# U.S. Department of Health and Human Services
# FY 2021 Annual Performance Report

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

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

In accordance with the Government Performance and Results Act (GPRA) of 1993, as amended in the GPRA Modernization Act (GPRAMA) of 2010, I am pleased to present the Fiscal Year 2021 Annual Performance Report, documenting the Department's performance during the past year. HHS provides further information detailing HHS performance at Performance.gov.

HHS has recently developed the HHS Strategic Plan FY 2022-2026, which is reflected in the separate FY 2023 Annual Performance Plan. The structure of this FY 2021 Annual Performance Report aligns with the HHS Strategic Plan FY 2018–2022 established by the previous administration. In FY 2021, HHS monitored over 900 performance measures to manage departmental programs and activities and improve the efficiency and effectiveness of these programs. As required by GPRAMA, this report includes a representative set of performance measures to illustrate progress toward achieving the Department's strategic goals in the HHS Strategic Plan FY 2018-2022 established by the previous administration. The information in this report spans the Department's 11 Operating Divisions and 14 Staff Divisions and includes work done across the country and throughout the world.

Each HHS division has reviewed its submission and I confirm, based on certifications from the divisions, that the data are reliable and complete. When results are not available because of delays in data collection, the report notes the date when the results will be available. Where known, impacts of the COVID-19 pandemic on HHS performance results are also identified in this report. The results presented here demonstrate that HHS is performing well across a wide range of activities.

Norris Cochran
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U.S. Department of Health and Human Services

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## Overview

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

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

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

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

## Mission Statement

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

## HHS Organizational Structure

The Department includes 11 OpDivs that administer HHS programs:

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

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

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

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

## Cross-Agency Priority Goals

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

## Agency Priority Goals

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

## Strategic Goals Overview

In the previous administration, the Department developed the HHS Strategic Plan FY 2018-2022. The HHS Strategic Plan FY 2018-2022 identified 5 strategic goals and 20 strategic objectives. The five strategic goals were:

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

## Performance Management

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

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

## Strategic Review

GPRAMA aligned agency strategic planning cycles to presidential election cycles and administrative transitions. As a result, the previous administration established HHS's FY 2018–2022 Strategic Plan with a set of strategic priorities that began in FY 2018. Instead of focusing on a review of the previous year's results, HHS used that FY 2020 Strategic Review process to inform goals and plans for the future.

## Annual Performance Report

The Annual Performance Report provides information on the Department's progress towards achieving the goals and objectives described in the HHS Strategic Plan. As required by GPRAMA and OMB Circular A-11, the organization of this FY 2021 report aligns with the HHS Strategic Plan FY 2018-2022 established by the previous administration and the information in this report reflects results available as of January 2022. The COVID-19 pandemic is impacting HHS programs in a variety of ways, and in some cases those impacts are still evolving given the dynamic nature of the situation. The pandemic may impact the ability of some HHS programs to achieve projected targets, or result in the need to revise targets in future years. Where known, impacts of the COVID-19 pandemic on HHS performance results are identified in the sections below.

## Strategic Goal 1: Reform, Strengthen, and Modernize the Nation's Healthcare System

## Objective 1.1: Promote affordable health care, while balancing spending on premiums, deductibles, and out-of-pocket costs

In the previous administration, the Office of the Secretary led this objective. The following divisions were responsible for implementing programs under this strategic objective: AHRQ, CMS, and FDA. The narrative below provides a brief summary of progress made and achievements or challenges.

### Objective 1.1 Table of Related Performance Measures

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

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

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

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit did Medicare coverage recommence. This is known as the coverage gap (or "donut hole"). The Affordable Care Act began closing the coverage gap through a combination of manufacturer discounts and gradually increasing federal subsidies until it closed in 2020. The discount applies at the point of sale, and both the beneficiary cost sharing and the manufacturer discounts count toward the annual out-of-pocket threshold (known as True Out-of-Pocket Costs). This performance measure reflects CMS's effort to reduce the average out-of-pocket costs paid by non-Low Income Subsidy Medicare beneficiaries while in the coverage gap, reached once the combined amount a beneficiary and their drug plan pay for prescription drugs reaches a certain level. This means that, starting in 2020, non-LIS beneficiaries, who reach this phase of Medicare Part D coverage pay no more than 25 percent of costs for all covered Part D drugs. CMS's tracking of this measure has shown that that in most years non-LIS out-of-pocket costs have decreased beyond the targets required by statute (2019 exceeded the target goal).

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | 30% | 40% |
| **Result** | N/A | N/A | N/A | N/A | 20.21% | 24.2% | 12/15/22 |
| **Status** | N/A | N/A | N/A | N/A | Baseline | Target Not Met | Pending |

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

Medicare is leading the way by publicly announcing, tracking, and reporting payments tied to APMs that are taking on a downside risk, while working through the Health Care Payment Learning and Action Network (HCP-LAN or LAN) to ensure that its large group of papers, providers, purchasers, patients, product manufacturers, and policymakers across the United States also adopt aligned goals to move towards downside risk APMs. The final CY 2019 baseline for this new downside risk APM goal is 20.21 percent. Furthermore, the annual LAN summit was not held in its usual form in 2020 due to the impact of the COVID-19 pandemic; and there was no annual reporting on goals. The FY 2020 target was not met due to the unprecedented impact of the COVID-19 pandemic, more limited opportunities for enrollment in new CMMI models, and a plateauing of participation in the Medicare Shared Savings Program.

## Objective 1.2: Expand safe, high-quality health care options, and encourage innovation and competition

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

### Objective 1.2 Table of Related Performance Measures

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

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Prior Result -1.0% | Prior Result -1.0% | Prior Result - 0.5% | Prior Result - 0.25% |
| **Result** | 84 per 1,000 | 83.7 per 1,000 | 84.5 per 1,000 | 83.7 per 1,000 | 84.6 per 1,000 | 4/30/22 | 4/30/23 |
| **Status** | Actual | Actual | Actual | Target Not Met | Target Not Met | Pending | Pending |

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

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

CMS calculates this measure using the number of readmissions per 1,000 eligible beneficiaries. Eligible beneficiaries are dually eligible individuals of any age. CMS found an increase in the readmissions rate from 2018 to 2019 of 1.07 percent. CMS continues to believe the experience from 2015 to 2019 demonstrates a similar “plateauing” of readmissions around 84.0 per 1,000 rate.

### *Improve hospital patient safety by reducing preventable patient harms (Lead Agency – CMS; Measure ID – QIO11)[1,,2]*

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

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

Beginning in FY 2018, CMS lists the result as “data unavailable” due to analytic issues surrounding the preliminary 2018 all cause harm metrics. Due to the inability to collect, track, and report on data in accordance to the specified methodology as well as inconsistencies in availability of patient charts due

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

to COVID-19, CMS discontinued reporting on this measure. Ensuring patient safety continues to be a CMS priority.

***Reduce the standardized infection ratio (SIR) central line-associated bloodstream infection (CLABSI) in acute care hospitals (Lead Agency - CDC; Measure ID - 3.3.3)[3,4]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | Baseline | 0.90 | 0.80 | 0.70 | 0.63 | .50 | .45 |
| **Result** | 1.0 | 0.89 | 0.81 | 0.74 | 0.69 | 0.86 | 11/30/22 |
| **Status** | Actual | Target Exceeded | Target Not Met but Improved | Target Not Met but Improved | Target Not Met but Improved | Target Not Met | Pending |

Reducing health care-associated Infections (HAIs) across all health care settings supports the HHS mission to prevent infections and their complications as well as reduce excess health care costs in the U.S. These efforts also align with the National Action Plan to Prevent Health Care Associated Infections: Roadmap to Elimination (National HAI Action Plan),[5] National Action Plan for Combatting Antibiotic Resistance Bacteria (CARB), and Healthy People 2030 Goals.

CDC did not meet its FY 2020 target for reducing the CLABSI SIR, representing a 14% decrease compared to the 2015 baseline (Measure 3.3.3). The 2020 increase in CLABSI was likely due to the increased burden on healthcare providers and strain on infection prevention and control programs within healthcare facilities wrought by the COVID-19 pandemic. The year ~~2020~~ marked an unprecedented time for hospitals, many of which were faced with extraordinary circumstances of increased patient caseload, staffing challenges, and other operational changes due to the COVID-19 pandemic that may have limited the implementation and effectiveness of standard infection prevention practices. In addition, the impact of COVID-19 on patients, especially respiratory failure requiring longer ventilator care, may have increased the likelihood of some HAIs. The data highlight the need to strengthen infection prevention and control practices and build resiliency in these programs to withstand future pandemics or events that strain the healthcare system and return to the steady progress in patient safety prior to the pandemic.

CDC is on track to meet other 2020 National HAI Action Plan targets, however some may show increases in 2020 and 2021 due to the COVID-19 pandemic.

***Reduce standardized infection ratio for hospital-onset Clostridioides difficile infections (Lead Agency - CDC; Measure ID - 3.2.4b)[6]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | Baseline | 0.84 | 0.76 | 0.75 | 0.70 | .70 | .60 |
| **Result** | 1.00 | 0.92 | 0.80 | 0.71 | 0.58 | 0.52 | 3/31/22 |

[3] The baseline for this measure was updated in FY 2015 and will affect future targets and data reporting for FY 2016 onward.
[4] CDC uses a standardized infection ratio (SIR), the ratio of the observed number of infections to the number of predicted infections, to measure progress in reducing HAIs compared to the baseline period (FY 2015). In 2015, CDC developed a new baseline for all HAIs including CLABSI to better assess national and local prevention progress and identify gaps for tailored prevention.
[5] https://health.gov/hcq/prevent-hai-action-plan.asp
[6] CDC rebaselined measure 3.2.4b in 2015, and subsequent targets were adjusted to align to changes in the current HHS HAI Action Plan.

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

Clostridioides difficile infection (CDI)[7] is a preventable, life-threatening bacterial infection that can occur in both inpatient and outpatient health care settings. CDC provides data-driven strategies and tools for targeted intervention to the health care community to help prevent CDI, as well as resources to help the public safeguard its own health. CDI prevention is a national priority, with a 2020 target to reduce CDI by 50 percent in the National Action Plan for CARB and to reduce hospital-onset CDI by 30 percent in the current National HAI Action Plan. In FY 2020, the SIR for hospital-onset CDI was 0.52, exceeding not just the 2020 target, but also surpassing the 2020 HAI Action Plan CDI goal. CDC is also on track to meet the 2020 National Action Plan for CARB target for CDI.

## Objective 1.3: Improve Americans' access to health care and expand choices of care and service options

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

### Objective 1.3 Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 8,600 | 8,901 | 10,359 | 11,600 | 13,600 | 21,860 | 46,000 |
| **Result** | 9,773 | 10,388 | 12,212 | 13,204 | 17,933 | 60,696 | 80,188 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded |

Telehealth services have proven effective in providing access to care where there are provider shortages or other barriers to care. The integration of behavioral health services through a telehealth option will increase tele-behavioral health encounters nationally among American Indians and Alaska Natives (AI/AN). Expanding tele-behavioral health service delivery will increase access to specialty care such as child psychiatry and addiction psychiatry. Historical results show the increasing demand for these services as the measure consistently exceeded targets. Due to the COVID-19 pandemic, and flexibilities offered through the emergency act waivers, IHS increased efforts to expand access to telehealth by immediately offering technical assistance support to behavioral health clinics as they transitioned from office-based visits to tele-behavioral health visits. With the expansion of telehealth services during the COVID-19 response, IHS accelerated efforts to increase the number of tele-behavioral health visits and accurately capture visits. The FY 2021 result of 80,188 encounters reflects these efforts and the

[7] https://www.nejm.org/doi/full/10.1056/NEJMoa1408913

extraordinary circumstances and response to the COVID-19 pandemic. During FY 2021, IHS continued to expand access to care for tele-behavioral health services.

## Objective 1.4: Strengthen and expand the health care workforce to meet America's diverse needs

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

### Objective 1.4 Table of Related Performance Measures

Support field strength (participants in service) of the National Health Service Corps (NHSC) (Lead Agency - HRSA; Measure ID - 2010.03[8] )[9]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 8,495 | 9,153 | 9,219 | 8,705 | 11,410 | 13,700 | 14,338 |
| **Result** | 9,683 | 10,493 | 10,179 | 10,939 | 13,053 | 16,229 | 19,984 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded |

The National Health Service Corps addresses the nationwide shortage of health care providers in health professional shortage areas by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. The NHSC field strength indicates the number of providers actively serving with the NHSC in underserved areas in exchange for scholarship or loan repayment support.

As of FY 2019, this measure calculated the number of primary care medical, dental, and mental and behavioral health practitioners providing service nationwide through the following programs: NHSC Scholarship Program, NHSC Loan Repayment Program, NHSC Students to Service Loan Repayment Program, Substance Use Disorder Loan Repayment Program, Rural Communities Loan Repayment Program, and the State Loan Repayment Program.
As of September 30, 2021, 18,897 practitioners were providing service nationwide through these programs, which collectively serve the immediate needs of underserved communities and support the development and maintenance of a pipeline of health care providers capable of meeting the needs of these communities in the future.

[8] Measure formerly numbered as 4.I.C.2.

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

## Strategic Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play

## Objective 2.1: Empower people to make informed choices for healthier living

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

### Objective 2.1 Table of Related Performance Measures

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

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

Although cigarette smoking remains the leading cause of tobacco-related disease, tobacco users are increasingly shifting consumption to other tobacco products and dual use with other combusted tobacco, which include cigars, cigarillos and little cigars, pipe tobacco, roll-your-own tobacco, and hookah. This has resulted in a slowing of the decline in the consumption of all combustible tobacco, and indicates that the use of non-cigarette combustible products has become more common in recent years and that some smokers may be switching to other combustible tobacco products rather than quitting smoking cigarettes completely. Per capita combustible tobacco product consumption remained unchanged from 1,004 cigarette equivalents in FY 2019 to 1,004 cigarette equivalents in FY 2020.

CDC supplies credible evidence showing the dangers of secondhand smoke, as well as proven interventions to reduce exposure, which provide a strong foundation for state and community efforts to promote smoke-free environments. CDC research contributes to the evidence base that informs the activities of CDC's National Tobacco Control Program (NTCP), a nationwide investment that supports all 50 states, the District of Columbia, eight U.S. territories, and 12 tribal organizations for comprehensive tobacco control efforts including reducing secondhand smoke exposure.

CDC also provides direct assistance to help people quit smoking tobacco through 1-800-QUIT-NOW. In March 2012, CDC launched the first-ever paid, national tobacco education campaign, Tips from Former Smokers® (Tips®). The Tips® campaign profiles real people who are living with serious long-term health effects due to smoking and secondhand smoke exposure.

During the 28-week 2020 Tips® campaign (which included three weeks at the start of the campaign when the Tips® ads were tagged with the Tips® campaign website instead of 1-800-QUIT-NOW and three weeks with holidays when the Tips® ads were paused), there were a total of about 305,000 calls to 1-800-QUIT-NOW. A total of about 51,000 of these calls were attributable to the Tips® campaign. The average weekly call volume during the 2020 campaign was up by about 20% compared to the average

weekly call volume during the three weeks preceding the campaign. Population-based strategies, including mass-reach public education campaigns like CDC's Tips® campaign, are a proven way to promote tobacco cessation treatments and increase utilization.

***Reduce the age-adjusted proportion of adults (age 20 years and older) who are obese (Lead Agency - CDC; Measure ID - 4.11.10a)[10]***

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

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

Adult obesity rates have been on the rise since 1999-2000. The proportion of adults (aged 20 years and older) who have obesity increased from 30.5 percent in 1999-2000 to 42.4 percent in 2017-2018. Disparities exist by race/ethnicity, age, sex, education, and income level. Obesity is a complex health issue resulting from a combination of causes including individual and environmental factors. Individual behaviors such as unhealthy diet and lack of physical activity contribute to obesity, and environmental factors can make it easier or harder to make these behaviors changes. Many states and communities do not have supports in place that encourage healthy eating and active living. These supports require societal will to establish healthier standards so all adults have access to healthy foods and opportunities to be physically active where they live, learn, work, and play.

## Objective 2.2: Prevent, treat, and control communicable diseases and chronic conditions

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

### Objective 2.2 Table of Related Performance Measures

Increase the percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test who are virally suppressed (Lead Agency - HRSA; Measure ID - 4000.03[11] )

[10] Data for this measure are collected and reported every other year.
11 Formerly numbered 16.III.A.4.

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 83% | 83% | 83% | 83% |
| **Result** | 83% | 85% | 86% | 87% | 88% | 89.4% | 12/31/22 |
| **Status** | Actual | Actual | Actual | Target Exceeded | Target Exceeded | Target Exceeded | Pending |

The Ryan White HIV/AIDS Program (RWHAP) works to improve health outcomes by preventing disease transmission or slowing disease progression for disproportionately impacted communities. One-way RWHAP accomplishes its mission is through the provision of medications that help patients reach HIV viral suppression. People living with HIV who use medications designed to virally suppress the disease are less infectious, which reduces the risk of their transmitting HIV to others.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 53% | 56% | 59% | 62% | 66% | 70% | 70% |
| **Result** | 42% | 43% | 38% | 45.3% | 48% | 50% | 9/30/22 |
| **Status** | Target Not Met | Target Not Met but Improved | Target Not Met | Target Not Met but Improved | Target Not Met but Improved | Target Not Met but Improved | Pending |

In the United States, on average 5 to 20 percent of the population contracts the flu, more than 200,000 people are hospitalized from seasonal flu-related complications, and approximately 36,000 people die from seasonal flu-related causes. This measure reflects the universal influenza vaccination recommendation and aligns with the Advisory Committee on Immunization Practices' updated recommendation (as of 2010) for the seasonal influenza vaccine. Seasonal influenza vaccination rates for adults aged 18 and older increased slightly from 48 percent in FY 2019 to 50 percent in FY 2020. Interpretation of these results should take into account limitations of the survey, which include reliance on self-reporting of vaccination status and a decrease in response rates.

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

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

- Increasing patient and provider education to improve demand and implement system changes in practitioner office settings to reduce missed opportunities for vaccinations.
- Funding state and local health departments to implement the Standards for Adult Immunization Practice in large health care systems, community health centers, pharmacies, and other settings.
- Partnering with professional organizations (e.g., F1.3 American Pharmacists Association, American College of Physicians, American Academy of Family Physicians, American College of Obstetricians and Gynecologists) and other organizations (e.g., National Association of Chain Drug Stores, National Association of Community Health Centers, American Immunization Registry Association) to develop and implement strategies to improve adult immunization at provider, practice, and systems levels.
- Enhancing evidence-based communication campaigns to increase public awareness about adult vaccines and recommendations. CDC routinely conducts literature reviews and surveys of the general public and healthcare providers to provide a deeper understanding of the target audiences for development of adult immunization communication messages and campaigns.

- Partnering with the National Adult and Influenza Immunization Summit, a national coalition of partners and stakeholders represented by clinicians, public health, industry, government, and other entities with the common goal to promote immunization for adults.
- Expanding the reach of vaccination programs including new venues such as pharmacies and other retail clinics. CDC has existing partnerships to implement adult immunization practice standards, HPV vaccination, and pandemic vaccine program planning efforts to expand access to pandemic vaccine. As of 2016-2017 influenza season, nearly one in four adults who got an influenza vaccine were vaccinated in a pharmacy or retail setting.
- Designing and funding investigations into the factors associated with disparities in adult vaccination among racial and ethnic minority populations and projects designed to expand the evidence base for interventions to increase vaccination among adults with chronic medical conditions and underserved populations.
- Collaborating with numerous existing and new partners to expand flu vaccine coverage, with specific efforts to address racial and ethnic disparities for the 2020-2021 influenza season. For example, CDC is working with the National Association for Community Health Centers to implement evidence-based strategies to increase adult vaccination coverage among underserved priority populations. CDC has developed a large portfolio of new partnerships to promote COVID-19 and flu vaccination in high-risk populations, including communities of color, those living in rural settings, adults with chronic medical conditions (cardiovascular, diabetes, chronic lung conditions, etc.) and those in congregate settings (i.e., long-term care facilities, homeless shelters, and prisons).

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

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

Within ASPR, the Biomedical Advanced Research and Development Authority (BARDA) uses an end-to-end strategy to prepare for the next influenza pandemic by supporting development, licensure, and manufacturing of better products to detect, treat, and prevent seasonal and pandemic influenza. This strategy relies on the development of superior influenza diagnostics, treatments, and vaccines that can be rapidly manufactured. BARDA continues to focus on developing capabilities to recognize potential pandemic influenza viruses in point-of-care settings, speeding influenza diagnosis to prompt early antiviral use and will also continue to support advanced development of new nucleotide sequencing technologies and prodromal or pre-symptomatic biomarkers for influenza. The targets for this measure have been met or exceeded each year. There are no missing or delayed data. The data source is stable and quality assurance procedures are conducted. The measure reflects that ASPR uses a comprehensive portfolio approach to develop and acquire a broad array of medical countermeasures for pandemic influenza and emerging infectious diseases. The ASPR investments reflected through this data highlight support for advanced research and development, stockpiling, procurement, and capacity expansion. Important context is that previous and ongoing investments in addressing the pandemic influenza threat proved invaluable to accelerate the COVID-19 response by jump-starting therapeutic and vaccine development using platform technologies for more rapid production and increased fill/finish capability. By continuing to widen availability of enhanced influenza diagnostic tools, BARDA promotes effective, timely management and treatment of seasonal and pandemic influenza, and reduces its impact on health,

communities, the Nation, and internationally. Targets are set based on ongoing active projects in BARDA's Influenza Therapeutics branch specifically as it relates to complex advanced research and development projects that are on the product development pathway to FDA licensure. The products reported for this measure include those from ongoing clinical trials and manufacturing campaigns only related to pandemic influenza.

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

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

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

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

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

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

## Objective 2.3: Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support

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

### Objective 2.3 Table of Related Performance Measures

***Reduce the age-adjusted annual rate of overdose deaths involving synthetic opioids other than methadone (e.g., fentanyl) among states funded through CDC's multi-state surveillance and prevention cooperative agreement (per 100,00 residents) (Lead Agency - CDC; Measure ID - 7.2.7b)*** [12]

| | FY 2015 | FY 2016 | FY 2017 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Baseline | 8.7 per 100,000 residents | 8.3per 100,000 residents | 8.0 per 100,000 residents | 7.7 per 100,000 residents |
| **Result** | N/A | N/A | N/A | 9.0 per 100,000 residents | 11.2 per 100,000 residents | 12.4 per 100,000 residents | 1/30/22 | 1/30/23 |
| **Status** | N/A | N/A | N/A | Actual | Target Not Met | Target Not Met | Pending | Pending |

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

The age-adjusted annual rate of opioid deaths involving synthetic opioids other than methadone (e.g., fentanyl) in FY 2019 was 12.4 per 100,000 residents among states funded for the PfS program, which did not meet the target of 8.3 per 100,000 residents. The growing issue of polysubstance use means that an opioid-involved overdose often occurs in combination with exposure to other opioids and/or other non-opioid substances. Some examples of polysubstance exposures found in combination in overdose deaths include illicitly-manufactured fentanyl (IMF) and heroin; illicitly-manufactured fentanyl and cocaine; heroin and methamphetamine; and prescription or illicit opioids and benzodiazepines. The overdose epidemic has also grown increasingly complex by co-involvement of prescription and illicit drugs.

***Reduce the age-adjusted rate of overdose deaths involving natural and semisynthetic opioids (T40.2) or methadone (T40.3) as a contributing cause of death among states funded through CDC's multi-state surveillance and prevention cooperative agreement (per 100,000 residents. (Lead Agency - CDC; Measure ID - 7.2.7c)*** [13]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 4.2 per 100,000 residents | 4.1 per 100,000 residents | 3.9 per 100,000 residents | 3.7 per 100,000 residents |
| **Result** | N/A | N/A | 5.7 per 100,000 residents | 4.9 per 100,000 residents | 4.5 per 100,000 residents | 1/30/22 | 1/30/23 |
| **Status** | N/A | N/A | Actual | Target Not Met | Target Not Met but Improved | Pending | Pending |

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

CDC monitors the reduction of overdose deaths involving all opioids among the states funded specifically for PfS awards made in FY 2016. Since 2016, as the epidemic has evolved, CDC has scaled its programs from an initial cohort of states to a program with a national scope. This performance measure reports outcomes based on the number of funded states and includes overdoses caused by methadone. These data allow CDC to better guide prevention activities related to safer prescribing. In FY 2019, the age-adjusted annual rate of opioid deaths involving prescription opioids was 4.5 per 100,000 residents among states funded for the PfS program. This did not meet the FY 2019 target but was an improvement from the previous year.

CDC has tailored its response as the epidemic continues to evolve and will continue to take action to further reduce overdose deaths. In the face of stay-at-home orders due to COVID-19, several states funded through CDC's Overdose to Action (OD2A) have succeeded in deploying harm reduction measures. For example, since March 1, 2021 in Ohio, through a first responder partnership, 328 naloxone kits have been distributed and more than 500 clients have been referred to treatment services. In Louisiana, public health opioid prevention outreach coordinators (OPOCs) continued to educate Louisiana residents on overdose prevention and awareness. OPOCs successfully made contact through virtual and in-person outreach to more than 4,047 individuals since September 1, 2020. Materials delivered in the community totaled more than 14,378 pieces/packets. OPOCs also worked with the local human services organization to deliver more than 234 Narcan kits to individuals, clinics, first responders, and universities.

***Increase the number of substance use treatment admissions with Medication-Assisted Treatment (MAT) planned as part of Opioid Use Disorder Treatment (Lead Agency - SAMHSA; Measure ID - 2.3.19K)*** [14]

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 200,000 | 220,000 | 242,000 | 280,000 |
| **Result** | 197,162 | 194,261 | 245,638 | 268,303 | 211,743 | 8/31/22 | 8/31/23 |
| **Status** | Actual | Actual | Actual | Target Exceeded | Actual | Pending | Pending |

SAMHSA expects the number of people receiving MAT and the number of admissions to substance abuse treatment with MAT to increase. States are continuing to develop their systems with increased resources from grant programs, such as the State Opioid Response grants, Tribal Opioid Response grants, and Targeted Capacity Expansion: Medication-Assisted Treatment Prescription-Drug and Opioid Addiction grants. Medicaid systems have increased their focus on opioid-related technical assistance, and outreach efforts from across HHS promote the use of MAT. SAMHSA uses data from the Treatment Episode Dataset (TEDS) to track the provision of substance use treatment for opioid use disorders, which includes tracking the planned use of MAT at admission.[15] In CY 2015, 197,162 treatment admissions had

[14] TEDS Annual Report, which is based on calendar year data, can be found at: https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set. CY 2015, CY 2016, and CY 2017 were updated; states are allowed to update and/or correct their data at any given time.
[15] MAT consists of provision of methadone, buprenorphine or extended-release naltrexone, in combination with counseling and behavioral therapies. TEDS is a compilation of client-level data routinely collected by the individual state administrative data systems to monitor their substance use treatment systems. TEDS records do not represent individuals; rather, each record represents a treatment episode. Thus, an individual admitted to treatment twice within a calendar year counts as two admissions. TEDS does not include all substance use treatments. It

MAT as a planned part of the treatment plan. In CY 2016, 194,261 admissions had MAT planned and 245,638 opioid admissions had MAT planned in CY 2017, and 268,303 opioid admissions had MAT planned in CY 2018. In CY 2019, 211,743 treatment admissions had MAT as a planned part of the treatment plan. MAT data for CY 2020 will be available in 2022.

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

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2014** | N/A | N/A | N/A |
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | N/A | N/A | N/A |
| **FY 2018** | Develop at least one new electronic clinical decision support tool related to safe pain management and opioid prescribing. | Developed and tested a dashboard that aggregates pain-related information into one consolidated view for clinicians. Information includes data such as pain medications, pain assessments, pain-related diagnoses, and relevant lab test results. | Target Met |
| **FY 2019** | 1) Test, revise, and disseminate at least one new electronic clinical decision tool related to safe pain management and opioid prescribing and<br>2) Partner with stakeholders to identify additional evidence-based electronic clinical decision tools related to safe pain management and opioid prescribing and make them publicly available. | Worked with CDC to test, revise, and disseminate two opioid clinical decision support (CDS) tools using the Connect web platform | Target Met |
| **FY 2020** | Develop, test, and disseminate at least one electronic clinical decision support tool related to opioids or safe chronic pain management. | Through two contracts, began designing, developing, and disseminating new patient-facing and clinician-facing clinical decision support applications for chronic pain management. | Target Met |
| **FY 2021** | Evaluate electronic clinical decision support tools related to chronic pain management and disseminate the results of the evaluation | 9/30/22 | Pending |

Addressing the nation's opioid epidemic is an ongoing focus of AHRQ's Health Services Research, Data, and Dissemination portfolio. In FY 2017, AHRQ launched a new initiative to ensure that health care professionals have access to evidence supporting safe pain management and opioid prescribing at the

includes treatment admissions and discharges at facilities licensed or certified by a state substance abuse agency to provide care for people with a substance use disorder (or at facilities that are administratively tracked for other reasons). In general, facilities reporting TEDS data are those that receive state alcohol and/or drug agency funds (including federal block grant funds) for the provision of alcohol and/or drug treatment services.

point of care through electronic Clinical Decision Support (CDS). CDS Connect is the infrastructure for developing and sharing these CDS tools.[16]

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

In FY 2021, both contracts completed the design of the CDS applications, followed by testing and deployment at their pilot sites. Each of the contracts has begun a self-evaluation of their CDS and will disseminate resources and lessons learned through AHRQ's CDS Connect platform. The will include implementation guides and other materials for re-use by other healthcare systems. Each project's self-evaluation is in addition to a separate evaluation of AHRQ's overall CDS initiative, which began in FY2020. However these activities have been delayed due to COVID and will not be completed until FY 2022.

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

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

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

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| | | naltrexone, an effective treatment for OUD. | |
| **FY 2021** | Conduct a Phase I clinical trial of an anti-opioid vaccine and a new medication to treat OUD. | NIH conducted one Phase I clinical trial to test the safety and efficacy of an anti-opioid vaccine, and two Phase I clinical trials to test the safety and efficacy of two novel treatment drugs for OUD. | Target Met |

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

In FY 2021, NIH funded three Phase I clinical trials to develop a vaccine and two medications for treating OUD. One research team tested the safety and efficacy of an oxycodone vaccine in people with OUD. If successful, this vaccine and others like it would prevent opioids from entering the brain, thereby providing protection against their effects, including overdose. Another research team evaluated, in people with OUD, the safety and biological effects of a novel compound that works by suppressing dopamine release, a key brain chemical involved in addiction. Combining this novel compound with buprenorphine/naloxone, an existing medication for OUD that balances opioid signaling in the brain, could improve treatment outcomes for OUD. The third research team tested, in healthy volunteers, the safety and activity of a compound that activates the brain's orexin-1 receptors, which play a key role in influencing the brain's reward system, particularly drug-directed behavior. Preclinical findings show that it could help people with OUD by reducing opioid, intake, craving, and relapse.

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

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

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

[17] Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020.

increase access to treatment, which include Healthy Transitions continuation grants and contracts for technical assistance and evaluation.

The prevalence of receiving depression care among youth with major depressive episode and severe impairment in the past year remained stable between 2016 and 2018. In CY 2019, the rate was 49.7 percent, which exceeds the target (48.5 percent) by 1.2 percent. In FY 2018, in addition to supporting contracts for technical assistance and evaluation, SAMHSA continued support for 14 continuation grants and supported 4 new grants. SAMHSA will work to improve this result in CY 2020 and CY 2021 by providing technical assistance to grantees and by continuing to monitor major depressive episodes in youth ages 12-17. The agency anticipates that these efforts made to improve access to services will lead to identifying reductions in the percentage of youth who report major depressive episodes.

### *Increase the percentage of adults with Serious Mental Illness (SMI) receiving mental health services (Lead Agency - SAMHSA; Measure ID - 2.3.19L)* [18]

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 67.0% | 68.0% | 71.0% | 75.0% |
| **Result** | N/A | 64.8% | 66.7% | 64.1% | 65.5% | 64.5% | 12/31/22 |
| **Status** | N/A | N/A | N/A | Target Not Met | Target Not Met But Improved | Target Not Met | Pending |

NSDUH defines the mental health services as inpatient treatment/counseling, outpatient treatment/counseling, or the use of prescription medication for mental health problems. In CY 2019, 65.5 percent of the adults aged 18 or older received the mental health services, which was less than the target (68.0 percent). In FY 2021, SAMHSA continued to provide guidance to agencies on how to administer mental health services to individuals with SMI. Federal efforts, including ISMICC, discretionary grant programs, and SAMHSA's Clinical Support Services for SMI Technical Assistance Center enabled agencies to provide coordinated efforts and resources to individuals with SMI.

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

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

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

1. Treatment—Increase uptake of medications for the treatment of opioid use disorder:
    a. By 15 percent the number of unique patients receiving prescriptions for buprenorphine in U.S. outpatient retail pharmacies (excluding implantable or long-acting injection products).

[18] The latest full NSDUH report, the 2020 NSDUH full report, is available at https://www.samhsa.gov/data/release/2020-national-survey-drug-use-and-health-nsduh-releases

b. By 100 percent the number of prescriptions for long-acting injectable or implantable buprenorphine from retail, long-term care, and mail-order pharmacies in the U.S.
c. By 25 percent the number of prescriptions for extended-released naltrexone from retail, long-term care, and mail-order pharmacies in the U.S.
d. By 57 percent the number of providers with a DATA 2000 waiver authorizing buprenorphine prescribing for opioid use disorder treatment.

2. Overdose intervention—Increase availability and access to overdose-reversing drugs:
   a. By 50 percent the number of prescriptions dispensed for naloxone in U.S. outpatient retail and mail-order pharmacies.

## Objective 2.4: Prepare for and respond to public health emergencies

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

### Objective 2.4 Table of Related Performance Measures

***Maintain the percentage of CDC-funded Public Health Emergency Preparedness (PHEP) state and local public health agencies that can convene, within 60 minutes of notification, a team of trained staff that can make decisions about appropriate response and interaction with partners (Lead Agency - CDC; Measure ID - 13.5.3)***[19]

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

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

In response to the pandemic, CDC allowed PHEP recipients to use FY 2019 PHEP funds to support critical COVID-19 response activities. Specific examples of how recipients planned to use funds include laboratory equipment, reagents and other specialized materials and supplies needed for lab processing and testing of COVID-19 samples; electronic staffing systems; communications and call center

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

equipment; and contact tracing. CDC also modified FY 2019 and FY 2020 PHEP program requirements as a result of the current COVID-19 pandemic response underway in the 62 PHEP jurisdictions. To support this critical work and reduce recipient burden, CDC integrated PHEP planning requirements with COVID-19 pandemic response activities, allowing recipients to use their response to the current public health incident to demonstrate their preparedness capabilities. Among the changes, CDC has waived all drill requirements, including the staff assembly drill (Measure 13.5.3). As a result, data will not be reported for FY 2019 and FY 2020.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | 3 | 3 | 3 | 3 | 3 | 3 |
| **Result** | N/A | 3 | 5 | 9 | 7 | 3 | 6 |
| **Status** | N/A | Target Met | Target Exceeded | Target Exceeded | Target Exceeded | Target Met | Target Exceeded |

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

## Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan

## Objective 3.1: Encourage self-sufficiency and personal responsibility, and eliminate barriers to economic opportunity

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

### Objective 3.1 Table of Related Performance Measures

***Increase the percentage of adult Temporary Assistance for Needy Families (TANF) work-eligible individuals who entered employment (Lead Agency - ACF; Measure ID - 22B)[20]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | 17.3% | 17.4% |
| **Result** | N/A | N/A | 18.0% | 17.5% | 17.2% | 6/30/22 | 6/30/23 |
| **Status** | N/A | N/A | Actual | Actual | Pending | Pending | Pending |

TANF provides states with block grants to design and operate programs that help needy families reach self-sufficiency, with a focus on preparing parents for work. This program measure assesses how effectively recipients transition from cash assistance to employment. Full success requires not only that recipients be employed, but also that they remain employed, increase their earnings, and demonstrate a reduction in dependency on cash assistance. In FY 2019, 17.2 percent of TANF work-eligible individuals who were unemployed at baseline were employed (i.e. reporting earnings) in the following quarter.

ACF is committed to helping the states identify innovative and effective employment strategies and offering a range of targeted technical assistance efforts. As one example, ACF provides research on potential areas for employment and skill-building.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 76.84% | 83.01% | 85.26% | 84.84% | 82.88% | 81.76% | 76.05% |
| **Result** | 82.19% | 84.42% | 84% | 82.06% | 80.95% | 75.30% | 77.8% |
| **Status** | Target Exceeded | Target Exceeded | Target Not Met | Target Not Met | Target Not Met | Target Not Met | Target Exceeded |

In FY 2020, 179 locations offered ACF Matching Grant Program services. This is a decrease from 250 locations in FY 2017. Since the program provides $2,750 funding for each eligible individual served,

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

program funding is directly linked to the number of eligible participants. While providing services, grantees must match federal funds by at least 50 percent. ACF encourages grantees to experiment in the delivery of services at one or more sites to improve efficiencies and outcomes.

ACF attributes the drop in performance for indicator 16C to the impact of the COVID-19 pandemic in the second half of the FY. Indeed, this 180-day measure was on track to greatly exceed the FY target with 83.67 percent of individuals deemed self-sufficient in the first half of the year.

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

## Objective 3.2: Safeguard the public against preventable injuries and violence or their results

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

### Objective 3.2 Table of Related Performance Measures

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

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

Family Violence Prevention and Services Act grantee data for fiscal years 2017 through 2020 show that more than 90 percent of domestic violence program clients reported improved knowledge of safety planning as a result of grantee efforts. Safety planning, sharing information about shelters and supportive services, is considered appropriate assistance that Hotline advocates have been providing survivors for more than 25 years. Safety planning is a core function of the Hotline services, and Hotline advocates provide in-depth advocacy, support, and safety planning to all contacts. These data correlate

with other indices of longer-term client safety and well-being.[21] Since many program participants receive short-term crisis assistance and would not expect to report significant change, consistently achieving a higher than 90 percent benchmark is unrealistic.

***Decrease the percentage of children with substantiated or indicated reports of maltreatment that have a repeated substantiated or indicated report of maltreatment within six months (Lead Agency - ACF; Measure ID - 7B)[22]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 6.30% | 6.20% | 6.30% | 6.74% | 6.50% | 6.40% | 6.0% |
| **Result** | 6.40% | 6.50% | 6.90% | 6.70% | 6.60% | 6.2% | 10/31/22 |
| **Status** | Target Not Met but Improved | Target Not Met | Target Not Met | Target Met | Target Not Met, but Improved | Target Exceeded | Pending |

In FY 2018, the rate of repeat child maltreatment decreased to 6.7 percent, which met the target for that year. In FY 2019, the rate continued to decrease to 6.6 percent, which was an improvement, but fell just short of the target of 6.5 percent. For FY 2020, the rate of recurrence decreased to 6.2 percent, exceeding the target of 6.4 percent. ACF will continue to support states in their efforts to support children and families who are experiencing a crisis, while ensuring the safety of children. The renewed emphasis on prevention efforts may also assist on improving performance in this area.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 41.6% | 41.6% | 41.5% | 37.5% |
| **Result** | N/A | N/A | N/A | 38.1% | 36.3% | 33.3%[23] | 27.2% |
| **Status** | N/A | N/A | N/A | Target Not Met | Target Not Met | Target Not Met | Target Not Met |

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

In FY 2019, IHS identified successful strategies among the IHS Areas and sites that met or exceeded the

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

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

[23] Interim result.

target screening rates for intimate partner violence. Strategies that sites identified as a pathway to success include: frequent data review and communication of data to staff; staff training that targeted the use of specific screening tools; and inclusion of this important measure in facility quality improvement projects. IHS uses this information to increase support and to cultivate knowledge about this measure across sites and to provide technical assistance and training to IHS health care providers and sites. In FY 2020, IHS continued to encourage dissemination of these evidence-based strategies across all facilities. IHS provided training on the appropriate screening and injury assessments and documentation in the IHS electronic health record reporting system. IHS provided outreach and assistance to tribal sites upon request including a virtual training made available in FY 2020 regarding a specific Intimate Partner Violence (IPV) lethality risk screening tool. In addition, IHS recorded a two-hour live training webinar provided to Urban health organizations that discussed screening tools and appropriate interventions to offer patients experiencing intimate partner violence. Due to COVID-19 response efforts, opportunities for facilities to participate and complete trainings were limited.

Although several IHS Areas met or exceeded the FY 2020 and FY 2021 targets, IHS did not meet the national target of 41.5 percent in FY 2020 or the national target of 37.5 percent in FY 2021. The IHS COVID-19 pandemic response and the transition from in person primary care to virtual care at several sites, may have impacted screening women for DV/IPV. To avoid potential coronavirus exposure risk, there have been fewer in-person visits and many health care services for prevention and health maintenance were postponed by patients during the pandemic. While patients with acute illness or the need for emergency care were still seen at IHS facilities, the COVID-19 pandemic response limited healthcare provider – patient interactions and reduced opportunities to screen the general population. Due to the sensitivity of the DV/IPV screening, proper administration requires the health care provider to ensure the patient is comfortable responding without external influence. Therefore, increased telehealth visits that occur within a patient's home would not necessarily meet the safety and security recommendations to be applied during the DV/IPV assessment.

## Objective 3.3: Support strong families and healthy marriage, and prepare children and youth for healthy, productive lives

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

### Objective 3.3 Table of Related Performance Measures

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

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

The ACF Office of Head Start (OHS) strives to increase the percentage of Head Start children in high-

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

In FY 2020, ACF unveiled a rule to better improve the quality of Head Start services by refining the Designation Renewal System (DRS), which determines whether Head Start and Early Head Start agencies deliver high-quality and comprehensive services to the children and families. The final rule on the DRS will become effective on October 27, 2020 and promotes increased quality in Head Start classrooms by establishing quality thresholds for each domain of the CLASS®. Any grantee with a score below one or more quality thresholds will be designated for quality improvement. For these grantees, OHS will provide support for quality improvement in teacher-child interactions and teaching practices. Additionally, this rule raises minimum expectations for all grantees regarding quality of the classroom learning environment. Any grantee with a score below one or more of the now higher minimum thresholds will be designated for competition. The final rule is available at https://www.federalregister.gov/documents/2020/08/28/2020-17746/head-start-designation-renewal-system.

There are no results for this performance measure in FY 2021 since CLASS reviews were not conducted due to the COVID-19 pandemic.

### *Reduce the proportion of children and adolescents ages 2 through 19 who are obese (Lead Agency - CDC; Measure ID - 4.11.10b)*[24]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | 15.7% | N/A | N/A[25] | N/A | 18.8% | N/A |
| **Result** | N/A | 18.5% | N/A | 19.3% | N/A | 5/30/22 | N/A |
| **Status** | N/A | Target Not Met | N/A | Baseline | N/A | Pending | N/A |

CDC funds a number of interventions that target obesity as well as related chronic diseases. The percentage of all children and adolescents (ages 2 to 19 years) that have obesity increased from 16.8 percent in FY 2008 to 19.3 percent in FY 2018, exceeding the target of 15.2 percent. Despite this overall increase, there has been progress among children from lower-income families enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children. Research shows behaviors that influence excess weight gain include early infant weight gain, lack of responsive feeding approaches, eating high-calorie, low-nutrient foods and beverages, not getting enough physical activity, sedentary activities, medication use, and sleep routines. Public health and healthcare practitioners can educate individuals about healthy lifestyle choices and ways to improve their diet and increase physical activity.

[24] The data for this performance goal are collected and reported every other year.

[25] CDC is using this year to re-baseline this indicator.

However, it can be difficult for many children and parents to make healthy food choices and get enough physical activity due to underlying social determinants of health, which include housing insecurity, food insecurity, education, poverty). Places such as child care centers, schools, or communities can affect diet and activity through the foods and drinks offered and the opportunities provided for physical activity.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 86% | 86% | 87% | 90% | 90% | 90% | 91% |
| **Result** | 88.2% | 91.6% | 90.7% | 90% | 90% | 92% | 12/30/21 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Met | Target Met | Target Exceeded | Pending |

The Transitional Living Program (TLP) supports community-based, adult-supervised residences for youth ages 16 to under 22 who cannot safely live with their own families, or for whom living with their families provides undue hardships. This long-term shelter program offers otherwise homeless youth housing for up to 18 months and provides the educational, employment, health care and life skills necessary for youth to transition into self-sufficient living. The TLP safe and appropriate exit rate is the percentage of TLP youth discharged during the year who find immediate living situations that are consistent with independent living. During FY 2019, TLPs met the 90 percent target for this measure by attaining a 90 percent safe and appropriate exit rate. During FY 2020, TLPs exceeded the 90 percent target with an actual result of 92 percent safe and appropriate exit rate.

Because safe and stable housing is one of the core outcomes for the TLP program, ACF proposes to keep this performance standard and increase the annual target to 90 percent.

***(For adult-serving programs) Increase the proportion of participants who, at program exit, express positive attitudes towards marriage (Lead Agency – ACF; Measure ID – 22G)*** [26]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | 77.4% | 77.9% |
| **Result** | N/A | N/A | 87.52% | 87.38% | 85.60% | 85.79% | 3/31/22 |
| **Status** | N/A | N/A | Actual | Actual | Actual | Target Exceeded | Pending |

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

At program exit, adults in healthy marriage programs are asked the extent to which they agree or disagree with two statements: "It is better for children if their parents are married"; and "Living together is just the same as being married" (this statement is reverse-coded). These questions measure

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

the perceived benefits clients see of marriage following involvement of a healthy marriage program. In particular, responses to these questions show whether clients, at program exit, value marriage as positive for children and something more valuable than just living together without marriage. In FY 2017, 87.52 percent of the 11,494 adults who answered these questions on their exit survey expressed positive views toward marriage at program exit. This proportion remained relatively stable in FY 2018 at 87.38 percent, but this represented a larger number of clients (15,596). In FY 2019, 85.6 percent of the 17,908 adults who answered these questions expressed positive views at program exit, a decrease from fiscal years 2018 and 2017. The proportion was similar in FY 2020, with 85.79 percent of the 17,555 adults who answered these questions expressing positive views at program exit.

***(For adult-serving programs) Increase the proportion of married couples who, at program exit, view their marriage as lifelong (Lead Agency – ACF; Measure ID – 22H)*** [27]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | 85.1% | 85.2% |
| **Result** | N/A | N/A | 94.9% | 94.2% | 94.7% | 95.2% | 3/31/22 |
| **Status** | N/A | N/A | Actual | Actual | Actual | Target Exceeded | Pending |

At program exit, adults in healthy marriage programs who are in relationships are asked the extent to which they agree or disagree with the following statement: "I view our marriage/relationship as lifelong." This question measures whether clients, following involvement in a healthy marriage program, view their relationships as a lifelong commitment. In FY 2017, 94.9 percent of 8,975 adult clients (in couple relationships) who answered this question on their exit survey viewed marriage as lifelong. In FY 2018 this number was 94.2 percent, which again reflects a higher number of clients (11,829). In FY 2019 this number was 94.7 percent, which reflects a higher number of clients (13,485) than answered the question in fiscal years 2017 and 2018. A larger proportion of clients in FY 2020 reported that they viewed their marriage as lifelong with 95.19 percent of the 13,356 clients who answered this question reporting agreement with the statement.

***(For youth-serving programs) Increase the proportion of youth who express attitudes supportive of the success sequence (Lead Agency – ACF; Measure ID – 22I)*** [28,29]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | Baseline | 50.4% | 58.5% |
| **Result** | N/A | N/A | 61.33% | 65.15% | 69.20% | 69.71% | 3/31/22 |
| **Status** | N/A | N/A | Actual | Actual | Actual | Target Exceeded | Pending |

At program exit, youth in Healthy Marriage programs were asked the extent to which they agree or disagree with five statements "It is okay to live with a boyfriend/girlfriend without being married," "It is okay to live with a boyfriend/girlfriend without a plan to be married," "It is okay to have kids without being married," "It is okay to have kids without a plan to be married," and "It is hard on kids to be raised by a single parent." These questions measure the perceived benefits of marriage and of adhering to the

[27] This is a new measure. ACF is in the process of collecting data and determining targets.
[28] This is a new measure. ACF is in the process of collecting data and determining targets.
[29] To align with the school year, grantees serving youth clients in schools will likely stop offering services in the summer of 2020, several months before the end of the fiscal year in September. Thus, the FY 2020 results might primarily reflect the attitudes of youth clients not served in schools. This pattern also happened in FY 2016 and the percentage of youth who were supportive of the success sequence was much lower than other years (56.4 percent). Therefore, ACF proposes a lower target, aligning with ACF's proposed adjustments for COVID-19 in FY 2020.

"success sequence,"[30] following involvement in the youth-focused healthy marriage program. Responses to these questions show whether youth view marriage as something positive for children and value marriage over other types of relationships. In FY 2017, 61.33 percent of 8,026 youth clients who answered these questions on their exit survey expressed attitudes supportive of the success sequence. In FY 2018, this rate was 65.15 percent of 8,617 youth clients who answered these questions, and in FY 2019 this rate was higher at 69.2 percent of 14,691 youth clients who answered these questions. The FY 2020 rate was similar to the previous year with 69.71 percent of the 10,399 youth clients who answered these questions expressing attitudes supportive of the success sequence.

## Objective 3.4: Maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers

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

### Objective 3.4 Table of Related Performance Measures

***Demonstrate improvement in nursing home health care quality by reducing the number of one-star nursing homes (Lead Agency - CMS; Measure ID - QIO7.3)[31]***

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

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

In April 2019, CMS made improvements to each of the rating system domains under the Five Star Quality Rating System. In October 2019, CMS removed measures related to residents' reported experience with pain and as a result, CMS set a new baseline. CMS advised providers that thresholds for quality measure ratings will be updated every six months beginning April 2020, however CMS is no longer able to calculate future targets or results based on the former methodology.

[30] The Millennial Success Sequence: Marriage, Kids, and the "Success Sequence" among Young Adults. 2017. Wang W. and Wilcox W.B. AEI/Institute for Family Studies.

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

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

| | CY 2015 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | CY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 17.9% | 16.7% | 16% | 16% | 15.5% | 15.4 % | 15.3% |
| **Result** | 17.1% | 16.7% | 15.4% | 14.6% | 14.0% | 14.5% | 4/30/22 |
| **Status** | Target Exceeded | Target Met | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Pending |

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

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

### *Improve dementia capability of long-term support systems to create dementia-friendly, livable communities (Lead Agency ACL; Measure ID – ALZ.3)*[32,33]

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

Of the community dwelling individuals living with Alzheimer's Disease and Related Dementias (ADRD), approximately one-third live alone, exposing them to numerous risks, which include unmet needs, malnutrition and injury, and various forms of neglect and exploitation.[34] With the number of people living with ADRD in the United States projected to grow by almost 300 percent by 2050[35], it is important to develop effective and coordinated service delivery and health care systems that are responsive to the

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

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

[34] Gould, E., Maslow, K., Yuen, P., Wiener, J. *Providing Services for People with Dementia Who Live Alone: Issue Brief.* Accessed April 14, 2014.

[35] Alzheimer's Association. *2017 Alzheimer's Disease Facts and Figures.* Accessed May 9th, 2017 at http://www.alz.org/alzheimers_disease_facts_and_figures.asp

needs of these individuals and their caregivers.

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

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

Program participants report annually on program progress in advancement of the dementia-capability of grantees and program partners. Data reported include changes in the range of services and supports each grantee provides to people with dementia, grantee capacity to provide specialized services to people with a cognitive impairment or dementia and their caregivers, implementation of dementia training for staff, and the degree to which the grantee organizations have standardized their procedures for assessing dementia among their consumers. ACL uses grantee responses to calculate grantee level of improvement between reporting periods. ACL ensures the quality of the assessment results through frequent contact with grantees, clear guidance for grantees regarding their grant activities and reporting expectations, and timely review of grantee performance data. If grantees appear to be underperforming based on the data provided, grant officers provide technical assistance.

***Increase the success rate of the Protection and Advocacy Program's individual or systemic advocacy, thereby advancing individuals with developmental disabilities right to receive appropriate community based services, resulting in community integration and independence, and have other rights enforced, retained, restored and/or expanded (Lead Agency ACL; Measure ID – 8F)[36]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | N/A | 79.6% | TBD |
| **Result** | N/A | N/A | 78.1% | 78.9% | 78.8% | 77.95% | 1/31/23 |
| **Status** | N/A | N/A | Actual | Actual | Actual | Target Not Met | Pending |

Under the Developmental Disabilities Assistance and the Bill of Rights Act of 2000 (DD Act), each state and territory has a Developmental Disabilities Protection and Advocacy (P&A) program designated by the state's governor. The DD Act and other authorizing statutes give the P&A the authority to advocate for the rights of individuals with disabilities. The DD Act states that each P&A has the authority to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State."[37] P&As provide a range of legal services and use a range of remedies, including self-advocacy assistance, negotiation, investigation, and litigation, to advocate for traditionally unserved or underserved individuals with developmental

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

[37] 42 U.S.C. 15043

disabilities. P&A authorities are critical to preventing abuse and neglect of people with disabilities and safeguarding individuals' right to live with dignity and self-determination.

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

## Strategic Goal 4: Foster Sound, Sustained Advances in the Sciences

## Objective 4.1: Improve surveillance, epidemiology, and laboratory services

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

### Objective 4.1 Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 70% | 75% | 80% | 82% | 90% | 90% | 90% |
| **Result** | 69% | 75% | 80% | 86% | 90% | 92% | 96% |
| **Status** | Target Not Met | Target Met | Target Met | Target Exceeded | Target Met | Target Exceeded | Target Exceeded |

Advancing national implementation of Electronic Laboratory Reporting (ELR) is a priority in CDC's efforts to protect the public's health. ELR replaces paper-based reporting, which accelerates reporting to public health labs; reduces the reporting burden on clinicians, hospitals, and commercial laboratories; and decreases errors and duplicate reporting. As of FY 2021, electronic laboratory reports accounted for nearly 96 percent of laboratory reports for reportable conditions received, which met the target and was an improvement over FY 2020. CDC will retire its ELR measure as it has exceeded the measure's goal and achieving additional gains in regard to ELR volume has diminishing returns.

The program considers moving from 62 percent in 2013 to 96 percent in 2021 a success.

***Increase the percentage of notifiable disease messages transmitted in HL7 format to improve the quality and streamline the transmission of established surveillance data (Lead Agency – CDC; Measure ID - 8.B.1.4)***[38]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | Baseline | 10% | 40% | 40% | 40% | 40% | 40% |
| **Result** | 1% | 3% | 5% | 5% | 7.2% | 49% | 74% |
| **Status** | Actual | Target Not Met but Improved | Target Not Met but Improved | Target Not Met but Improved | Target Not Met but Improved | Target Exceeded | Pending |

During FY 2020, the investments CDC made in technology and infrastructure positioned CDC to efficiently receive data related to the COVID-19 outbreak. Within hours of the COVID-19 emergency declaration, CDC's National Notifiable Disease Surveillance System (NNDSS), which helps public health monitor, control, and prevent diseases, issued a COVID-19 event code, which states used to notify CDC

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

of cases. CDC also updated the system used to receive this information so the COVID-19 data could be available to CDC programs. The data received as a result of this work positioned CDC's disease experts and Emergency Operations Center to better understand and support the national response.

The high volume of COVID-19 cases reported to CDC, which substantially increased the results for Measure 8.B.1.4 in 2020 continued to impact the measure during 2021, with 74% of messages for new notifiable disease cases transmitted in HL7 format. During the 2021 calendar year, NNDSS processed an average of over 1.8 million new HL7 case notifications each month.

As of December 2021, 45 of the 57 reporting jurisdictions have implemented at least one of the new HL7 messages and 34 of the 45 have implemented more than one. Forty three jurisdictions are using NNDSS to send COVID-19 notifications to CDC. Of these, 38 jurisdictions are sending notifications in the HL7 format. In addition to the increase in the percentage of notifiable disease messages transmitted in HL7 format resulting from the COVID-19 response, data transmissions continue to improve and remain much more stable indicating that CDC has achieved a more routine and reliable mode.

While further implementation of Message Mapping Guides (MMG) – a way to transmit data on diseases, for other conditions – has been temporarily delayed by COVID-19 response activities, with ongoing data modernization efforts and the best practices adopted to date, CDC anticipates more states participating in the system and for states to begin transmitting health data related to sexually transmitted diseases, vaccine preventable diseases, and foodborne diseases in future years. Efforts in 2021 focused on continued progress on the modernization process.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | N/A | 50 | 55 | 60 |
| **Result** | N/A | N/A | N/A | 74 | 68 | 79 | 86 |
| **Status** | N/A | N/A | N/A | Actual | Target Exceeded | Target Exceeded | Target Exceeded |

The Sentinel Initiative comprises multiple components including the Sentinel System, and its Active Risk Identification and Analysis (ARIA) program, FDA Catalyst, and the Biologics Effectiveness and Safety System. The Sentinel Initiative has continued to evolve rapidly in the last two years. In 2019, Congress required that FDA build on Sentinel's core successes by establishing a new Real-World Evidence Medical Data Enterprise with access to at least 10 million electronic medical records. The year 2021 marks six years of the Sentinel System serving as a fully-functional and integrated part of FDA's regulatory process. Sentinel has proven to be a vital source of safety information that informs regulatory decision-making and expands knowledge of how medical products perform once they are widely used in medical practice. In 2020, FDA began to leverage Sentinel in novel ways as part of a multi-layered response to the COVID-19 pandemic. These activities range from developing the capability for near real-time drug monitoring to inform the potential for drug shortages, describing the course of illness among patients with COVID-19, and evaluating the impact of therapies being used in COVID-19 patients under real-world conditions.

## Objective 4.2: Expand the capacity of the scientific workforce and infrastructure to support innovative research

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

### Objective 4.2 Table of Related Performance Measures

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

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | N/A | N/A | N/A |
| **FY 2018** | Develop four novel neurotechnologies for stimulating/recording in the brain to enable basic studies of neural activity at the cellular level | Projects funded through the BRAIN Initiative led to novel innovations in four neurotechnologies to enable basic studies of neural activity at the cellular level. | Target Met |
| **FY 2019** | Test new and/or existing brain stimulation devices for two new therapeutic indications in humans through the BRAIN Public-Private Partnership. | The BRAIN Initiative Public-Private Partnership Program initiated testing of brain stimulation devices for six new therapeutic indications in humans and continued to enable current and potential BRAIN investigators to gain access to medical device tools and technologies from some of the top medical device manufacturers. | Target Met |
| **FY 2020** | Provide broad access to new research approaches and techniques for acquiring fundamental insight about how the nervous system functions in health and disease | The BRAIN Initiative supported the development of novel technologies for brain stimulation and recording and efforts to disseminate resources and integrate them into neuroscience research practice. | Target Met |
| **FY 2021** | Expand our understanding of brain function at the cellular or circuit level using three to five new tools and technologies | BRAIN Initiative investigators have used multiple new tools and technologies to expand our understanding of brain function at the cellular or circuit level. | Target Met |

The NIH-funded Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative® accelerates the development and application of new neurotechnologies that will enable researchers to gain deeper understanding of how the human brain functions in normal conditions as well as states of disease or dysfunction. BRAIN-funded research to use and disseminate new tools and resources are

expanding knowledge about brain function at the cellular and circuit levels. For example: 1) Improved monoclonal antibody labels allow higher resolution microscopic imaging of neural cells and circuits, including in the retina and the hippocampus, a part of the brain critical for learning and memory; 2) A browsable reconstruction of a human brain tissue sample with tens of thousands of neurons is available through a BRAIN-funded facility focused on mapping the connections between neurons in brain circuits; 3) Researchers reported the first example of wirelessly recording human brain activity in people with Parkinson's disease for extended periods of time in their home environments, opening new doors for customizable deep brain stimulation therapies that adapt as patients go about their normal lives; 4) Researchers are testing a neuromodulation device system as a treatment for Lennox-Gastaut Syndrome, a severe form of childhood-onset epilepsy, and using it to understand brain circuits involved in the disorder; and 5) Through a collaboration including more than 250 scientists across three continents, the BRAIN Initiative Cell Census Network used multiple new single cell analysis techniques to develop an unprecedented atlas of cell types and detailed diagram of neuron connections in the mammalian primary motor cortex, the brain's movement control center.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 40% | 40% | 40% | 50% | 50% | 50% | 20% |
| **Result** | 80% | 81% | 72% | 53% | 86% | 80% | 66% |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded |

To support the Department's mission and FDA's scientific expertise, FDA is launching a new FDA Traineeship Program while continuing other Fellowship programs. This performance goal focuses on FDA's efforts to retain a targeted percentage of the scientists who complete these programs. Additionally, it is important to realize that whether "graduates" from these programs continue to work for FDA or choose to work in positions in related industry and academic fields, they are trained in using an FDA-presented understanding of the complex scientific issues in emerging technologies and innovation, which furthers the purpose of this strategic objective. FDA reset the retention target to 20% in FY 2021 to reflect the new expanded program's expected baseline. Although the Traineeship program has not yet been fully implemented, and additional programs will come online over the next few years, FDA has met the initial target of 20% in FY 2021.

## Objective 4.3: Advance basic science knowledge and conduct applied prevention and treatment research to improve health and development

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

or maintain performance.

### Objective 4.3 Table of Related Performance Measures

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

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2014** | N/A | N/A | N/A |
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | N/A | N/A | N/A |
| **FY 2018** | Optimize properties of three nanoformulation for effective delivery and antigen-specific response in immune cells. | Developed, tested, and optimized, in animal models, three unique nanodelivery systems for effective anti-cancer immunotherapeutics | Target Met |
| **FY 2019** | Further optimize top two candidate nanoformulation for co-delivery of multiple antigens to enhance anti-tumor response in one animal model. | Further optimized two unique nanodelivery systems for effective anti-cancer immunotherapeutics in different animal models and showed promising results for consideration in clinical trials | Target Met |
| **FY 2020** | Further optimize the top candidate nanoformulation for co-delivery of antigens, adjuvants and immuno-modulators and evaluate its efficacy and long-lasting immunity (over 3 months) in preclinical models with established tumors. | Further optimized two nanodelivery systems that were identified as the top candidates. Researchers are testing both systems in cancer patients who have advanced stages of cancer. | Target Met |
| **FY 2021** | Further optimize the top candidate nanoformulation for co-delivery of antigens, adjuvants and immuno-modulators and evaluate its efficacy towards near and distance metastatic lesions in preclinical models with established tumors. | While the two nanodelivery systems are being tested in clinical trials, they have been further optimized to increase their effectiveness. Early results in an animal model showed that they can successfully deliver multiple interventions simultaneously to induce an immune response to eradicate both local and distant tumors. | Target Met |

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

NIH-funded research has demonstrated the effectiveness of using nano-enabled immunotherapy to deliver cancer drugs and vaccines to immune cells to enhance their ability to kill cancer cells. In FY 2021, NIH-funded researchers delivered two interventions simultaneously in an animal model of colon cancer, leading to the total elimination of both the primary colon tumor and the distant metastatic tumors that developed. In addition to co-delivering drugs, the researchers used nano-enabled immunotherapies in another animal model to increase tumor vaccine efficacy and provide long-lasting immunity against

tumor development. With additional research and development, NIH expects that these nano-enabled immunotherapies will offer new treatment options for people with cancer or provide effective vaccines for people at high risk of developing cancers.

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

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | Strategy 1: Continue enrolling participants into two studies to test the safety, tolerability, and effectiveness of VRC01 as an intravenous prevention strategy. | Enrollment of participants continued for both studies. | Target Met |
| **FY 2018** | Strategy 2: Analyze primary results of a Phase 2a study examining the long-acting injectable, cabotegravir, for the prevention of HIV | Analysis of primary results has been conducted and results are in press. | Target Met |
| **FY 2019** | Strategy 3: NIH-funded investigators complete final analysis of an open-label extension study that builds on the findings of an earlier trial and aims to assess the continued safety of the dapivirine vaginal ring in a more real-world context and study participants' adherence | NIH-funded investigators completed final analysis of an open-label extension study that built on the findings of an earlier trial and aimed to assess the continued safety of the dapivirine vaginal ring and study participants' adherence to its use. | Target Met |
| **FY 2020** | Strategy 1: Complete follow-up of participants in studies testing the safety, tolerability, and effectiveness of VRC01. | NIH-funded investigators completed follow-up of participants in two studies testing the safety, tolerability, and effectiveness of VRC01. | Target Met |
| **FY 2021** | Strategy 1: Analyze data of two studies testing the safety, tolerability, and effectiveness of VRC01 broadly neutralizing antibody (bnAb). | NIH-funded investigators analyzed data from the two studies and published their findings online in March 2021. | Target Met |

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

Since FY 2016, NIH has funded two proof-of-concept studies to assess whether giving people without HIV an infusion of VRC01, a "broadly neutralizing antibody" or bnAb (capable of stopping a wide range of HIV strains from infecting human cells), every eight weeks was an effective way to protect against HIV. In FY 2021, the researchers showed that VRC01 can safely prevent people from contracting some types of HIV. However, in both studies an infusion of VRC01 at eight-week intervals over twenty months did not significantly reduce the overall rates of HIV transmission in study participants. These findings suggest that a combination of two or more neutralizing antibodies may be needed to effectively prevent HIV.

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

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2014** | Complete Discovery Phase whole genome sequencing and analysis of 582 family members from 111 families with late onset AD to identify genomic regions associated with increased risk of AD; sequencing of the coding regions of the DNA (whole exome sequencing) of 5,000 cases / 5,000 controls for both risk raising and protective loci; and whole exome sequencing and analysis of one individual from ~1,000 additional AD families to identify regions associated with increased risk or protection from AD. | Sequencing and an initial level of analysis were completed. | Target Met |
| **FY 2015** | Initiate Replication Phase to validate genes / regions of interest identified from case-control and family sequencing in ~50,000 samples from well phenotyped individuals by targeted sequencing and/or genotyping. | Sample selection for whole genome sequencing on additional multiply affected families was initiated. Planning of the Replication Phase has begun. | Target Met |
| **FY 2016** | Begin confirmation of genomic regions of interest identified in the Discovery Phase using samples from the Replication phase.<br><br>Begin harmonization of data from Discovery phase datasets with data from Replication Phase for confirmation of regions of interest. | Sample selection/sequencing Discovery Extension phases completed (4,000 additional whole genomes). Data analysis for Extension Phase initiated. Genomic Center for Alzheimer's Disease funded (all ADSP quality control and data harmonization). | Target Met |
| **FY 2017** | Continue confirmation of genomic regions of interest in the Discovery and Replication phase datasets.<br><br>Continue harmonization of Discovery Phase and Replication Phase datasets. | NIH met its target of confirming genomic regions of interest in the Discovery and Replication phase data sets and continues to harmonize the Discovery Phase and Replication Phase data sets. | Target Met |
| **FY 2018** | Continue confirmation of genomic regions of interest in the Discovery phase using samples from the Replication phase.<br><br>Continue harmonization of Discovery Phase and Replication Phase datasets.<br><br>Begin analysis of genomic regions of interest in the genomes of minority cohorts. | NIH continued confirmation of genomic regions of interest in the Discovery Phase using samples from the Replication Phase, continued harmonization of Discovery Phase and Replication Phase datasets, and began analysis of genomes of minority cohorts. | Target Met |
| **FY 2019** | Begin analysis of genomic regions of interest in the ADSP Discovery Follow-Up Phase using whole genome sequence data from ethnically diverse cohorts.<br><br>Continue confirmation of genomic regions of interest in the Discovery Phase using samples from the Follow-Up phase. | The ADSP Discovery Follow-Up Phase has begun to analyze genomic regions of interest using whole genome sequence data from ethnically diverse cohorts. The ADSP has continued its confirmation of genomic regions identified in the Discovery Phase of the | Target Met |

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| | Continue harmonization of Discovery Phase and Follow-Up Phase datasets. | project. Genetic data for all phases of the ADSP have been harmonized. | |
| **FY 2020** | Continue analysis of ADSP Discovery Follow-Up Phase in ethnically diverse cohorts. Continue confirmation of genomic regions of interest from Discovery Phase and Discovery Follow-Up Phase in ethnically diverse datasets. Compare data on genomic regions of interest by ethnicity. | Data analysis for the ADSP Discovery follow-up Phase continued. Ongoing data analysis includes analysis from genomic regions of interest in ethnically diverse cohorts with increased sample size and data comparison on genomic regions of interest by ethnicity. | Target Met |
| **FY 2021** | Continue analysis of ADSP Discovery Follow-Up Study in ethnically diverse cohorts. Continue confirmation of genomic regions of interest from Discovery Phase and Discovery Follow-Up Phase in ethnically diverse datasets. Begin harmonization of phenotypic data with ADSP genetic data across multiple types of study approaches from large epidemiology and clinical cohorts that are outside of the ADSP. | Data analysis for the ADSP Discovery Follow-up Study continued, and an initiative was launched to expand the ADSP sample sets to represent more diverse populations. The ADSP continued its confirmation of genomic regions of interest in ethnically diverse cohorts and identified important functional genomic elements that characterize the architecture of the Alzheimer's Disease genome. The ADSP continued to perform quality control and harmonize genetic data across all cohorts and all phases of the study. | Target Met |

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

The overall goal of the NIH-supported Alzheimer's Disease Sequencing Project (ADSP) is to identify genetic variants associated with risk of and protection from AD and apply this knowledge to develop a new treatment approach, drug target, or pathway to prevent late-onset AD. More than 150 investigators from institutions across the globe participate in the project. In FY 2021, the ADSP continued to identify and confirm genes associated with AD by performing quality control and harmonizing genetic data across all the different cohorts of patients. These steps are essential to generating the comprehensive and accurate dataset required for AD gene identification. The ADSP also expanded its work with ethnically diverse populations, including Hispanic/Latino and Black/African American, by launching the Diverse Population Initiative to increase the diversity of the ADSP sample sets. This effort will provide a greater opportunity to identify genes associated with AD and improve the ability to identify specific therapeutic targets that can inform the development of new treatment strategies for many different populations. This initiative is also expected to move the field closer to being able to predict who will develop AD, giving doctors the ability to intervene early on before symptoms appear. Lastly, the ADSP began using machine learning and artificial intelligence to analyze the genetic data, which is expected to lead to the identification of even more new genes and genetic pathways, which will be useful for identifying more promising approaches to prevent and treat AD.

## Objective 4.4: Leverage translational research, dissemination and implementation science, and evaluation investments to support adoption of evidence-informed practices

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

### Objective 4.4: Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 64.1 % | 62.4 % | 57.3% | 56.4% | 64.5% | 65.8% | 69.3% |
| **Result** | 59.4 % | 53.4% | 53.4% | 61.5% | 62.8% | 66.3% | 10/30/22 |
| **Status** | Target Not Met | Target Not Met | Target Not Met | Target Exceeded | Target Not Met, but Improved | Target Exceeded | Pending |

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

The FY 2018 result represented an increase with grantees reporting 61.5 percent of funds directed at evidence-based practices, which then increased again in FY 2019 with an actual result of 62.8 percent. In FY 2020, the percentage spent on evidence-based practices increase to 66.3 percent, exceeding the target of 65.8 percent. ACF will continue to promote evaluation and innovation to expand the availability and use of evidence-informed and evidence-based practice over time.

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

| Fiscal Year | Target | Result | Status |
|---|---|---|---|
| **FY 2014** | N/A | N/A | N/A |
| **FY 2015** | N/A | N/A | N/A |
| **FY 2016** | N/A | N/A | N/A |
| **FY 2017** | Develop two strategies for translating validated basic knowledge, clinical interventions, or behavioral interventions to diverse communities and clinical practice through establishing the Partnerships to | Several U54 PACHE Partnerships have developed and/or validated evidence-based interventions and tools to help reduce the burden of cancer disparities in underserved communities across the | Target Met |

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

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

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

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

## Strategic Goal 5: Promote Effective and Efficient Management and Stewardship

## Objective 5.1: Ensure responsible financial management

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

### Objective 5.1 Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 [39] | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 8.5% | 9.14 % | 9.5 % | 8.08% | 7.9% | 7.77% | N/A[40] |
| **Result** | 9.5% | 10% | 8.3% | 8.10% | 7.87% | 6.78% | 10.28% |
| **Status** | Target Not Met | Target Not Met | Target Exceeded | Target Met | Target Exceeded | Target Exceeded | Actual |

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

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

Per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

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

| | FY 2015 | FY 2016 [41] | FY 2017 | FY 2018 | FY 2019 | FY 2020[42] | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 3.5% | 3.4% | 3.3% | 1.66% | 1.65% | 0.74% | 1.14% |

[39] CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.
[40] The FY 2021 target was not established.
[41] Ibid.
[42] Ibid.

| | FY 2015 | FY 2016 [41] | FY 2017 | FY 2018 | FY 2019 | FY 2020[42] | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Result** | 3.6% | 3.41% | 1.67% | 1.66% | 0.75% | 1.15% | 1.58% |
| **Status** | Target Not Met | Target Met | Target Exceeded | Target Met | Target Exceeded | Target Met | Target Met |

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

In FY 2021, CMS met its target of 1.14 percent, reporting an actual improper payment estimate of 1.58 percent, or $1.37 billion. The improper payment estimate due to lacking or insufficient documentation is 0.65 percent or $0.56 billion, representing 41.19 percent of total improper payments. The increase from the prior year's estimate of 0.43 percent is due to year-over-year variability, and is not statistically different from the prior year. As the rate is already low, variation in sampled error values or error category breakouts can cause minor shifts in the total estimated error rate. Per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 12.5% | 11.5% | 10.4% | 9.4% | 8.0% | 7.15% | 6.17% |
| **Result** | 12.1% | 11.0% | 9.5% | 8.12% | 7.25% | 6.27% | 6.26% |
| **Status** | Target Met | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Met |

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

In FY 2020, CMS met its target of 6.17 percent, with an actual improper payment estimate of 6.26 percent, or $25.03 billion. While the factors contributing to improper payments are complex and vary by year, the primary causes continue to be insufficient documentation and medical necessity errors. Per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

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

***Reduce the improper payment rate in the Medicaid Program (Lead Agency - CMS; Measure ID - MIP9.1)[43]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 6.70% | 11.5 % | 9.57% | 7.93% | N/A | N/A | N/A |
| **Result** | 9.78% | 10.48% | 10.10% | 9.79% | 14.90% | 21.36% | 21.69% |
| **Status** | Target Not Met | Target Exceeded | Target Not Met but Improved | Target Not Met but Improved | Actual | Actual | Actual |

***Reduce the improper payment rate in the Children's Health Insurance Program (Lead Agency - CMS; Measure ID - MIP9.2)[44]***

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 6.50% | 6.81% | 7.38% | 8.20% | N/A | N/A | N/A |
| **Result** | 6.80% | 7.99% | 8.64% | 8.57% | 15.83% | 27.00% | 31.84% |
| **Status** | Target Not Met | Target Not Met | Target Not Met | Target Not Met but Improved | Actual | Actual | Actual |

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

Due to the COVID-19 Public Health Emergency (PHE), in FY 2020, CMS exercised its enforcement discretion by temporarily suspending all improper payment related engagement/communications and data requests to providers and state agencies from CMS. CMS adjusted the sample size for the FY 2021 Medicaid and CHIP measurement programs to account for ongoing challenges incurred by providers and states during COVID-19 while continuing to maintain appropriate accountability measures and meet the statutory obligations.

The national Medicaid improper payment (MIP 9.1) estimate for FY2020 HHS AFR is 21.69 percent or $98.72 billion. The national Medicaid component rates are 13.90 percent for Medicaid FFS, 0.04 percent for Medicaid managed care, and 16.62 percent for the Medicaid eligibility component.

The national CHIP gross improper payment (MIP 9.2) estimate for FY 2020 is 31.84 percent, or $5.37 billion. The national CHIP component rates are 13.67 percent for CHIP FFS, 0.48 percent for CHIP managed care, and 28.71 percent for the CHIP eligibility component.

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

One area driving the FY 2021 Medicaid and CHIP improper payment estimates is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the PPACA requirements in the PERM eligibility reviews. CMS began utilizing the updated eligibility component beginning in the FY 2019 measurement cycle. A federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of eligibility determinations, and increases the oversight of identified vulnerabilities. CMS has completed the measurement of all states under the revamped eligibility component and established a national baseline in FY 2021.

In order to reduce the national Medicaid and CHIP improper payment rates, states are required to develop and submit states-specific Corrective Action Plans (CAPs) to CMS. Each year, CMS also outlines actions the agency will implement to prevent and reduce improper payments for all error categories on a national level. Please refer to the 2021 HHS AFR or detailed information on corrective actions.

## Objective 5.2: Manage human capital to achieve the HHS mission

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

### Objective 5.2 Table of Related Performance Measures

***Increase HHS employee engagement through Federal Employee Viewpoint Survey (FEVS) (Lead Agency - ASA; Measure ID - 2.6)*** [45,46]

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | 67% | 68% | 69% | 72.5% | 73% | 75% | 73% |
| **Result** | 68% | 70% | 72% | 72.8% | 73.5% | 76.5% | 3/30/22 |
| **Status** | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Target Exceeded | Pending |

Employee engagement is foundational to achieving the level of active strategic management needed for building and sustaining the 21st century workforce. The Office of Personnel Management (OPM) FEVS measures employee engagement because it drives performance.[47] Engaged employees look at the whole of the organization and understand their purpose within the agency's mission. This understanding leads to better decision-making. The FEVS survey usually opens in May each year; however, due to COVID-19 and workplace disruptions, OPM postponed the survey again for 2021 with results expected in March 2022.

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

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | 80 days | 80 days | 80 days | 80 days |
| **Result** | N/A | 108 days | 101 days | 94 days | 113 days | 83 days | 110 days |
| **Status** | N/A | Actual | Actual | Target Not Met but Improved | Target Not Met | Target Not Met but Improved | Target Not Met |

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

During FY 2021, the customer base continued to grow due to a surge in hiring in response to the COVID-19 crisis. While the expanded use of shared certificates enabled by the maturation of the HireNow resume search tool, the average time to hire at HHS increased from 83 days to 110 days. Multiple factors such increased demand and employee churn as well as parts of the hiring process that are not controlled by HR (e.g., badging and security) contributed to the increase in cycle time.

## Objective 5.3: Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals

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

### Objective 5.3 Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Baseline | 96.5% | 97% | 100% |
| **Result** | N/A | N/A | N/A | 96% | 95% | 98% | 99% |
| **Status** | N/A | N/A | N/A | Actual | Target Not Met | Target Exceeded | Target Not Met but Improved |

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

It is the responsibility of the OpDiv Chief Information Security Officers and StaffDiv system owners to maintain their system ATOs. The implementation of a series of proactive initiatives coupled with the creation of several new information systems in support of HHS' COVID-19 response, HHS has made continued improvements toward meeting the ATO compliance target.

***Improve the score to an "A" in each of the Federal Information Technology Acquisition Reform Act (FITARA) related Scorecard Metrics, per GAO and the House Oversight and Government Reform Committee (Lead Agency - ASA; Measure ID - 3.4)*** [48]

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

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

## Objective 5.4: Protect the safety and integrity of our human, physical, and digital assets

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

### Objective 5.4 Table of Related Performance Measures

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

| | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|---|---|
| **Target** | N/A | N/A | N/A | Baseline | 6.8% | 6.5% | 6.2% |
| **Result** | N/A | N/A | N/A | 7% | 4.5% | 4.7% | 4.8% |
| **Status** | N/A | N/A | N/A | Actual | Target Met | Target Met | Target Met |

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

Phishing is a fraudulent attempt to obtain sensitive information (e.g., usernames and passwords) to access a system or network. Statistics suggest phishing attacks remain one of the main threat vectors targeting the healthcare industry. HHS trains and educates its personnel to reduce the likelihood of staff mistaking phishing email attempts for legitimate communications through a combination or training, education, and tools. The response rates to phishing training drills remain well below the industry average. HHS will continue this program in FY 2022 and strive to improve user reporting and resistance rates.

### *Maintain the number of days since last major incident of personally identifiable information (PII) breach (Lead Agency - ASA; Measure ID - 3.6)*[49]

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

If an employee misuses, loses, or otherwise compromises PII, the action may result in steep financial costs and damage to the Department's reputation. This measure serves as an enterprise-wide countdown since the last breach, based on the OMB definition of a major incident in the Department. HHS has not reported a major breach in more than 1,461 days. HHS works closely with OpDiv privacy programs to continue to protect PII that is collected, used, maintained, shared, and disposed of by HHS information systems.

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

## Evidence Building Efforts

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

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

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

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

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

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

## Cross-Government Collaborations

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

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

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

## Lower-Priority Program Activities

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

## Data Sources and Validation

Please refer to https://www.hhs.gov/about/budget/fy2023/performance/performance-plan-data-sources-and-validation/index.html?language=es for supporting information on the performance goals in the HHS FY 2021 Annual Performance Report.