the high level of variability inherent in this goal that requires estimating the number of compliance checks that each State will be able to conduct. In addition, some of expiring contracts will need to be renewed in the next year to continue these efforts. Although, most States are expected to renew, there are always factors that may prohibit them from doing so. Accordingly, the FY 2014 and FY 2015 targets consider these challenges but have still been increased.

The CDC will continue to support the National Tobacco Control Program (NTCP) in 50 States and the District of Columbia, eight territories/jurisdictions, eight tribal support centers, and six national networks. NTCP grants support evidence-based efforts by State, tribal and territorial health department to prevent initiation of tobacco use among young adults, promote tobacco use cessation, eliminate exposure to secondhand smoke, and identify and eliminate tobacco-related disparities. It will also provide national leadership for a comprehensive, broad-based approach to reducing tobacco use which involves: preventing young people from starting to smoke; eliminating exposure to secondhand smoke; promoting quitting; and, identifying and eliminating disparities in tobacco use among population groups.

[152] The FY 2014 target for this performance measure has been revised in light of the most recent data trend.

[153] Head Start programs have a correction period during which they may make changes to their annual PIR data. While this document previously included 89.4 percent as the percentage of Early Head Start children with screenings completed, this updated figure reflects the finalized 2010 data.

These are some of the efforts the CDC will employ to meet the future target for reduction of adolescent and adult smoking.

Underage drinking prevention is a key component of the Strategic Prevention Framework State Incentive Grant (SPF SIG) program, for HHS and for the nation as a whole. This nationwide problem has been shown to be linked to violent behavior, risky sexual behavior and later alcohol dependence. The SPF SIG program provides funding to States, federally recognized tribes and U.S. territories to support local communities in preventing the onset and progression of substance abuse and substance abuse-related problems including underage drinking. The SPF SIG program also provides a unique opportunity for States, tribes, territories and their communities to build capacity and a prevention infrastructure based on SAMHSA's Strategic Prevention Framework. Over the long term, it is anticipated that the capacity and interventions implemented through the SPF SIG program can make a difference at the State level.

The suicide hotline (Lifeline) has seen a yearly increase in calls answered, a trend that SAMHSA projects to continue. During FY 2013, SAMHSA awarded a new 3-year cooperative agreement with a continued focus on serving callers in distress, as well as expanding capacity of the Crisis Chat service for individuals seeking help online. The growth in average quarterly Lifeline calls can likely be attributed to the following: continued outreach and marketing of the National Suicide Prevention Lifeline service; wide distribution of the Lifeline number by third party organizations seeking to provide their clients with a 24/7 emergency resources; heavy promotion of the Lifeline through social media outreach on Facebook and other social media sites; and significant marketing and outreach to veterans of the Veterans Crisis Line, which also uses the 1-800-273-8255 Lifeline number.

SAMHSA works to support those adults who may be severely mentally ill and homeless. Grants are awarded to organizations to assist this population in gaining access to sustainable permanent housing, treatment, and recovery supports. A measure of the performance of these grantees is the self-reported sense of positive functioning by the individual 6 months after beginning to receive homeless support services. SAMHSA expects to maintain performance in FY 2014 and realize an increase in FY 2015.

ACF, through the Early Head Start program, aims to promote prevention and wellness early in the life span. For the 2012-2013 program year, 84.3 percent of Early Head Start program children completed medical screenings expected for their age. The Early Head Start program underwent a large expansion under the American Recovery and Reinvestment Act, which resulted in expanded enrollment and many new programs, which faced challenges establishing partnerships needed to promptly complete medical screenings for the increased number of enrolled children. Despite these challenges, ACF aims to achieve a target rate of 93 percent in FY 2014 and FY 2015. The Office of Head Start is in the process of developing a toolkit for programs to assist them in the tailored use of an online, web-based Well Visit Planner, which is a free online pre-visit planning tool designed to engage parents in planning for and partnering more fully in their child's well visit. Studies continue to show gaps in the quality of well-child care. Improving care means improving communication and partnerships with parents and meeting the unique needs and priorities of each child and family.

The CVD-Comprehensive Assessment measure logic used in this IHS measure addressing coronary heart disease in American Indian and Alaska Native populations was revised in FY 2013. The FY 2011 and FY 2012 results were collected historically from the IHS electronic health record even though the FY 2013 measure logic was not used in FY 2011 and FY 2012. Performance for this program is expected to increase in FY 2014 and FY 2015 due to continued efforts by IHS to promote the Million Hearts Initiative at the regional and local levels.

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	2.3 cases/100,000	2.2 cases/100,000	2.1 cases/100,000[154]	2.0 cases/100,000	1.9 cases/100,000
Result	3.5 cases/100,000	3.0 cases/100,000	2.6 cases/100,000	Jul 31, 2014	Jul 31, 2015	Jul 31, 2016
Status	Historical Actual	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	90%	90%	90%	90%	90%	90%
Result	92%	92%	91%	Sep 30, 2014	Sep 30, 2015	Sep 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		N/A	Set Baseline	47 %	50 %	53 %
Result		41 %	39 %	42 %	Sep 30, 2015	Sep 30, 2016
Status		Historical Actual	Baseline	Target Not Met but Improved	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Set Baseline[155]	27.4 %	26.3 %	24.9 %	21 %	19.1 %
Result	25.4 %[156]	24.9 %	Jun 30, 2014	Jun 30, 2015	Jun 30, 2016	Jun 30, 2017
Status	Baseline	Target Exceeded	Pending	Pending	Pending	Pending

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

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

[156] CDC updates results as additional HIV surveillance data are received. Because state and local health departments rely on reports from doctors' offices and laboratories, as well as medical record abstracts and death records, incomplete or duplicate information is sometimes received, requiring additional follow up before the data can be considered complete. CDC routinely updates these data in published surveillance reports for up to four years as more information is reported to CDC.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	N/A	Set Baseline	13.53	12.18	10.83
Result	21.76	20.06	18.74	Nov 30, 2014	Nov 30, 2015	Nov 30, 2016
Status	Historical Actual	Historical Actual	Baseline	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	1.9	1.8	1.7	1.7	1.5	1.5
Result	1.6	1.5	1.5	Sep 30, 2014	Sep 30, 2015	Sep 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the number of adults and children internationally with advanced HIV infection receiving antiretroviral therapy (ART). (Lead Agency - CDC; Measure ID - 10.A.1.5)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		Set Baseline	N/A	2,813,684	3,310,618	3,895,317
Result		1,941,177	2,620,177	3,623,255	Dec 15, 2014	Dec 31, 2015
Status		Baseline	Target Not In Place	Target Exceeded	Pending	Pending

American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Lead Agency - IHS; Measure ID - 24)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	80%	74.6%	77.8%	Set Baseline	74.8%	73.9%
Result	79%[157]	75.9%[158]	76.8%	74.8%[159]	Oct 31, 2014	Oct 31, 2015
Status	Target Not Met	Target Exceeded	Target Not Met but Improved	Baseline	Pending	Pending

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

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

[159] Beginning in FY 2013 this measure will match the revised CDC Immunization Schedule and Healthy People 2020; therefore, results will differentiate the use of the 3 or 4 dose Hib vaccine for individual patients. CDC will identify the new measure as 4313*314 with the *3 representing the Hib vaccine. In previous years, CDC did not make a distinction between the 3 or 4 dose vaccine Individual sites will continue to use their choice of 3 doses or 4 doses of Hib. Until results are compiled, the agency does not know what the impact will be to the baseline result.

Plans for the Future

Because the current Priority Goal measure for reducing Salmonella Enteritidis (SE) infections includes all infections related to chickens, determining which infections are attributable to shell eggs (as opposed to broiler chickens) makes it difficult to determine whether the FDA's egg rule is having the desired effect of reducing the likelihood that contaminated shell eggs are the cause for a particular infection. The FDA will continue inspections of large and small egg producers, while continuing to refine its egg rule enforcement policies with straightforward inspection, re-inspection, and warning strategies, aiming to reduce Salmonella Enteritidis infections each year through 2015. This will also continue as a HHS Priority Goal for FY 2014–2015.

Immunization continues to be one of the most cost-effective public health interventions. CDC supports immunization efforts nationwide such as maintaining infant measles, mumps, and rubella immunization coverage at 90 percent. To combat influenza in FY 2014, the CDC has set a target of increasing the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza to 50 percent. The CDC will continue to maintain effective control efforts with its 68 State and local partners contributing to the low and declining tuberculosis rates in the U.S. For other infectious diseases such as MRSA infections, CDC expects a decline each year from FY 2013–2015 based on strategies and actions healthcare providers are implementing to reduce infection. Consistent reductions year over year are expected in the proportion of persons with an HIV diagnosis at later stages of disease within three months of diagnosis, monitoring the effectiveness of efforts to decrease the number of domestic HIV infections diagnosed at later stages of disease. In addition, in FY 2014 and FY 2015 the number of adults and children internationally with advanced HIV infection receiving antiretroviral therapy is expected to increase.

IHS, beginning in FY 2013, is changing its childhood immunizations measure to match the CDC Immunization Schedule and Healthy People 2020, setting a baseline that it expects to maintain in FY 2014. The IHS Public Health Nursing Data Mart captures data related to clinical and quality improvement activities and IHS is working through Area Immunization Coordinators to ensure that IHS meets or exceeds childhood immunizations measures.

Goal 3. Objective F: Protect Americans' health and safety during emergencies, and foster resilience to withstand and respond to emergencies

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	Awards contracts for advanced development of recombinant-based influenza vaccines. Initiate clinical study to determine the safety of an anthrax vaccine. Issue RFP to establish Centers of Innovation for Advanced Development and Manufacturing Issue RFP to establish a network of domestic vaccine and biologics manufacturers	CBRN Licensed= 0; EUA= +1; Pan Flu/EID Licensed= +1; EUA= 0	CBRN Licensed= +0; EUA= +3; Pan Flu/EID Licensed= +3; EUA= +0	Licensure of 2 more Chemical, Biological, Radioactive and Nuclear threats and emergency use authority for 2 more counter-measures. Licensure of 2 more pan flu vaccines.	Increase the number of new CBRN and emerging infectious disease medical counter-measure under EUA or licensed FY 2015 Target: CBRN: Licensed= +4; EUA= +2. Pan Flu/EID: Licensed= +5; EUA= +3

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Result	Baseline	Awarded contract for Recombinant-based flu vaccines. Started large clinical studies to evaluate safety H5N1 vaccines. Issued RFP to establish Centers of Innovation for Advanced Development and Manufacturing. Proposals received and are under evaluation. Issued RFI to discern the capabilities of US vaccines and biologics manufacturing, which will inform the subsequent RFP.	**Target: EUAs= +1;** CBRN EUA= 1 anti-neutropenia cytokine drug for acute radiation treatment (Neupogen) Flu EUA = 4 Pre-EUA packages submitted to FDA by BARDA on H5N1 vaccines BLA Submissions= 3: (cell-based seasonal and H5N1 influenza vaccines – 2 and botulinum antitoxin - 1) **Pan Flu/EID Licensed= +1;** Licensures = 1: Influenza point-of-care diagnostic device (Simplexa) Awarded 3 contracts establishing the Centers for Innovation in Advanced Development and Manufacturing (CIADM) Issued RFP to establish domestic network of fill finish manufacturers for pandemic influenza and drug shortages.	**CBRN EUA= 2;** ST-246 antiviral for smallpox approved by FDA for EUA and Neupogen an anti-neutropenia cytokine for radiation treatment. 2 other packages were submitted but not acted on during the performance period. **Pan Flu licensed=3**; Licensed by FDA are: 1) Flucelvax, the first cell0based seasonal influenza vaccine, 2) FluBlØk, the first recombinant-based seasonal influenza vaccine, and 3) Aura, a next generation portable ventilator for adults. While not part of the goal, BARDA saw the first anthrax antitoxin and the first botulinum antitoxin licensed by FDA. Both projects were supported by Project BioShield and approved under the FDA's Animal Efficacy Rule.	N/A	N/A
Status	Target Met	Target Met	Target Met	Target Not Met but Improved	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	75 %	83 %	91 %	94 %	95 %	95 %
Result	89 %[160]	87 %	89 %	Dec 31, 2014	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem
Result	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	Dec 31, 2014	Dec 31, 2015
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Complete and evaluate the pilot vaccine adverse-effects program and participate in at least one international workshop or conference.	Apply novel technologies, including mass spectrometry, to quantify the absolute amount of hemagglutinin in the reference standards that are used to determine influenza vaccine potency.	Evaluate and compare new methods to determine the potency of influenza vaccines.	Develop and evaluate new methods to produce high-yield influenza vaccine reference strains	Continue evaluation of new methods to produce high-yield influenza vaccine reference strains	Continue evaluation of new methods to produce high-yield influenza vaccine reference strains.

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Result	Nov 30, 2010	The studies were delayed in FY 2011 awaiting the delivery of required equipment. In FY 2011, CBER did complete preliminary studies to evaluate the use of mass spectrometry to determine the absolute amount of hemagglutinin in reference standards and define initial sample conditions. (Target not met but improved)	In FY 2012 CBER met the goal by evaluating three new methods for the determination of influenza vaccine potency. These methods (ELISA using monoclonal antibodies to capture antigen, Surface Plasmon Resonance, and label-free, antibody-free mass spectrometry) were used to measure the potency of inactivated influenza vaccines from several manufacturers. In each case, the results demonstrated the potential of each method and indicated that further development and evaluation was warranted.	In FY 2013, CBER met the target to develop and evaluate new methods to produce high-yield influenza vaccine reference strains. Activities to meet this target include: • Multiple assays were evaluated to determine the best methods for assessing vaccine reference strain yield. • Further modifications were made to previously developed influenza vaccine reference strains for the 2009 H1N1 pandemic strain, which is now included in the seasonal vaccine. • One new influenza reference strain was developed as a possible vaccine candidate for the H7N9 influenza virus that emerged in China during 2013.	Dec 31, 2015	Dec 31, 2016
Status	Target Met	Target Not Met but Improved	Target Met	Target Met	In Progress	In Progress

Plans for the Future

For FY 2014, ASPR plans to continue manage the procurement and advanced development of medical countermeasures for chemical, biological, radiological, and nuclear agents (referred to as CBRN); Project BioShield procurements; and the advanced development and procurement of medical countermeasures for pandemic influenza and other emerging infectious diseases, with acquisitions to meet the requirements. In FY 2015, it plans to significantly increase its development and acquisition activities.

The CDC will work to increase the percentage of public health agencies that can assemble, make key decisions and quickly respond during an emergency. Because many emergencies provide little to no notice but still require a rapid response, the CDC will continue focusing on improving the percentage of grantees who can convene key staff within 60 minutes of notification, raising this number to 95 percent in FY 2015.

The FDA is planning to maintain laboratory surge capacity for potentially contaminated foods in FY 2014 to perform analysis on at least 2,500 radiological samples and 2,100 chemical samples per week. This effort will have public health value even in non-deliberate food contamination situations because contaminated food products will be identified and removed from the marketplace more quickly. The FDA will also continue to evaluate new methods to produce high-yield influenza vaccine reference strains, to build capacity to respond to seasonal influenza and potential pandemics.

Goal 4. Objective A: Strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud, and integrating financial, performance, and risk management.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	7,742	8,350	8,600	8,700	8,600	9,000
Result	8,438	8,881	9,206	Oct 31, 2014	Oct 31, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	3.2	3.4	3.6	3.6	3.6	3.4
Result	4.3	4.2	4.1	4	Nov 7, 2014	Nov 9, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	0.8%	0.6%	0.7%	0.7%	0.6%	Prior Result -0.1PP
Result	0.7%	0.8%	0.8%	0.7%	Jan 30, 2015	Jan 31, 2016
Status	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	4.5%	4.7%	4.5%	6%[161]	5.1%[162]	4.9%
Result	4.9%	5.25%	6.2%	5.3%	Oct 31, 2014	Oct 30, 2015
Status	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending

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

[162] The FY 2014 target for this performance measure has been revised in light of the most recent data trend.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	19%	19%	17%	16%	16%	16%
Result	16.04%	16.23%	16.07%	Oct 30, 2014	Oct 30, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	9.5%	8.5%	5.4%	8.3%	9.9%	9.8%
Result	9.1%	8.6%[163]	8.5%[164]	10.1%	Nov 15, 2014	Nov 15, 2015
Status	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	14.3%	13.7%	10.4%	10.9%	9%	8.5%
Result	14.1%	11%	11.4%	9.5%	Nov 15, 2014	Nov 15, 2015
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target			N/A	31%	36%	42%
Result			27%[165]	31.8%	Nov 30, 2014	Nov 30, 2015
Status			Target Not In Place	Target Exceeded	Pending	Pending

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

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

[165] 27% is the FY 2012 baseline for this goal calculated based on the result of leads at the end of the first year of the Fraud Prevention System (FPS) (July 2012). The targets for 2013 and 2014 are calculated by increasing the baseline by 15% each year.

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Further develop component measures of payment error for the Part D program	Report Baseline Composite Error Rate for the Part D program.	3.2%	3.1%	3.6%	3.5%
Result	Additional component measure reported.	Baseline 3.2%	3.1%	3.7%	Nov 15, 2014	Nov 15, 2015
Status	Target Met	Target Met	Target Exceeded	Target Not Met	In Progress	In Progress

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Set Baseline[166]	8.4%[167]	7.4%[168]	6.4%[169]	6%	5.6%
Result	9.4%	8.1%	7.1%	5.8%	Nov 15, 2014	Nov 15, 2015
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target			Report national error rates in the 2012 Agency Financial Report based on 17 CHIP States	Report rolling average error rate in the 2013 Agency Financial Report based on States reported in 2012-2013	Report rolling average error rate in the 2014 Agency Financial Report	Estimate the Payment Error Rate in CHIP - TBD
Result			8.2%	7.1%	Nov 15, 2014	Nov 15, 2015
Status			Target Met	Target Met	In Progress	In Progress

166 Previously listed as MCD1.1 in the FY 2013 HHS OPA as "Set Baseline." The target/reporting schedule was revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

167 Previously listed as MCD1.1 in the FY 2013 HHS OPA as 7.4%. The target/reporting schedule was revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

168 Previously listed as MCD1.1 in the FY 2013 HHS OPA as 6.4%. The target/reporting schedule was revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

169 Previously listed as MCD1.1 in the FY 2013 HHS OPA as TBD. The target/reporting schedule was revised to comply with the current HHS Agency Financial Report (and to be consistent with other Medicare error rate measures).

Plans for the Future

ACL will continue to maintain current levels of clients served per million dollars of funding in its home and community-based services program, as shown by level targets for FY 2013-2015. Performance has largely trended upward and performance targets have been consistently achieved. This reflects the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers (ADRCs) and increased commitments and partnerships at the State and local levels have all had a positive impact on program efficiency.

Despite challenging caseloads, OMHA will continue to strive to meet customer expectations and maintain the high customer satisfaction at current levels.

Achieving full enrollment in Head Start programs can be difficult due to the wide variation in grantee size/type and changing community demographics; however by FY 2015, through continued program support and technical assistance, ACF expects under-enrollment in Head Start programs to be 0.1 percentage point less than the previous year's actual result in both FY 2014 and FY 2015. Error rates in the Title IV-E foster care program have dropped. Of the 18 States reviewed during the FY 2013 reporting period, 11 had error rates below five percent; and seven States had error rates below 2 percent. In light of recent performance, ACF has adjusted out-year targets and will continue to work with States to strengthen oversight of Title IV-E eligibility and address payment errors in order to move toward the target of 5.1 percent for FY 2014 and 4.9 percent for FY 2015. Historical trend data for the Community Services Block Grant (CSBG) administrative funds expended performance measure have fluctuated, with sub-grantees spending between 16 and 23 percent on administrative expenses. Given recent performance on this measure, ACF aims to continue to meet a target level of 16 percent for FY 2014 and FY 2015.

In order to protect the integrity of the Medicare Trust Fund, CMS must ensure that the correct Medicare payments are made to legitimate providers for covered, appropriate and reasonable services for eligible beneficiaries. CMS will enhance its efforts to reduce improper payments for Medicare FFS and Medicare Parts C and D and continue to use predictive analytics to focus on areas where incidence or opportunity for improper payments and/or fraud is greatest, with the expectation that error rates will decline in FY 2014 and FY 2015 for Medicare Fee-for-Service and Part C. The target for Part D in FY 2014 was adjusted upward due to the FY 2013 result, but CMS expects the Part D error rate to decline in later years. In addition, through its efforts to use predictive techniques to reduce fraud. CMS expects a yearly increase in the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action.

CMS also plans to continue implementing effective corrective actions across States to decrease improper payments, including those associated with eligibility errors related to Medicaid and the Children's Health Insurance Program. Their future targets have been set with the expectation that the Medicaid error rate will fall in the coming years. HHS also expects CHIP improper payments to decrease as States refine their outreach and documentation efforts.

Goal 4. Objective B: Enhance access to and use of data to improve HHS programs and support improvements in the health and well-being of the American people

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	10.8 months	10 months	10 months	10 months	9.5 months	9.5 months
Result	10.8 months	10 months	10 months	10 months	Oct 30, 2014	Oct 30, 2015
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

Increase the combined count of webpage hits, hits to the locator, and hits to Substance Abuse and Mental Health Data Archive (SAMHDA) for SAMHSA-supported data sets (Lead Agency - SAMHSA; Measure ID - 4.4.10)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	5,195,000	5,585,000	6,000,300	1,792,523[170]	1,882,149[171]	2,390,402
Result	3,716,660	3,864,940	1,707,165[172]	2,298,464[173]	Dec 31, 2014[174]	Dec 31, 2015[175]
Status	Target Not Met	Target Not Met but Improved	Target Not Met	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	Set Baseline	350,000	1,169,208	1,215,976	2,924,842	3,071,084
Result	256,243	1,113,531	1,829,111	2,924,842	Oct 31, 2014	Oct 31, 2015
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Plans for the Future

AHRQ's MEPS Household Component is targeting a two week reduction in FY 2014 for the point-in-time file relative to our time for data release accomplished in FY 2013. Further acceleration is targeted for the

[170] Reduction in target reflects a change in the data collection methodology.

[171] Reduction in target reflects a change in the data collection methodology.

[172] There is no delay between fiscal year funding and the performance year.

[173] There is no delay between fiscal year funding and the performance year.

[174] There is no delay between fiscal year funding and the performance year.

[175] There is no delay between fiscal year funding and the performance year.

current MEPS Household Component solicitation, with data delivery taking place in FY 2014 through FY 2018.

SAMHSA is tracking information usage from its publicly available resources by tracking a combined count of hits for a pool of key resources. During January of 2012, advancements were made to assure the methodology of how hits are counted. These advancements resulted in a change in the target for FY 2013 and that target was exceeded. Given the pace of technological changes associated with automation, SAMHSA continues to carefully monitor and test the methodology used to quantify this type of measurement, expecting improvements for FY 2014 and FY 2015.

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

Goal 4. Objective C: Invest in the HHS workforce to help meet America's health and human service needs

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	80 Average Number of Days	61 Average Number of Days	60 Average Number of Days	60 Average Number of Days	60 Average Number of Days
Result	65 Average Number of Days	61 Average Number of Days	65 Average Number of Days	68 Average Number of Days	Dec 2, 2014	Dec 31, 2015
Status	Historical Actual	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

Plans for the Future

The ASA Office of Human Resources (OHR) set aggressive Agency-wide goals that significantly exceed the OPM federal hiring targets. OHR remains committed to the goal of hiring in an average of 60 days. To optimize performance, OHR has implemented a number of process and systems improvements to support hiring managers in their recruitment efforts. Beginning in FY 2012, HHS began transitioning the Department's HR services to a mission-based, fully-integrated operating environment. The increase in hiring time in FY 2013 is likely attributable to that transition.

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

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target		12.0%	14.0%	16.0%	18.0%	20.0%
Result		13.0%	22.0%	38.0%	Dec 3, 2014	Dec 15, 2015
Status		Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	13,232 $MTCO_2e$	12,968 $MTCO_2e$	12,708 $MTCO_2e$	12,454 $MTCO_2e$	12,205 $MTCO_2e$	11,961 $MTCO_2e$
Result	11,750 $MTCO_2e$	13,404 $MTCO_2e$[176]	13,448 $MTCO_2e$	11,129 $MTCO_2e$	Dec 2, 2014	Dec 15, 2015
Status	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending

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

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Target	N/A	100.0%	100.0%	100.0%	100.0%	100.0%
Result	32.0%	85.0%	94.0%	Dec 1, 2013[177]	Dec 3, 2014	Dec 15, 2015
Status	Historical Actual	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

Plans for the Future

HHS will continue to support initiatives toward the achievement of the goals in the Executive Order 13514 and the Sustainability Performance Plan. FY 2014 and FY 2015 targets maintain the goal of 20 percent of employees using telework or Alternative Work Schedule to avoid commuting at least 4 days per pay period, a threshold already exceeded. HHS has set aggressive goals to move from the FY 2010 level of 32 percent of devices with power management enabled to 100 percent of devices with power management by 2013 and to maintain that level continuing through FY 2015. $MTCO_2e$ emission reduction targets for subsequent periods are expected to stabilize and improve going forward. HHS is replacing conventionally (petroleum based) powered vehicles with alternative fuel vehicles as possible, reducing the amount of HHS greenhouse gas emissions.

[176] Due to an error in calculation, HHS initially reported a result of 9,375 $MTCO_2e$ for FY2011. However, after correcting this significant error, the accurate number has been calculated at 13,404 $MTCO_2e$. Measures are now in place to prevent similar miscalculations in the future.

[177] Result is pending due to internal review of data.

Evaluation and Research

As part of the HHS mission to provide health and human services to the Nation, the Department is committed to continuously improving on the delivery of those services. That goal is accomplished through the evaluation of HHS programs to examine the performance of those programs in achieving their intended objectives. An important component of the HHS evaluation function is communicating the findings and recommendations of completed evaluation studies. The Department produces a Performance Improvement Report, available at http://aspe.hhs.gov/evaluation/performance/, to make available to its stakeholders and the public summaries of evaluation studies recently completed and others in progress. The Department organizes evaluations by the strategic goals and objectives of the most current HHS Strategic Plan.

Throughout this Plan, narrative sections under strategic goals and objectives describe how evaluations contributed to the strategic directions the Department has chosen to improve health and human services outcomes for the populations it serves. In addition, strategies related to conducting research and evaluations, and applying that knowledge to programs and other efforts, are included throughout the Plan.

HHS OIG FY 2013 Top Management and Performance Challenges

The HHS OIG has identified the top management and performance challenges for FY 2013. HHS management is committed to working toward resolving these challenges. The performance measures in this document track such challenges as implementing the Affordable Care Act, combating fraud and waste, enhancing quality of care, and ensuring food and medical safety. In addition, HHS employs a robust program integrity process. For further information about these challenges, please read the HHS FY 2013 Agency Financial Report located at http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf.

GAO High Risk Items

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

The programs identified by GAO are:

CMS - Medicare Program
CMS - Medicaid Program
FDA - Revamping Federal Oversight of Food Safety
FDA - Protecting Public Health through Enhanced Oversight of Medical Products

To read about HHS's progress toward addressing these high-risk items, find the 2013 GAO High-Risk Series Update here: http://www.gao.gov/assets/660/652133.pdf

A copy of the CMS plan for addressing risk within Medicare and Medicaid programs is available at: http://www.cms.gov/apps/files/2013_CMS_GAO_High_Risk_Program_Report.pdf

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

Lower-Priority Program Activities

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

Changes in Performance Measures

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2014 REPORT Released 4/2013	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
ACF	22.2LT and 22B	Revise	Increase the percentage of adult TANF recipients who become newly employed.	Increase the percentage of newly employed adult TANF recipients.	This change is a minor reordering of the current language in order to improve clarity.
ACL	3.2	Revise	Increase the number of older persons with severe disabilities who receive home-delivered meals.	Increase the percentage of older persons with severe disabilities who receive home-delivered meals.	Changing from a number to a percentage will make the measure more budget neutral.
AHRQ	1.3.38	Revise FY 14 Target	1400 users of research	1350 users of research	Users of research is not increasing at the rate predicted in earlier target setting.
AHRQ	4.4.5	Retire	Increase the number of Effective Health Care (EHC) Program products	Retire	As of FY 2014, PCHR portfolio activities will no longer be funded by appropriated funding.
CDC	3.2.1	Retire	Decrease the number of antibiotic courses prescribed for ear infections in children under five years of age per 100 children. (Outcome)	Retire	This measure does not represent a significant budget activity, and CDC has a limited ability to directly impact this complex issue. Additionally, this measure is only a small representation of antibiotic prescribing patterns and may not accurately reflect all changes in prescribing behavior.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2014 REPORT Released 4/2013	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
CMS	MCR25	Revise	FY 2014 2.3 million	Report as a contextual measure	CMS leadership has directed that, going forward, this will no longer be a GPRA goal with a target, but instead will be reported as a contextual measure.
CMS	MCR28.1	Revise measure	FY 2014 Target TBD	Revise measure. MCR28.1 will remain a GPRA goal, but will not be part of the FY 2014-15 HAI Agency Priority Goal.	The Healthcare Associated Infection Agency Priority Goal workgroup feels that CLABSI is nearly tapped out, meaning there aren't any significant interventions in place in which they confidently believe we can demonstrate improvement over the next two (2) years. CMS has begun discussions to adjust the HHS Strategic Plan to reflect, that CLABSI will no longer be included in the agency priority goal.
CMS	MSC1	Revise FY 2014 Target	6.9%	6.7%	Target was reduced due to success of the FY 2012 result. With the recent budget cuts, however, our goal will be to avoid backsliding of the measure.
CMS	PHI2	Revise measure	9.7 million	Retire targeted measure after FY 2014. Report as a contextual indicator after FY 2014.	This number will be reported as a contextual measure for the HHS Strategic Plan in the future as new coverage options become available to young adults in 2014.
CMS	QIO4	Retire	99%	Retire in FY 2015	This goal has reached its upper-limits. Also, due to the possibility of negative con-sequences (antibiotic overuse) continuing to increase the target, causing additional negative health consequences to the beneficiary, we propose discontinuing after FY 2014.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2014 REPORT Released 4/2013	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
FDA	223205	Revise FY 2014 Target	2,500	2,200	This revision is due to a provision in GDUFA which changes the methodology for counting the total ANDA actions. Prior to GDUFA, individual deficiency letters were communicated to the sponsor from the responsible disciplines (chemistry, bioequivalence, labeling, microbiology, etc.). Beginning in FY 2013, the GDUFA Commitment Letter requires a single Complete Response letter, as opposed to multiple deficiency letters from each discipline. The lower target reflects this logistical change in counting actions, but does not reflect an actual drop in performance.
FDA	280005	Revise FY 2014 Target	Total number of compliance check inspections of retail establishments in States under contract. Target: 80,000	Total number of compliance check inspections of retail establishments in States under contract. Target: 85,000	Target increased by 5,000
HRSA	16.I.A.1	Revise wording	Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served.	Proportion of persons served by the Ryan White HIV/AIDS Program who are racial/ethnic minorities.	The revised wording makes the statement of the performance measure more technically correct.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2014 REPORT Released 4/2013	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
HRSA	6.I.C.2	Revise wording	Percentage of health professionals supported by Bureau of Health Professions programs who enter practice in underserved areas	Percentage of individuals supported by Bureau of Health Professions who completed a primary care training program and are currently employed in underserved areas	Previous wording was vague and assumed all program completers and graduates were eligible to enter practice. In some cases, graduates or completers move on to additional or more advanced training opportunities. Revising the wording will better reflect the type of data collected to support this measure
HRSA	10.I.A.1	Revise wording	Increase the number of children served by the Maternal and Child Health Block Grant	Number of children served by the Maternal and Child Health Block Grant	Remove word "increase" to be consistent with how this measure is to be worded in the OPA and new HHS Strategic Plan
HRSA	4.I.C.1 4.I.C.2	Target change	Number of individuals served by NHSC clinicians and Field strength of NHSC	FY 2014 target changes	These measures are budget dependent. Since the enacted FY 2013 budget differed from the CR assumptions used in the FY 2014 CJ, the FY 2014 field strength (and hence patients served) targets changed.
HRSA	1.I.A.1	Target change	Number of patients served by health centers	Number of patients served by health centers	FY 2014 target changed due to funding level
HRSA	29.IV.A.3	Revise measure wording	Increase the number of people receiving direct services through Outreach grants	Increase the number of people receiving direct services through Office of Rural Health Policy Outreach grants	Changed to make the program clearer.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2014 REPORT Released 4/2013	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
HRSA	24.II.A.2	Target change	Increase the number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups	Increase the number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups	FY 2014 target changed to reflect higher past performance
HRSA/ OASH	36.II.B.1	Target change	Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24	Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24	FY 2014 target changed to reflect resources and prior performance
NIH	CBRR-10	Revised FY 2014 Target	Increase the Molecular Libraries Program (MLP) inventory to 350 small molecule probes that can be used in biological research to interrogate basic biological processes or disease.	Increase the Molecular Libraries Program (MLP) inventory to 375 small molecule probes that can be used in biological research to interrogate basic biological processes or disease.	The network is continuously improving in both speed and quality of the probes produced resulting in a greater than expected inventory of small molecule probes.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2014 REPORT Released 4/2013	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
NIH	SRO-5.13	Revised FY 2014 Target	Test 10,000 compound main library in an additional 25 qHTS and test 30 subsets of possible high risk chemicals in high-content screens.	Test 10,000 compound main library in an additional 15 qHTS and test 20 subsets of possible high risk chemicals in high-content screens.	The partial shutdown in October 2013 caused a delay in work, and the robot used in this program that conducts most of the testing is not yet back online. Additionally, the sequester will reduce funding for HTS activities by an additional 25%.
NIH	SRO-8.7	Revised Measure	By 2015, identify three (3) key factors influencing the scaling up of research-tested interventions across large networks of services systems such as primary care, specialty care and community practice.	By 2018, identify three effective system interventions generating the implementation , sustainability and ongoing improvement of research-tested interventions across health care systems.	The measure is extended and revised to support the HHS Strategic Plan 2014-2018.
OASH	6.1.5	Retire	Enhance the Department's capability to rapidly and appropriately respond to medical emergencies and urgent health needs, through maintaining response teams. (baseline – 2007: 46) (Outcome)	Retire	Change in mission focus for the Commissioned Corps as well as Departmental resources dedicated to Corps' training and readiness.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2014 REPORT Released 4/2013	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
OMHA	1.1.1	Revise FY 2014 Target	Increase the percentage of BIPA cases closed within 90 days to 39%	Increase the percentage of BIPA cases closed within 90 days to 21%	Significant increases in FY 2013 appeals and in FY 2014 projection

Data Sources and Validation

Administration for Children and Families (ACF)

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

Measure ID	Data Source	Data Validation
1.1LT and 1B (ACF)	State *LIHEAP Household Report* and Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey	ACF obtains weighted national estimated numbers of LIHEAP income eligible (low income) households from the Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey. The estimates are subject to sampling variability. The Census Bureau validates ASEC data. ACF aggregates data from the states' annual *LIHEAP Household Report* to furnish national counts of LIHEAP households that receive heating assistance (including data on the number of LIHEAP recipient households having at least one member who is 60 years or older and the number of LIHEAP recipient households having at least one member who is five years or younger). The aggregation and editing of state-reported LIHEAP recipiency data for the previous fiscal year are typically completed in September of the following fiscal year. Consequently, the data are not available in time to modify ACF interventions prior to the current fiscal year (i.e. there is at least a one-year data lag). There are no federal quality control or audit requirements for the data obtained from the *LIHEAP Household Report*. However ACF provides to states an electronic version of the *LIHEAP Household Report* that includes formulae that protect against mathematical errors. ACF also cross checks the data against LIHEAP benefit data obtained from the states' submission of the annual *LIHEAP Grantee Survey* on sources and uses of LIHEAP funds.
2B (ACF)	Biennial CCDF Report of State Plans	The CCDF State Plan preprint requires states to provide information about their progress in implementing the program components related to professional development and early learning. On a biennial basis, the information for this measure will be available through state plans.

Measure ID	Data Source	Data Validation
3A (ACF)	Classroom Assessment Scoring System (CLASS: Pre-K)	CLASS: Pre-K is a valid and reliable tool that uses observations to rate the interactions between adults and children in the classroom. Reviewers, who have achieved the standard of reliability, assess classroom quality by rating multiple dimensions of teacher-child interaction on a seven point scale (with scores of one to two being in the low range; three to five in the mid-range; and six to seven in the high range of quality). ACF will implement ongoing training for CLASS: Pre-K reviewers to ensure their continued reliability. Periodic double-coding of reviewers will also be used, a process of using two reviewers during observations to ensure they continue to be reliable in their scoring.
3C (ACF)	Program Information Report (PIR)	The PIR is a survey of all grantees that provides comprehensive data on Head Start, Early Head Start and Migrant Head Start programs nationwide. Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.
3F (ACF)	Program Information Report (PIR)	The PIR is a survey of all grantees that provides comprehensive data on Head Start, Early Head Start and Migrant Head Start programs nationwide. Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.
4.1LT and 4A (ACF)	The Runaway and Homeless Youth Management Information System (RHYMIS)	RHYMIS incorporates numerous business rules and edit checks, provides a hot-line/help desk and undergoes continuous improvement and upgrading. Extensive cleanup and validation of data take place after each semi-annual transfer of data from grantee systems into the national database. Historically, the reporting response rate of grantees has exceeded 97 percent every year.

Measure ID	Data Source	Data Validation
7D (ACF)	State Annual Reports	States are required to submit an Annual Report addressing each of the CBCAP performance measures outlined in Title II of CAPTA. One section of the report must "provide evaluation data on the outcomes of funded programs and activities." The 2006 CBCAP Program Instruction adds a requirement that the states must also report on the OMB performance measures reporting requirements and national outcomes for the CBCAP program. States were required to report on this new efficiency measure starting in December 2006. The three percent annual increase represents an ambitious target since this is the first time that the program has required programs to target their funding towards evidence-based and evidence-informed programs, and it will take time for states to adjust their funding priorities to meet these new requirements.
7P1 (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). States' Statewide Automated Child Welfare Information Systems (SACWIS) are undergoing reviews to determine the status of their operation and the system's capability of reporting accurate AFCARS data. To speed improvement in these data, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.

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

Measure ID	Data Source	Data Validation
7Q (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). States' Statewide Automated Child Welfare Information Systems (SACWIS) are undergoing reviews to determine the status of their operation and the system's capability of reporting accurate AFCARS data. To speed improvement in these data, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.
7S (ACF)	Regulatory Title IV-E Foster Care Eligibility Reviews	Data validation occurs on multiple levels. Information collected during the onsite portion of the review is subject to quality assurance procedures to assure the accuracy of the findings of substantial compliance and reports are carefully examined by the Children's Bureau Central and Regional Office staff for accuracy and completeness before a state report is finalized. Through the error rate contract, data is systematically monitored and extensively checked to make sure the latest available review data on each state is incorporated and updated to reflect rulings by the Departmental Appeals Board and payment adjustments from state quarterly fiscal reports. This ensures the annual program error rate estimates accurately represent each state's fiscal reporting and performance for specified periods. The Children's Bureau also has a database (maintained by the contractor) that tracks all key milestones for the state eligibility reviews.

Measure ID	Data Source	Data Validation
12B (ACF)	CSBG Information System (CSBG/IS) survey administered by the National Association for State Community Services Programs (NASCSP)	The Office of Community Services (OCS) and NASCSP have worked to ensure that the survey captures the required information. The CSBG Block Grant allows states to have different program years; this can create a substantial time lag in preparing annual reports. States and local agencies are working toward improving their data collection and reporting technology. In order to improve the timeliness and accuracy of these reports, NASCSP and OCS are providing states training, and better survey tools and reporting processes.
14D (ACF)	SF-PPR, Family Violence Prevention and Services Program Progress Report Form	Submission of this report is a program requirement. The outcome measures and the means of data collection were developed with extensive input from researchers and the domestic violence field. The forms, instructions, and several types of training have been given to states, tribes and domestic violence coalitions.
16.1LT and 16C (ACF)	Matching Grant Progress Report forms	Data are validated with methods similar to those used with Performance Reports. Data are validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages, and retentions.
18.1LT and 18A (ACF)	Performance Report (Form ORR-6)	Data are validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages, and retentions.

Measure ID	Data Source	Data Validation
20C (ACF)	Office of Child Support Enforcement (OCSE) Form 157	States currently maintain information on the necessary data elements for the above performance measures. All states were required to have a comprehensive, statewide, automated Child Support Enforcement system in place by October 1, 1997. Fifty-three states and territories were Family Support Act-certified and Personal Responsibility and Work Opportunity Reconciliation Act-certified (PRWORA) as of July 2007. Certification requires states to meet automation systems provisions of the specific act. Continuing implementation of these systems, in conjunction with cleanup of case data, will improve the accuracy and consistency of reporting. As part of OCSE's audit of performance data, OCSE Auditors review each state's and territory's ability to produce valid data. Data reliability audits are conducted annually. Self-evaluation by states and OCSE audits provide an on-going review of the validity of data and the ability of automated systems to produce accurate data. Each year OCSE Auditors review the data that states report for the previous fiscal year. The OCSE Office of Audit has completed the FY 2010 data reliability audits. Since FY 2001, the reliability standard has been 95 percent.
22.2LT and 22B (ACF)	National Directory of New Hires (NDNH)	Beginning with performance in FY 2001, the above employment measures – job entry, job retention, and earnings gain – are based solely on performance data obtained from the NDNH. Data are updated by states, and data validity is ensured with normal auditing functions for submitted data. Prior to use of the NDNH, states had flexibility in the data source(s) they used to obtain wage information on current and former TANF recipients under high performance bonus (HPB) specifications for performance years FY 1998 through FY 2000. ACF moved to this single source national database (NDNH) to ensure equal access to wage data and uniform application of the performance specifications.

Administration for Community Living (ACL)

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

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

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

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

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

Agency for Healthcare Research and Quality (AHRQ)

Measure ID	Data Source	Data Validation

Measure ID	Data Source	Data Validation
1.3.21 (AHRQ)	MEPS website	Data published on website (http://meps.ahrq.gov/) A number of steps are taken from the time of sample selection up to data release to ensure the reliability and accuracy of MEPS data including: • Quality control checks are applied to the MEPS sample frame when it is received from NCHS as well as to the subsample selected for MEPS. • Following interviewer training, performance is monitored through interview observations and validation interviews. • A variety of materials and strategies are employed to stimulate and maintain respondent cooperation. • All manual coding and data entry tasks are monitored for quality by verification at 100 percent until an error rate of less than 2 percent is achieved for coding work or less than 1 percent for data entry. • All specifications developed to guide the editing, variable construction and file creation are monitored through data runs that are used to verify that processes are conducted correctly and to identify data anomalies. • Analytic weights are developed in a manner that reduces nonresponse bias and improves national representativeness of survey estimates. • The precision of survey estimates are reviewed to insure they are achieving precision specifications for the survey. • Prior to data release, survey estimates on health care utilization, expenditures, insurance coverage, priority conditions and income are compared to previous year MEPS data and other studies. Significant changes in values of constructed variables are investigated to determine whether differences are attributable to data collection or variable construction problems that require correction. • Expenditure data obtained from the MEPS medical provider survey are used to improve the accuracy of household reported data.

Measure ID	Data Source	Data Validation
1.3.38 (AHRQ)	Surveys/case studies	The Hospital Survey on Patient Safety Culture (HSOPS) is a survey which measures organization patient safety climate. AHRQ staff - from the Patient Safety Portfolio and the Office of Communications and Knowledge Transfer (OCKT) – in collaboration with Westat, the HSOPS support contractor, have developed methods and conducted validation studies of HSOPs using a multi-modal approach. First, we have compared HSOPs to the AHRQ Patient Safety Indicators (PSIs), which are based on individual hospital administrative data and are indicators of harm. Next, AHRQ compared HSOPS to HCAHPS, which characterizes the patient's experience with care. In addition, we have compared HSOPS to CMS pay-for-performance-measures. Finally, AHRQ has conducted multiple case studies of the utilization and implementation of HSOPS by individual hospitals and hospital systems.
4.4.5 (AHRQ)	All AHRQ systematic reviews are entered into a database, which is used to populate the AHRQ Effective Health Care Program Web site, http://effectivehealthcare.ahrq.gov.	Effective Health Care program products that are available to clinicians, consumers, and policymakers are counted biweekly and made available on the internet through the AHRQ Effective Health Care Program Web site. This is achieved by searching the EHC Web site and identifying all products that were released that period. Within 10 days of the end of each quarter the PCHR Portfolio lead or designate generates a list of published products. The count as well as the supporting list of reviews for each quarter can be found on AHRQ's shared drive. Each document listed and counted on the report can be independently verified by inspection at the AHRQ Effective Health Care Program Web site.

Assistant Secretary for Administration (ASA)

Measure ID	Data Source	Data Validation
1.1 (ASA)	Manual data calls for telework information through the use of spreadsheets.	Office of Human Resources Telework Liaisons
1.2 (ASA)	HHS data for fleet statistics comes from analysis and output via a resource called the Federal Automotive Statistical Tool (FAST). The input for the HHS data comes from an internal HHS data resource called the HHS Motor vehicle Management Information System (MVMIS). Per the intent of the metric, HHS's measure reflects actual fleet performance values when excluding all fuel products used by HHS law enforcement, protective, emergency response or military tactical vehicles (if any).	Both the FAST and MVMIS have internal validation processes
1.3 (ASA)	OCIO HHS administrative data.	
2.1 (ASA)	HHS personnel records	

Assistant Secretary for Preparedness and Response (ASPR)

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

Centers for Disease Control and Prevention (CDC)

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

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

Measure ID	Data Source	Data Validation
2.1.8 (CDC)	National HIV surveillance system	CDC conducts validation and evaluation studies of the data systems which monitor HIV to determine the quality of data generated by them. HIV data for 2010 are reported data from all 50 states. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". CDC requires a minimum of 12 months after the end of a calendar year to provide accurate trend data.
2.2.4 (CDC)	DHAP Legal Assessment Project	The Legal Assessment Project (LAP) is a legal research and policy analysis project led by CDC's Division of HIV/AIDS Prevention, Office of the Director. Using standard legal research methods, the LAP researches state statutes, regulations, and policies that affect states' ability to conduct effective HIV prevention.
2.8.1 (CDC)	The National TB Surveillance System	TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.
3.2.1 (CDC)	National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; and National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS	A 10% quality control sample of survey records was independently keyed and coded.
3.3.2a (CDC)	Emerging Infections Program / Active Bacterial Core Surveillance/Emerging Infections Program Surveillance for Invasive MRSA Infections	Surveillance Site personnel trained in methodology, updates annually; laboratory audits performed by Site staff
3.3.4 (CDC)	National Healthcare Safety Network (NHSN)	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.

Measure ID	Data Source	Data Validation
4.6.3 (CDC)	National Health Interview Survey, NCHS	NCHS validates the data
4.6.5 (CDC)	The primary data source for setting and reporting targets is the Youth Risk Behavior Surveillance System (YRBSS), which monitors priority health-risk behaviors and is conducted every other year (odd years). Beginning in FY 2011, the National Youth Tobacco Survey (NYTS) was added as an additional data source, which tracks closely with YRBSS. To obtain data on an annual basis, CDC will conduct the NYTS in the intervening years.	Validity and reliability studies of YRBSS and NYTS attest to the quality of the data. CDC conducts quality control and logical edit checks on each record
4.11.9 (CDC)	National Health Interview Survey (NHIS), CDC, NCHS	Data are reported from a national surveillance system and follows predetermined quality control standards.
7.2.4 (CDC)	National Highway Traffic Safety Administration Fatal Analysis Reporting System (FARS)	Data are from police accident reports for any crash on a public road that resulted in a fatality within 30 days of the crash. Each police accident report of an eligible crash is then entered into the national "Fatal Analysis Reporting System" database (FARS). The quality of the data is reviewed by state FARS data coordinator.
8.B.2.2 (CDC)	Electronic media reach of CDC Vital Signs is measured by CDC.gov web traffic and actual followers and subscribers of CDC's social media, e-mail updates and texting service The data source for this measure is Omniture® web analytics, which is a software product that provides consolidated and accurate statistics about interactions with CDC.gov and social media outlets as individuals seek and access information about *CDC Vital Signs.*	Monthly review of Omniture data by CDC Office of the Associate Director for Communication (OADC) and Vital Signs staff.
8.B.2.5 (CDC)	The data source for this measure is Omniture® web analytics, which is a software product that provides consolidated and accurate statistics about interactions with CDC.gov	Ongoing review of Omniture reports by Community Guide staff.

Measure ID	Data Source	Data Validation
8.B.4.2 (CDC)	Data are compiled annually at the end of the fiscal year to count the total number of trainees in field assignments in state, tribal, local, and territorial public health agencies. Data for each fiscal year represent the number of CDC directly-funded fellows in place at the end of the fiscal year and the fellows funded with contracts using funds from that fiscal year. In 2009, this measure included the Epidemic Intelligence Service (EIS), Preventive Medicine Residency/Fellowship (PMR/F), Public Health Prevention Service (PHPS), and the Public Health Associate Program (PHAP), formerly known as the Public Health Apprentice Program; the Public Health Informatics Fellowship Program (PHIFP) was added in 2010; the CDC-supported Emerging Infectious Diseases (EID) Laboratory Fellowships, CDC/Council of State and Territorial Epidemiologists' (CSTE) Applied Epidemiology Fellowship, Post-EIS Practicum (now known as the Health Systems Integration Program), PHPS Residency, and Applied Public Health Informatics Fellowship were added to the measure in FY 2011. The PHPS Residency pilot program ended in FY 2012. Trainees funded by other federal agencies are excluded.	Staff reviews and validates data through the fellowship programs' personnel systems.
8.B.4.3 (CDC)	Data are compiled annually at the end of the fiscal year to count the number of new trainees entering classes in the Epidemic Intelligence Service (EIS), Preventive Medicine Residency/Fellowship (PMR/F), Public Health Prevention Service (PHPS), Public Health Informatics Fellowship (PHIF), Prevention Effectiveness (PE) Fellowship, and Presidential Management Fellows (PMF) programs. As of 2010, Public Health Associate Program (PHAP) trainees are included. Trainees funded by other federal agencies are excluded.	Staff reviews and validates data through the fellowship programs' personnel systems.

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

Centers for Medicare & Medicaid Services (CMS)

Measure ID	Data Source	Data Validation
CHIP 3.3 (CMS)	Statistical Enrollment Data System	Each State must assure that the information is accurate and correct when the information is submitted to SEDS by certifying that the information shown on the CHIP forms is correct and in accordance with the State's child health plan as approved by the Secretary. CMS staff populates the data into various SEDS reports and verifies each of the enrollment measures. Each form has the following seven measures that are reported by service delivery system: 1: Unduplicated Number Ever Enrolled During the Quarter. 2: Unduplicated Number of New Enrollees in the Quarter. 3: Unduplicated Number of Disenrollees in the Quarter. 4: Number of Member-Months of Enrollment in the Quarter. 5: Average Number of Months of Enrollment (item 4 divided by item 1). 6: Number Enrolled At Quarter's End (point in time). 7: Unduplicated Number Ever Enrolled in the Year" (4th Quarter Only). CMS compares these enrollment measures to past quarters and trends over the life of each program to ensure that there aren't any anomalies in the data, and if apparent errors are detected, CMS corresponds with the State staff who are responsible for reporting enrollment statistics. If there are major increases or decreases, CMS investigates the causes of the changes in enrollment patterns.
MCD6 (CMS)	Developmental. The core set of measures required under CHIPRA was published in December 2009. CMS will initially use the automated web-based system - CHIP Annual Reporting Template System (CARTS) for the reporting of quality measures developed by the new program. This is the same system that was used for the CHIP Quality GPRA goal that was discontinued after FY 2010 (MCD2).	Developmental. CMS will monitor performance measurement data related to the core set of measures through CARTS.

Measure ID	Data Source	Data Validation
MCD8 (CMS)	Developmental. The core set of adult health care quality measures (Medicaid Adult Core Set) required under the Affordable Care Act Section 2701 was published in January 2012. CMS currently uses the automated web-based Medicaid Adult Quality Measures Template in the CHIP Annual Reporting Template System (CARTS) as the data source for assessing states' progress in reporting standardized adult health quality measurement data to CMS.	Developmental. CMS will monitor performance measurement data related to the core set of measures through CARTS.
MCR1.1a (CMS)	The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in all Medicare Advantage plans and in the original Medicare fee-for-service plan.	The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 4.0 Survey and Reporting Kit developed by the AHRQ. This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.
MCR1.1b (CMS)	The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in the original Medicare fee-for-service plan and in all Medicare Advantage plans.	The Medicare CAHPS are administered according to the standardized protocols as delineated in the Medicare Advantage and Prescription Drug Plan CAHPS Survey Quality Assurance Protocols & technical Specifications available at www.ma_pdpcahps.org. This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully analyzed and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.
MCR22 (CMS)	The PFS rules and regulations; the Relative Value Scale Update Committee (RUC) database; relevant PFS utilization data available at the time of analysis.	In progress. We conduct a series of clinical review meetings to check the appropriate valuation of the codes identified as potentially misvalued.

Measure ID	Data Source	Data Validation
MCR23 (CMS)	The Prescription Drug Event (PDE) data	CMS has a rigorous data quality program for ensuring the accuracy and reliability of the PDE data. The first phase in this process is on-line PDE editing. The purpose of on-line editing is to apply format rules, check for legal values, compare data in individual fields to other known information (such as beneficiary, plan, or drug characteristics) and evaluate logical consistency between multiple fields reported on the same PDE. On-line editing also enforces business order logic which ensures only one PDE is active for each prescription drug event. The second phase of our data quality program occurs after PDE data has passed all initial on-line edits and is saved in our data repository. We conduct a variety of routine and ad hoc data analysis of saved PDEs to ensure data quality and payment accuracy.
MCR25 (CMS)	The Common Working File (CWF) will be the primary data source for this analysis; the claims will undergo final-action to be consistent with the data available in the Integrated Data Repository (IDR) database. The claims will be used to identify Annual Wellness Exams for Original Medicare beneficiaries, using HCPCS code G0438 for Part B FFS initial AWV claims as well as the HCPCS code G0439 for subsequent AWVs. The baseline will consist of the total number of beneficiaries receiving any AWV claim in 2011 (the first year of the benefit), and will help inform future target estimates. CMS will base future annual utilization goals on the number of unique beneficiaries receiving any AWV service as estimated in total by the end of the most recent calendar year.	The CWF contains claims that are submitted by providers to Medicare and are from Systems of Record or other authoritative data sources. AWV utilization rates for Part B beneficiaries will be calculated and compared to previous months' or years' data to check for any unusual changes in data values.
MCR26 (CMS)	Medicare claims data. The data used to calculate the performance measures are administrative claims data submitted by hospitals and Medicare Advantage plans. Administrative claims data is a validated data source and is the data source for public reporting of hospital readmission rates on the Hospital Compare website (www.hospitalcompare.hhs.gov). ; As stated on the Hospital Compare website, research conducted when the measures were being developed demonstrated that the administrative claims-based model performs well in predicting readmissions compared with models based on chart reviews.	The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. CMS uses national administrative inpatient hospital claims data to calculate the readmission rate measure. The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. Inpatient hospital claims information is assumed to be accurate and reliable as presented in the database.

Measure ID	Data Source	Data Validation
MCR28.1 (CMS)	The CDC National Healthcare Safety Network	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
MCR28.2 (CMS)	The CDC National Healthcare Safety Network	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
MIP1 (CMS)	Comprehensive Error Rate Testing (CERT) Program.	The CERT program is monitored for compliance by CMS through monthly reports from the contractors. In addition, the OIG periodically conducts reviews of CERT and its contractors.
MIP5 (CMS)	The Part C Error Rate is comprised of the Risk Adjustment Payment Error (RAE) Estimate. The RAE measures errors in diagnostic data submitted by plans to Medicare. The diagnostic data is used to determine risk adjusted payments made to plans.	Data used to determine the Part C composite payment error rate is validated by several contractors. The Part C RAE estimate is based on data obtained from a rigorous Risk Adjustment Data Validation process in which medical records are reviewed by two independent coding entities in the process of confirming discrepancies for a national random sample of beneficiaries.

Measure ID	Data Source	Data Validation
MIP6 (CMS)	The components of payment error measurement in the Part D program are: A rate(s) that measures payment errors related to low income subsidy (LIS) payments for beneficiaries dually-eligible for Medicare and Medicaid and non-duals also eligible for LIS status. A rate that measures payment errors from errors in Prescription Drug Event (PDE) records. A PDE record represents a prescription filled by a beneficiary that was covered by the plan. A rate that measures payment errors resulting from incorrect assignment of Medicaid status to beneficiaries who are not dually eligible for Medicare and Medicaid. A rate that measures payment errors from errors in Direct and Indirect Remuneration (DIR) amounts reported by Part D sponsors to CMS. DIR is defined as price concessions (offered to purchasers by drug manufacturers, pharmacies, or other sources) that serve to decrease the costs incurred by the Part D sponsor for prescription drugs.	For the Part D component payment error rates, the data to validate payments comes from multiple internal and external sources, including CMS' enrollment and payment files. Data are validated by several contractors. Data for the LIS payment error measure come from CMS' internal payment and enrollment files for all Part D plan beneficiaries. Data for the PDE error measure come from CMS' PDE Data Validation process, which validates PDE data through contractor review of supporting documentation submitted to CMS by a national sample of Part D plans. The data element for incorrect Medicaid status is the PERM eligibility error rate, which is validated by the Medicaid program for the entire Medicaid population and is used by the Part D program as a proxy for incorrect Medicaid status. From the population of Part D beneficiaries who are eligible for Medicare and Medicaid, we randomly assign a subset, equal to the PERM rate, to be ineligible for Medicaid, resulting in payment error. Data for the DIR error measure come from audit findings for a national sample of Part D plans; the audits are conducted by contractors as part of the Financial Audit process conducted by CMS' Office of Financial Management (OFM).
MIP8 (CMS)	Our predictive analytics work, using FPS, will focus on activities in the areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk-based approach increases contractors' efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud	FPS captures the link between each individual ASR and each subsequent administrative action. The FPS Dashboard and supporting systems will enable a seamless reporting of all data necessary to develop the baseline and to measure performance against any future targets.
MIP9.1 (CMS)	As part of a national contracting strategy, adjudicated claims data and medical policies are gathered from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS and our contractors are working with the 17 States to ensure that the Medicaid and CHIP universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews.

Measure ID	Data Source	Data Validation
MIP9.2 (CMS)	As part of a national contracting strategy, adjudicated claims data and medical policies are gathered from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS and our contractors are working with the 17 States to ensure that the Medicaid and CHIP universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews.
MSC1 (CMS)	Nursing homes submit this information to the State Minimum Data Set database, which is linked to the national Minimum Data Set database.	The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self-reported by the nursing home. MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. Beginning in FY 2011, the data source is changed from MDS version 2.0 to MDS version 3.0. Beginning with the FY 2012 reporting period, we are reporting the prevalence of pressure ulcers, stage 2 and greater, in high-risk long stay residents. The previous measure included pressure ulcers, stage 1 through stage 4 for all long stay nursing home residents.
PHI2 (CMS)	Current Population Survey Annual Social and Economic Supplement (CPS-ASEC) data	National Health Insurance Survey (NHIS) data
PHI4.1 (CMS)	Exchange IT System Metrics	Operational standard operating procedures will include audit and verification of system metric output.
QIO4 (CMS)	Baseline State-level performance rates calculated using self-reported and validated data abstracted from hospitals participating in the CMS Hospital Inpatient Quality Reporting (IQR) program.	The accuracy and reliability of data from the QIO Clinical Warehouse are monitored constantly through reabstraction of a sample of approximately 48 medical records per year by the CMS Data Abstraction Center (CDAC) for a random sample of 800 hospitals per year.
QIO5 (CMS)	Data is self-reported by the dialysis facilities. Dialysis facilities submit directly to the 18 ESRD Networks who then submit directly to CMS through a file transfer.	Prior to monthly ESRD Network dashboard publishing, edit checks are programmed to ensure that only eligible facilities are reporting. A further check is conducted using a trend report comparing over 70% of all reported data with historical trends to ensure that missing case rates and case counts are in line with monthly annual trends.

Food and Drug Administration (FDA)

Measure ID	Data Source	Data Validation
212409 (FDA)	CDC/FoodNet	FoodNet Annual Reports are summaries of information collected through active surveillance of nine pathogens. A preliminary version of this report becomes available in the spring of each year and forms the basis of each year's Morbidity and Mortality Weekly Report (MMWR) FoodNet Surveillance. The FoodNet Final Report becomes available later in the year when current census information becomes available. The illness rates calculated for this Priority Goal use the same data and same methodology as the illness rates in the MMWR.. CDC's FoodNet system reports pathogen-specific illness data based on the calendar year, not the fiscal year. Therefore, achievement of the annual targets reported here is evaluated based on the calendar year data, not fiscal year data.
214305 (FDA)	Field Data Systems	These maximum capacities are extrapolated to estimate for times of emergency with the laboratory operating under abnormal conditions that are variable and uncertain. FDA and FERN work to maximize capabilities by continually improving methods and training along with increasing automated functionality and available cache of supplies. Through using these laboratories, with known instrumentation and methods, after examining the sample throughput during emergencies, and after consultation with the laboratories and FDA subject matter experts, the listed sample totals are the estimates reached. The surge capacity estimates provided in the performance measures for these laboratories have been examined under the stress of emergencies and outbreaks such as the melamine contamination, Deepwater Horizon oil spill, and the Japan nuclear event.

Measure ID	Data Source	Data Validation
214306 (FDA)	BioPlex and ibis Biosensor systems	CFSAN scientists have developed the means to evaluate and adapt commercially available instruments to develop and validate more rapid, accurate, and transportable tests to stop the spread of foodborne illness and cases of chemical contamination. Using one such system, known as Bioplex, CFSAN scientists are using the device to rapidly serotype pathogens such Salmonella. The Bioplex system can serotype 48 different samples in 3 to 4 hours, which vastly improves response time in foodborne illness outbreaks. CFSAN scientists also are using the ibis Biosensor system to speed the identification of Salmonella, E. coli, and other pathogens, toxins, and chemical contaminants.
223205 (FDA)	Review performance monitoring is being done in terms of cohorts, e.g., FY 2009 cohort includes applications received from October 1, 2008, through September 30, 2009. CDER uses the Document Archiving, Reporting, and Regulatory Tracking System (DARRTS). FDA has a quality control process in place to ensure the reliability of the performance data in DARRTS.	The Document Archiving, Reporting, and Regulatory Tracking System (DARRTS) is CDER's enterprise-wide system for supporting premarket and postmarket regulatory activities. DARRTS is the core database upon which most mission-critical applications are dependent. The type of information tracked in DARRTS includes status, type of document, review assignments, status for all assigned reviewers, and other pertinent comments. CDER has in place a quality control process for ensuring the reliability of the performance data in DARRTS. Document room task leaders conduct one hundred percent daily quality control of all incoming data done by their IND and NDA technicians. Senior task leaders then conduct a random quality control check of the entered data in DARRTS. The task leader then validates that all data entered into DARRTS are correct and crosschecks the information with the original document.
234101 (FDA)	CBER's Office of Vaccines Research and Review; and CBER's Emerging and Pandemic Threat Preparedness Office	The data are validated by the appropriate CBER offices and officials.
252202 (FDA)	CDRH Adverse Events Reports	FDA's adverse event reporting system's newest component is the Medical Device Surveillance Network (MedSun) program. MedSun is an initiative designed both to educate all health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events, medical errors and other problems to FDA and/or the manufacturer, and to ensure that new safety information is rapidly communicated to the medical community thereby improving patient care.

Measure ID	Data Source	Data Validation
262401 (FDA)	NCTR Project Management System; peer-review through FDA/NCTR Science Advisory Board (SAB) and the NTP Scientific Board of Counselors; presentations at national and international scientific meetings; use of the predictive and knowledge-based systems by the FDA reviewers and other government regulators; and manuscripts prepared for publication in peer-reviewed journals.	NCTR provides peer-reviewed research that supports FDA's regulatory function. To accomplish this mission, it is incumbent upon NCTR to solicit feedback from its stakeholders and partners, which include FDA product centers, other government agencies, industry, and academia. The NCTR SAB —composed of non-government scientists from industry, academia, and consumer organizations, and subject matter experts representing all of the FDA product centers—is guided by a charter that requires an intensive review of each of the Center's scientific programs at least once every five years to ensure high quality programs and overall applicability to FDA's regulatory needs. Scientific and monetary collaborations include Interagency Agreements with other government agencies, Cooperative Research and Development Agreements that facilitate technology transfer with industry, and informal agreements with academic institutions. NCTR also uses an in-house strategy to ensure the high quality of its research and the accuracy of data collected. Research protocols are often developed collaboratively by principal investigators and scientists at FDA product centers and are developed according to a standardized process outlined in the "NCTR Protocol Handbook." NCTR's Project Management System tracks all planned and actual expenditures on each research project. The Quality Assurance Staff monitors experiments that fall within the Good Laboratory Practices (GLP) guidelines. NCTR's annual report of research accomplishments, goals, and publications is published and available on FDA.gov. Research findings are published in peer-reviewed journals and presented at national and international scientific conferences.
280005 (FDA)	CTP's Tobacco Inspection Management System (TIMS) is a database that contains the tobacco retail inspection data submitted by state and territorial inspectors commissioned by FDA.	CTP/OCE has in place a process for ensuring the quality of the data in TIMS. OCE staff conduct random quality control checks of inspection data submitted for tobacco retail inspections where no violations were found. OCE staff conduct quality control checks for all tobacco retail inspections where potential violations were found.

Measure ID	Data Source	Data Validation
293206 (FDA)	FDA Nanotechnology Task Force; National Nanotechnology Initiative (NNI); Science Board to the FDA; FDA staff presentations at public meetings; and manuscripts and other written materials for publication in peer-reviewed journals and other communication forums.	FDA will validate its efforts in promoting innovation and predictability in the development of safe and effective nanotechnology-based products by assessing outcomes and other progress in five areas related to nanotechnology including science, research, policy, communication, and planning. Information from several data sources and relevant FDA activities will provide measures in the five areas related to nanotechnology. Information will be gathered and documented from multiple data sources, which may include agency source data, agency guidance and other written materials, the NNI, cooperation and coordination with other regulatory agencies, public meetings, publications, and other areas.

Health Resources and Services Administration (HRSA)

Measure ID	Data Source	Data Validation
1.I.A.1 (HRSA)	HRSA Bureau of Primary Health Care's Uniform Data System	Validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norm.
1.I.A.3 (HRSA)	HRSA/Bureau of Primary Health Care contractors that perform PCMH surveys.	Data validated by Health Center program staff.
3.III.A.1 (HRSA)	Program research records	Validated by program staff and research presentations.
4.I.C.2 (HRSA)	HRSA Bureau of Clinician Recruitment Service's Management Information Support System (BMISS)	BMISS is internally managed with support from the NIH which provides: Data Management Services, Data Requests and Dissemination, Analytics, Data Governance and Quality, Project Planning and Requirements Development, Training, and Process Improvement.
6.I.C.2 (HRSA)	Annual grantee data submitted through the Bureau of Health Profession's Performance Management System.	Data are entered through a web-based system that incorporates extensive validation checks. Once approved by the project officer (1st level of review), data are cleaned, validated, and analyzed by scientists within BHPr's Office of Performance Measurement (2nd level of review). Inconsistencies in data reported identified throughout the 2nd level of review are flagged and sent to the project officer for follow-up and correction.

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

Measure ID	Data Source	Data Validation
16.E (HRSA)	ADAP Quarterly Report data provided by State ADAPs.	Web-based data checked through a series of internal consistency/validity checks. Also HIV/AIDS program staff review submitted Quarterly reports, and provide technical assistance on data-related issues.
16.I.A.1 (HRSA)	HRSA HIV/AIDS Bureau's Ryan White HIV/AIDS Program Services Report	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all Ryan White HIV/AIDS Program Services Report (RSR) submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.
16.II.A.2 (HRSA)	HRSA HIV/AIDS Bureau's Ryan White HIV/AIDS Program Services Report	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all Ryan White HIV/AIDS Program Services Report (RSR) submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.
24.II.A.2 (HRSA)	Data are captured within the National Marrow Donor Program's computerized system, containing information pertaining to registered volunteer adult donors willing to donate blood stem cells to patients in need. Monthly reports generated from the computerized system to indicate the number of registered donors (broken down by self-reported race and ethnicity).	Validated by project officers analyzing comprehensive monthly reports broken down by recruitment organization. To decrease the likelihood of data entry errors, the program contractor utilizes value protected screens and optical scanning forms.
29.IV.A.3 (HRSA)	Reported by grantees through the Office of Rural Health Policy's Performance Improvement Measurement System	Validated by project officers

Measure ID	Data Source	Data Validation
36.II.B.1 (HRSA)	Family Planning Annual Report (FPAR). The FPAR consists of 14 tables in which grantees report data on user demographic characteristics, user social and economic characteristics, primary contraceptive use, utilization of family planning and related health services, utilization of health personnel, and the composition of project revenues. For this measure, FPAR Table 11: "Unduplicated number of Users Tested for Chlamydia by Age and Gender," is the data source.	The responsibility for the collection and tabulation of annual service data from Title X grantees rests with the Office of Population Affairs (OPA), which is responsible for the administration of the program. Reports are submitted annually on a calendar year basis (January 1 - December 31) to the regional offices. Grantee reports are tabulated and an annual report is prepared summarizing the regional and national data. The annual report describes the methodology used both in collection and tabulation of grantee reports, as well as the definitions provided by OPA to the grantees for use in completing data requests. Also included in the report are lengthy notes that provide detailed information regarding any discrepancies between the OPA requested data and what individual grantees were able to provide. Data inconsistencies are first identified by the Regional Office and then submitted back to the grantee for correction. Additionally, discrepancies found by the contractor compiling the FPAR data submits these to the Office of Family Planning (OFP) FPAR data coordinator who works with the Regional Office to make corrections. All data inconsistencies and their resolution are noted in an appendix to the report. These are included for two reasons: (1) to explain how adjustments were made to the data, and how discrepancies affect the analysis, and (2) to identify the problems grantees have in collecting and reporting data, with the goal of improving the process.

Indian Health Service (IHS)

Measure ID	Data Source	Data Validation
2 (IHS)	Clinical Reporting System (CRS); yearly Diabetes care and outcome audit	Comparison of CRS and audit results; CRS software testing; quality assurance review of site submissions
18 (IHS)	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions

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

Immediate Office of the Secretary (IOS)

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

National Institutes of Health (NIH)

Measure ID	Data Source	Data Validation
CBRR-1.1 (NIH)	Doctorate Records File and the NIH IMPAC II database	"Analyses of career outcomes for predoctoral and postdoctoral NRSA participants, compared to individuals that did not receive NRSA support," using the Doctorate Records File and the NIH IMPAC II administrative database. Contact: Jennifer Sutton Program Policy and Evaluation Officer Office of Extramural Programs (301) 435-2686
CBRR-1.2 (NIH)	NIH IMPAC II database	"Analyses of career outcomes for predoctoral and postdoctoral NRSA participants, compared to individuals that did not receive NRSA support," using the Doctorate Records File and the NIH IMPAC II administrative database. Contact: Jennifer Sutton Program Policy and Evaluation Officer Office of Extramural Programs (301) 435-2686

Measure ID	Data Source	Data Validation
CBRR-10 (NIH)	Publications, databases, administrative records and/or public documents.	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Further information on Probe Reports from the NIH Molecular Libraries Program can be found here: http://www.ncbi.nlm.nih.gov/books/NBK47352/ Further information on the Molecular Libraries Program can be found here: http://commonfund.nih.gov/molecularlibraries/ Further information on the S1P1 compound in clinical development can be found here: http://www.receptos.com/clinical-development-RPC1063.php Chung, D. H.; Moore, B. P.; Matharu, D. S.; Golden, J. E.; Maddox, C; Rasmussen, L.; Sosa, M. I.; Ananthan, S.; White, E. L.; Jia, F.; Jonsson, C. B.; Severson, W. E. A cell based high-throughput screening approach for the discovery of new inhibitors of respiratory syncytial virus. Virol. J., 2013, 10:19. doi: 10.1186/1743-422X-10-17 http://www.virologyj.com/content/10/1/19 Germain, AR., Carmody, LC., et.al. Cinnamides as selective small molecule inhibitors of a cellular model of breast cancer stem cells. Bioorg Med Chem Lett., 2013 Mar 15:23(6): 1834-1838. http://www.sciencedirect.com/science/article/pii/S0960894X13000474# Le, U.; Melancon, B. J.; Bridges, T. M.; Vinson, P. N.; Utley, T. J.; Lamsal, A.; Rodriguez, A. L.;Venable, D.; Sheffler, D. J.; Jones, C. K.; Blobaum, A. L.; Wood, M. R.; Daniels, J. S.; Conn, P. J.; Niswender, C. M.; Lindsley, C. W.; Hopkins, C. R. Discovery of a selective M4 positive allosteric modulator based on the 3-amino-thieno[2,3-b]pyridine-2-carboxamide scaffold: Development of ML253, a potent and brain penetrant compound that is active in a preclinical model of schizophrenia. Bioorg. Med. Chem. Lett. 2013 Jan 1;23(1):346-350. http://www.sciencedirect.com/science/article/pii/S0960894X12013649

Measure ID	Data Source	Data Validation
SRO-3.9 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. For additional information contact: NIAMS SPPB (Reaya Reuss, 301-496-8271, reussa@mail.nih.gov) These data have been presented at several international meetings and a manuscript is in preparation. Ombrello MJ, Remmers EF, Tachmazidou I, Grom A, Föll D, Martini A, Gattorno M, Ozen S, Prahalad S, Bohnsack J, Ilowite J, Mellins E, Russo R, Len C, Oliveira S, Yeung R, Wedderburn L, Anton J, Langefeld C, Thompson S, Zeggini E, Thomson W, Kastner D and Woo P, on behalf of the International Childhood Arthritis Genetics (INCHARGE) Consortium. Genome-wide association meta-analysis implicates *HLA-DRB1*, the *BTNL2/HLA-DRA* region, and a novel susceptibility locus on chromosome 1 in systemic juvenile idiopathic arthritis. Accepted for presentation at 2013 Annual Scientific Meeting of the American College of Rheumatology, San Diego, California, October 29, 2013. (Manuscript in preparation) Ombrello MJ, Remmers EF, Zeggini E, Thomson W, Kastner DL, Woo P, on behalf of the International Childhood Arthritis Genetics (INCHARGE) Consortium. Genome-wide association study of Still's disease. Presented as an abstract at the 7th Congress of the International Society of Systemic Autoinflammatory Diseases, Lausanne, Switzerland, May 23, 2013. Ombrello MJ, Remmers EF, Grom AA, Thomson W, Martini A, Gattorno M, Ozen S, Prahalad S, Bohnsack JF, Zeft A, Ilowite N, Mellins E, Russo R, Len C, Oliveira S, Yeung R, Wedderburn L, Anton J, Satorius C, Tachmazidou I, Langefeld C, Zeggini E, Thompson S, Woo P, and Kastner DL. Genome-wide association meta-analysis of eight independent systemic juvenile idiopathic arthritis collections reveals regional association spanning the MHC class II and III gene clusters. Presented as oral presentation at 2012 Annual Scientific Meeting of the American College of Rheumatology, Washington, DC, November 14, 2012

Measure ID	Data Source	Data Validation
SRO-5.13 (NIH)	Publications, databases, administrative records and/or public documents	1. Attene-Ramos MS, Huang R, Sakamuru S, Witt KL, Beeson G, Shou L, Schnellmann RG, Beeson CC, Tice RR, Austin CP, Xia M (2013) Systematic study of mitochondrial toxicity of environmental chemicals using quantitative high throughput screening. Chemical Research Toxicology 26:1323-1332. 2. Attene-Ramos MS, Miller N, Huang R, Michael S, Itkin M, Kavlock RJ, Austin CP, Shinn P, Simeonov A, Tice RR, Xia M (2013) The Tox21 robotic platform for assessment of environmental chemicals - from vision to reality. Drug Discovery Today 18:716-723. 3. Fox JT, Sakamuru S, Huang R, Teneva N, Simmons SO, Xia M, Tice RR, Austin CP, Myung K (2012) High-throughput genotoxicity assay identifies antioxidants as inducers of DNA damage response and cell death. Proc Natl Acad Sci 109:5423-5428.
SRO-6.4 (NIH)	Publications, databases, administrative records and/or public documents	Progress Reports for the following grant numbers: HL109146, HL109152, HL109164, HL109168, HL109172, HL109250, HL109257, and HL109086 Barnig C, Cernadas, M, et al. Lipoxin A4 Regulates Natural Killer Cell and Type 2 Innate Lymphoid Cell Activation in Asthma. Sci Transl Med 27 February 2013: Vol. 5, Issue 174, p. 174ra26 Sci. Transl. Med. DOI: 10.1126/scitranslmed.3004812 http://stm.sciencemag.org/content/5/174/174ra26.full
SRO-8.7 (NIH)	Publications, databases, administrative records and/or public documents	Saldana L and Chamberlain P. Supporting Implementation: The Role of Community Development Teams to Build Infrastructure. Am J Community Psychol. 2012 Dec] http://www.ncbi.nlm.nih.gov/pubmed/22430709 Robins, LS, et al. Barriers and Facilitators to Evidence-based Blood Pressure Control in Community Practice. Journal of the American Board of Family Medicine. 2013 Sep-Oct; 26(5): 539-557. http://www.ncbi.nlm.nih.gov/pubmed/24004706.

Office of the Assistant Secretary for Health (OASH)

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

Office of Medicare Hearings and Appeals (OMHA)

Measure ID	Data Source	Data Validation
1.1.1 (OMHA)	The Medicare Appeals System (MAS) is the sole appeals tracking and reporting system supporting Medicare Parts A, B, C, and D, Entitlement, and Income Related Monthly Adjustment Amount (IRMAA) appeals across Levels 2 and 3 of the appeals process. MAS allows users to track the processing of appeals electronically and facilitates the transfer of appeal data records throughout the various levels.	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included direction for development of a plan transitioning work from SSA to HHS. An element specifically included was "CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the Medicare program."[§931(a)(2)(E)] The Medicare Appeals System (MAS) was developed in response to this and implemented with the opening of the new Office of Medicare Hearings and Appeals on July 1, 2005. MAS is the sole appeals tracking and reporting system supporting Medicare Parts A, B, C, and D, Entitlement, and Income Related Monthly Adjustment Amount (IRMAA) appeals across Levels 2 and 3 of the appeals process. MAS allows users to track the processing of appeals electronically and facilitates the transfer of appeal data records throughout the various levels. MAS is able to import scanned documents, produce reports for analysis, reporting, and workflow management, and ensure consistency of information across the levels of Medicare Appeal. Throughout the adjudication process, MAS provides workflow management through team-specific task sharing – allowing all adjudicatory team members access to information on tasks that have been completed and those yet to be accomplished. The entire adjudicatory process, from the initial request for hearing to the decision, is tracked in MAS. The system's data collection includes appeal request information, case file location, claims information, parties to the appeal, and appeal dispositions. Processing appeals using MAS improves timeliness, assists in meeting required processing deadlines, and minimizes paper utilization. In addition to supporting case processing and workload balancing, data derived from MAS has been used for replies to Congressional queries, the OIG audit of the OMHA program, appellant satisfaction surveys, and tracking performance measures.

Measure ID	Data Source	Data Validation
1.1.5 (OMHA)	Appellate Climate Survey	The most recent version of the survey was administered by a third party contractor using a stratified random sample of appellants whose cases were closed within fiscal year 2013. The survey was designed to collect appellant: demographic information, overall satisfaction, satisfaction with hearing format, satisfaction with other aspects (e.g., scheduling, clarity of case processing documents, interaction with the ALJ team after the scheduling and prior to the hearing, and use of the OMHA website) and possible predictors of satisfaction (e.g., case fully heard and considered, ALJ behavior, etc).

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

Measure ID	Data Source	Data Validation
1.A.2 (ONC)	Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey, Electronic Medical Record Supplement	The NAMCS is nationally representative of office-based physicians. Historically, the response rate is approximately 68%. Beginning with survey year 2010, the survey allows ONC to evaluate trends in electronic health record adoption by region, provider specialty, and state. Estimates for FYs 2008-11 for this measure derive from the mail supplement to the NAMCS.
1.B.4 (ONC)	Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey, Electronic Medical Record Supplement	The NAMCS is nationally representative of office-based physicians. Historically, the response rate is approximately 68%. Beginning with survey year 2010, the survey allows ONC to evaluate trends in electronic health record adoption by region, provider specialty, and state. Estimates for FYs 2008-11 for this measure derive from the mail supplement to the NAMCS.

Substance Abuse & Mental Health Services Administration (SAMHSA)

Measure ID	Data Source	Data Validation
1.2.33 (SAMHSA)	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

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

Measure ID	Data Source	Data Validation
3.2.02a (SAMHSA)	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into the TRAC system. Validation and verification checks are run as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the TRAC database.
3.2.26 (SAMHSA)	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.2.30 (SAMHSA)	Data on children's outcomes were reported in the grantees' ED524 Bi-Annual Report submitted to their GPO every six months. The methods for collecting these measures varied by grantee, but were generally student self-report for the violence and substance use measures and school records for attendance and mental health services.	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things.
3.4.02 (SAMHSA)	Data are collected through standard instruments and submitted through the TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.4.20 (SAMHSA)	Data are submitted annually to SAMHSA by States, which obtain the information from local human service agencies that provide services.	SAMHSA's CMHS has developed additional error checks to screen data and contacts States and local providers concerning accuracy when data is reported outside expected ranges. CMHS has also issued guidance to all States and localities on data collection and monitors compliance with data collection through increased site visits to local PATH-funded agencies.
3.4.21 (SAMHSA)	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation).	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews.
3.4.25 (SAMHSA)	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.

Appendix A. FY 2010 – 2015 HHS Strategic Plan Goals and Objectives

Goal 1: Strengthen Health Care

Objective A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured
Objective B: Improve health care quality and patient safety
Objective C: Emphasize primary and preventive care, linked with community prevention services
Objective D: Reduce the growth of healthcare costs while promoting high-value, effective care
Objective E: Ensure access to quality, culturally competent care for vulnerable populations
Objective F: Promote the adoption and meaningful use of health information technology

Goal 2: Advance Scientific Knowledge and Innovation

Objective A: Accelerate the process of scientific discovery to improve patient care
Objective B: Foster innovation to create shared solutions
Objective C: Invest in the regulatory sciences to improve food and medical product safety
Objective D: Increase our understanding of what works in public health and human services practice

Goal 3: Advance the Health, Safety, and Well-Being of the American People

Objective A: Promote the safety, well-being, resilience, and healthy development of children and youth
Objective B: Promote economic and social well-being for individuals, families, and communities
Objective C: Improve the accessibility and quality of supportive services for people with disabilities and older adults
Objective D: Promote prevention and wellness
Objective E: Reduce the occurrence of infectious diseases
Objective F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies

Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

Objective A: Ensure program integrity and responsible stewardship of resources
Objective B: Fight fraud and work to eliminate improper payments
Objective C: Use HHS data to improve the health and well-being of the American people
Objective D: Improve HHS environmental, energy, and economic performance to promote sustainability

Goal 5: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

Objective A: Invest in the HHS workforce to meet America's health and human service needs today and tomorrow
Objective B: Ensure that the Nation's health care workforce can meet increased demands
Objective C: Enhance the ability of the public health workforce to improve public health at home and abroad
Objective D: Strengthen the Nation's human service workforce
Objective E: Improve national, state, local, and tribal surveillance and epidemiology capacity