U.S. Department of Health and Human Services
FY 2020 Annual Performance Plan and Report

Message from the HHS Performance Improvement Officer

The U.S. Department of Health and Human Services (HHS) supports and implements programs that enhance the health, safety, and well-being of the American people. 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 2020 Annual Performance Plan and Report, documenting the Department's performance during the past year. Further information detailing HHS performance is available at Performance.gov.

In FY 2018, HHS monitored over 1,000 performance measures to manage departmental programs and activities and improve the efficiency and effectiveness of these programs. This report includes a representative set of performance measures to illustrate progress toward achieving the Department's strategic goals. The information provided spans the Department's 11 operating divisions and 14 staff divisions and includes work 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. The results presented here demonstrate that HHS is performing well across a wide range of activities.

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Overview

The U.S. Department of Health and Human Services 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) provide leadership, direction, and policy and management guidance to the Department.

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 regulated 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 (AHRQ)[1]
- 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 and (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

[1] The FY 2020 Budget proposes to consolidate AHRQ's activities within NIH as the National Institute for Research Safety and Quality.

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)
- Office for Civil Rights (OCR)
- Departmental Appeals Board (DAB)
- Office of the General Counsel (OGC)
- Office of Global Affairs (OGA)
- Office of Inspector General (OIG)
- Office of Medicare Hearings and Appeals (OMHA)
- 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 Government Performance and Results Modernization Act (GPRAMA) requirement to address Cross-Agency Priority (CAP) Goals in the agency strategic plan, the annual performance plan, and the annual performance report, please refer to www.Performance.gov for the agency's contributions to those goals and progress, where applicable.

Agency Priority Goals

Information on the HHS Agency Priority Goals can be found at: www.Performance.gov.

Strategic Goals Overview

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

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

Performance Management

Performance goals and measures are powerful tools to advance an effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions, to achieve meaningful progress, 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 priority goals and conducting quarterly 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.
- Overseeing performance measurement, budgeting, strategic planning, and program integrity 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

The GPRA Modernization Act of 2010 aligned agency strategic planning cycles to Presidential election cycles and Administration transitions. As a result, HHS's FY 2018–2022 Strategic Plan established a new set of strategic priorities that began in FY 2018, making the necessary retrospective evidence from FY 2017 unavailable to agency leadership to conduct a review of progress against the agency's updated strategic objectives. Therefore, HHS was unable to categorize the strategic objectives as making Noteworthy Progress, Progressing, or a Focus Area for Improvement, which is the normal result of a strategic review. In place of a review of progress, HHS established a baseline of evidence for the FY 2018–2022 Strategic Plan to inform future strategic reviews. The agency's Annual Performance Report instead focuses on reporting the results of progress made and accomplishments achieved against performance goals. Strategic review summaries and categorizations of progress accompanying HHS's strategic objective descriptions will be reported in future agency Annual Performance Reports.

Annual Performance Plan and Report

The Annual Performance Plan and Report provides information on the Department's progress towards achieving the goals and objectives described in the HHS Strategic Plan FY 2018 – 2022. This report is organized according to that strategic plan and the information in the report reflects results available at the end of FY 2018.

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

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, CMS, and FDA.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	55.0%	53.0%	50.0%	48.0%	43.0%	37.0%	28.0%	25%
Result	52.0%	53.0%	49.0%	48.0%	04/30/19	4/30/20	4/30/21	4/30/22
Status	Target Exceeded	Target Met	Target Exceeded	Target Met	Pending	Pending	Pending	Pending

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

While Medicare Part D offers substantial insurance coverage for prescription drugs, 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"). For 2019, this gap in coverage is above $3,820 in total drug costs, and up until a beneficiary spends $100 out-of-pocket.

Public Law No. 115-123, also known as the Bipartisan Budget Act of 2018 enacted on February 9, 2018, increased the manufacturer discount for beneficiaries in the gap from 50 to 70 percent and reduced beneficiary cost sharing to 25 percent in 2019 for applicable drugs. The discount is applied 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 and to ensure that the coverage gap is closed completely by

2020 as required by law. For 2020 and beyond, the beneficiary, on average, will only be responsible for 25 percent of the costs of both generic and brand name drugs while in the coverage gap, which makes this coverage equivalent to coverage prior to reaching the gap.

Increase the percentage of Medicare Fee-for-Service (FFS) Payments tied to Alternative Payment Models (Lead Agency - CMS; Measure ID - MCR30.1)

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	
Target	N/A	Baseline	26%	30%	40%	50%	Discontinued	
Result	N/A	22%	26%	31%	38%	11/30/19	N/A	
Status	N/A	Historic Actual	Target Met	Target Exceeded	Target Not Met but Improved	Pending	N/A	

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	N/A	Baseline	TBD
Result	N/A	N/A	N/A	N/A	N/A	N/A	12/15/19	12/15/20
Status	N/A	N/A	N/A	N/A	N/A	N/A	Pending	Pending

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

To encourage alignment, Medicare is leading the way by publicly tracking and reporting payments tied to alternative payment models. Moving payments to more APMs in an aligned fashion and on an aligned timeframe increases the overall likelihood that new payment models will succeed. CMS uses a framework to describe and measure health care payments through the stages of transition from pure FFS to more advanced alternative payment models.

Despite falling short of its 2017 target, CMS continued to make good progress and increased the percentage of FFS Medicare payments tied to APMs to 38 percent. CMS will discontinue this goal in 2018 and replace it with a new measure tying FFS Medicare payments to the downside risk of APMs.

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

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, AHRQ, CDC, CMS, HRSA, OCR, ONC, and SAMHSA.

Objective 1.2 Table of Related Performance Measures

Increase the percentage of hospitals reporting implementation of antibiotic stewardship programs fully compliant with CDC Core Elements of Hospital Antibiotic Stewardship Programs (Lead Agency - CDC; Measure ID - 3.2.5)

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	Baseline	N/A	50.0%	61.3%	68.8%	84.4%	100.0%
Result	N/A	40.9 %	N/A	64%	76.4%	11/30/19	11/30/20	11/30/21
Status	N/A	Historic Actual	N/A	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Antibiotics have been a critical public health tool since the discovery of penicillin in 1928, which saved the lives of millions of people around the world. Today, however, CDC estimates that drug-resistant bacteria cause two million illnesses and approximately 23,000 deaths each year in the United States alone. In 2017, about 76.4 percent of U.S. acute care hospitals reported having an antibiotic stewardship program that incorporates all of the CDC Core Elements for Hospital Antibiotic Stewardship Programs. In FY 2019 and 2020, CDC will continue to work with public and private partners to encourage hospitals to continue implementing antibiotic stewardship programs that are fully compliant with CDC Core Elements for Hospital Antibiotic Stewardship Programs to improve health care, decrease health consequences (e.g., C. difficile infections), and ultimately prevent antibiotic resistance.

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

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Target	N/A	N/A	N/A	N/A	N/A	Prior Result -1.0%	Prior Result -1.0%	Prior Result - 0.5%
Result	85.7%	83.4%	84.0%	83.7%	4/30/19	4/30/20	4/30/21	4/30/22
Status	Historic Actual	Historic Actual	Historic Actual	Historic Actual	Pending	Pending	Pending	Pending

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital is

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

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.

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 2017, an estimated 12 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.

Based on national trends, which reflect a slowing in readmissions reductions for all Medicare beneficiaries after a number of years of larger declines, CMS has selected a more modest target reduction rate for CY 2020 of 0.5 percent.

Improve hospital patient safety by reducing preventable patient harms (Lead Agency – CMS; Measure ID – QIO11)[3,4,5,6]

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Target	N/A	N/A	N/A	N/A	86 harms	82 harms	78 harms	TBD
Result	N/A	98 harms	94 harms	90 harms	86 harms	12/31/19	12/31/20	12/31/21
Status	N/A	Historic Actual	Historic Actual	Historical Actual	Pending	Pending	Pending	Pending

Preventable harms can cause additional pain, stress, and costs to the patient and their family during intended treatment and increase spending on the part of payers. This measure utilizes the AHRQ National Scorecard, which includes abstraction from a nationally representative sample of approximately 20,000 hospital charts per year that yields clinical relevant yet highly standardized national hospital safety metrics. This represents an enormous contribution to the government's ability to measure, monitor, and improve patient safety at a national scale. As a composite of many different harms, the AHRQ 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 2016, the all cause harm metric is being calculated differently due to two significant events that impacted the calculation: Hospital Inpatient Quality Reporting Program changes and International Classification of Diseases, 9th Revision, to International Classification of Diseases, 10th Revision, conversions. As a result, CMS adjusted the previously reported targets and results for this performance goal. CMS anticipates that other changes to the sampling methodology will need to be made after 2019

[3] 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.
[4] 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.
[5] Targets and results for this performance goal have been revised since the release of the FY 2019 President's Budget due to significant revisions in methodology that impacted the calculation. (See performance narrative).
[6] 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.

based on improved definitions and sampling methodology, which may require the realignment of targets for 2020 and beyond.

Using this new sampling methodology, CMS observed a 4 percent decline from the 2014 revised baseline to 2015 and an 8 percent decline from 2014 to 2016, which resulted in an estimated 350,000 fewer hospital acquired conditions, 8,000 lives saved from harms avoided, and $2.9 billion in costs saved.[7] CMS has committed to a 20 percent reduction in all cause harm by 2019. The proposed 2019 target is a 20 percent reduction in patient harms from the 2014 baseline (annualized reduction [-4.4 percent] applied for 5 years). Given the progress to date and the active intervention of Hospital Improvement Innovation Networks, CMS and AHRQ believe that this is a challenging, yet achievable goal.

Reduce the standardized infection ratio (SIR) central line-associated bloodstream infection (CLABSI) in acute care hospitals (Lead Agency - CDC; Measure ID - 3.3.3)[8,9]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	0.5	0.4	Baseline	0.90	0.80	0.70	0.60	.50
Result	0.54	0.5	1.0	.89	11/30/19	11/30/20	11/30/21	11/30/22
Status	Target Not Met but Improved	Target Not Met but Improved	Historic Actual	Target Exceeded	Pending	Pending	Pending	Pending

Reducing health care-associated Infections (HAIs) across all health care settings supports the HHS mission to prevent infections and their complications as well as reduce excess health care costs in the U.S. These efforts also align with the National Action Plan to Prevent Health Care Associated Infections: Roadmap to Elimination (National HAI Action Plan),[10] National Action Plan for Combatting Antibiotic Resistance Bacteria (CARB), and Healthy People 2020 Goals. CDC exceeded its FY 2016 target with a result of 0.89 SIR, which is an 11 percent decrease compared to the new 2015 baseline. In FY 2019 and 2020, CDC will continue to monitor HAIs and to develop strategies for prevention.

Reduce standardized infection ratio for hospital-onset Clostridioides difficile infections (Lead Agency - CDC; Measure ID - 3.2.4b)[11, 12]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	Baseline	Baseline	0.84	0.76	0.75	0.70	.70
Result	N/A	1.00	1.00	0.92	3/31/19	3/31/20	3/31/21	3/31/22
Status	N/A	Historic Actual	Historic Actual	Target Not Met but Improved	Pending	Pending	Pending	Pending

Clostridioides difficile infection (CDI)[13] 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 the 2015 National HAI Action Plan.[14] In FY 2016, the SIR for hospital-onset CDI was 0.92. Although the target of 0.84 was not met, progress was made in

[7] https://www.ahrq.gov/news/newsroom/press-releases/declines-in-hacs.html
[8] The baseline for this measure was updated in FY 2015 and will affect future targets and data reporting for FY 2016 onward.
[9] 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.
[10] https://health.gov/hcq/prevent-hai-action-plan.asp
[11] FY 2019 targets reflects proposed changes to program resources for antibiotic resistance.
[12] CDC rebaselined Measure 3.2.4b in 2015, and subsequent targets were adjusted to align to changes in the current HHS HAI Action Plan.
[13] https://www.nejm.org/doi/full/10.1056/NEJMoa1408913
[14] https://health.gov/hcq/prevent-hai-action-plan.asp

reducing CDIs in these health care settings. FY 2019 and 2020 targets are set at 0.70, which is consistent with the current HAI Action Plan CDI goal.

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

Accessing health services involves gaining entry into the health care system, usually through payment; gaining access to diverse options for receiving treatment, services, and products, including physical locations and online options; and having a trusted relationship with a health care provider. Efforts to improve access to care are not limited to physical health care. Improving access to behavioral and oral health care, including through innovative solutions that use health information technology, also is critical, especially for populations experiencing disparities in access. To improve outcomes in this objective, HHS is working to address the high cost of care, lack of availability of services, and lack of culturally competent care.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, CMS, HRSA, IHS, IOS, OCR, OGA, and SAMHSA.

Objective 1.3 Table of Related Performance Measures

Track the number of unique individuals who received direct services through Federal Office of Rural Health Policy (FORHP) Outreach grants, subject to the availability of resources (Lead Agency - HRSA; Measure ID - 29.IV.A.3)[15]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	395,000	400,000	400,000	410,000	415,000	420,000	425,000	200,000
Result	703,070	820,176	837,511	993,187	704,700	10/31/19	10/31/20	10/31/21
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

FORHP Outreach grants focus on improving access to care in rural communities through the work of community coalitions and partnerships. These grants often focus on disease prevention and health promotion, but can also support expansion of services such as primary care, mental and behavioral health care, and oral health services. Over 700,000 people received direct services supported through Outreach grants in FY 2017. In FY 2019 and 2020, FORHP will continue to fund non-categorical grants that allow rural communities to respond to health care challenges and issues unique to rural areas.

Improve patient and family engagement by improving shared decision-making (Lead Agency - CMS; Measure ID - MCR31)[16]

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Target	N/A	Baseline	N/A	N/A	76%	Baseline	TBD	TBD
Result	N/A	74.6%	75.2%	75.4%	75.85%	7/31/19	7/31/20	7/31/21
Status	N/A	Historic Actual	Historic Actual	Historic Actual	Target Not Met but Improved	Pending	Pending	Pending

Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce unnecessary costs.

[15] A new cohort of FORHP Outreach grants is awarded for a three-year project period. During the first year of the project period, the number of people receiving direct services through the FORHP Outreach grants tends to be lower due to program start up. The numbers generally increase throughout the project period as outreach efforts are implemented.

[16] The methodology for this measure changed in CY 2018. Due to this change, a new baseline needs to be established before future targets are set.

Similarly, Congress designed the Merit-based Incentive Payment System (MIPS) to tie Medicare payments to clinicians to quality and cost efficient care, to drive improvement in care processes and health outcomes, and to increase the use of health care information. The purpose of this performance goal is to help assess an important component of patient experience of care with their provider. Shared decision making between patient, caregiver, and provider is considered to be a fundamental component of a patient-centered health care system that leads to improved health outcomes for patients.

The final results reported are representative of the survey results from the Shared Decision Making Summary Survey Measure (SSM), which is collected and reported through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Physician Quality Reporting programs, the Merit-Based Incentive Program, and the CAHPS for Accountable Care Organizations (ACOs) Survey administered by ACOs participating in the Medicare Shared Savings Program. The SSM is the percentage of patients who gave positive responses on experience in sharing decision making with providers on topics related to medications, procedures, and information sharing. A higher score indicates a better experience with shared decision making.

CMS set the CY 2017 target for this goal at 76 percent, which is between the 80th and 90th percentiles for all Shared Savings Program ACOs that used the CY 2015 Shared Savings Program quality measure benchmarks. The mean performance on this measure was 75.40 percent in CY 2016 and was 75.85 percent in CY 2017.

Because the agency implemented a revised shortened version of the survey in CY 2018 for both ACOs and MIPS, the CY 2018 performance period was a developmental year. CMS plans to re-establish the baseline for this goal based on the results from the new survey for CY 2018, which is expected to be available to CMS in April 2019. In addition, CMS intends to provide targets for CY 2019, CY 2020, and CY 2021 when the new survey scores are available.

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	8,600	8,901	10,359	11,600	13,600	14,900
Result	7,397	8,298	9,773	10,388	12,212	13,204	12/31/20	12/31/21
Status	Historic Actual	Historic Actual	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

IHS increased efforts to expand access to care through the integration of telemedicine with community-based services. An important specialty care delivered through this telehealth option includes behavioral health services. The FY 2018 target was 11,600, and the FY 2018 result was a total of 13,204 encounters. IHS exceeded its FY 2018 target by 14 percent. From FY 2013 to FY 2018, results for this measure increased by 79 percent. In FY 2019 and 2020, IHS will continue to expand access to care through telehealth behavioral services.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: CDC, CMS, HRSA, IHS, OCR, and SAMHSA.

Objective 1.4 Table of Related Performance Measures

Support field strength (participants in service) of the National Health Service Corps (NHSC) (Lead Agency - HRSA; Measure ID - 4.I.C.2)[17, 18,19]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	7,128	7,522	8,495	9,153	9,219	8,705	11,410	12,570
Result	8,899	9,242	9,683	10,493	10,179	10,939	12/31/19	12/31/20
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

As of September 30, 2018, 10,939 primary care medical, dental, and mental and behavioral health practitioners were providing service nationwide through the following programs: NHSC Scholarship Program, NHSC Loan Repayment Program, NHSC Students to Service Loan Repayment Program, and the State Loan Repayment Program. These programs collectively serve the immediate needs of underserved communities and support the development and maintenance of a pipeline of health care providers capable of meeting the needs of these communities in the future. In FY 2019 and 2020, NHSC will continue to assist students through scholarships and loan repayments and professionals through

[17] This measure reports on the number of people who received assistance through the NHSC scholarship and loan programs who are currently in the field. NHSC field strength data include awards made from the FY 2017 Zika Supplemental, which supported providers in the U.S. territories.

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

[19] Previously HRSA reported an FY 2019 target of 8,810 NHSC participants in the field. Since the publication of the FY 2019 APP/R, HRSA has received additional FY 2019 funding and has increased its targets accordingly.

loan repayment awards as incentives to practice in underserved communities.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ATSDR, CDC, FDA, HRSA, IHS, NIH, OASH, OCR, OGA, and SAMHSA.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	1,145	1,128	967	903	838
Result	1,277	1,216	1,211	1,164	1,114	7/31/19	7/31/20	7/31/21
Status	Historic Actual	Historic Actual	Historic Actual	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

Although cigarette smoking remains the leading cause of tobacco-related disease, tobacco users are increasingly shifting consumption to other tobacco products and dual use with other combusted tobacco, which include cigars, cigarillos and little cigars, pipe tobacco, roll-your-own tobacco, and hookah. This has resulted in a slowing of the decline in the consumption of all combustible tobacco, and indicates that the use of non-cigarette combustible products has become more common in recent years and that some smokers may be switching to other combustible tobacco products rather than quitting smoking cigarettes completely. Per capita combustible tobacco product consumption declined from 1,164 cigarette equivalents in FY 2016 to 1,114 cigarette equivalents in FY 2017. In FY 2019 and 2020, CDC will continue to monitor combustible tobacco consumption to inform its strategies on reducing tobacco-related disease.

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	34.4%	N/A	33.2%	N/A	33%	N/A	32.3%
Result	N/A	37.7%	N/A	39.6%	N/A	10/31/19	N/A	10/31/21
Status	N/A	Target Not Met	N/A	Target Not Met	N/A	Pending	N/A	Pending

National Health and Nutrition Examination Survey data for FY 2016 show that 39.6 percent of adults are

[20] Data for this measure are collected and reported every other year.

obese, an increase in the proportion of obese adults reported in FY 2014 (37.7 percent). There are some community factors that affect diet and physical activity. These factors include the affordability and availability of healthy food options (e.g. fruits and vegetables), peer and social supports, marketing and promotion, and policies that determine whether a community is designed to support physical activity. In FY 2019 and 2020, CDC will continue to implement evidence-based strategies and increase healthy eating and active living through its support for states and communities throughout the United States.

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

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

The Office of the Secretary leads 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.

Objective 2.2 Table of Related Performance Measures

Increase the percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test who are virally suppressed (Lead Agency - HRSA; Measure ID - 16.III.A.4)[21]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	83%	83%	83%
Result	N/A	N/A	83%	85%	10/31/19	10/31/20	10/31/21	10/31/22
Status	N/A	N/A	Historic Actual	Historic Actual	Pending	Pending	Pending	Pending

The Ryan White HIV/AIDS Program (RWHAP) works to improve health outcomes by preventing disease transmission or slowing disease progression for disproportionately impacted communities. One way RWHAP accomplishes its mission is through the provision of medications that help patients reach HIV viral suppression. People living with HIV who use medications designed to virally suppress the disease are less infectious, which reduces the risk of their transmitting HIV to others. In FY 2019 and 2020, RWHAP will continue to play a central role in ending the HIV epidemic by ensuring that persons living with HIV have access to regular care, receive antiretroviral medications, and adhere to a regular schedule for taking their medications.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	47%	50%	53%	56%	59%	62%	62%	62%
Result	42%	44%	42%	43%	38%	9/30/19	9/30/20	9/30/21

[21] Changes in the Ryan White Services Report on how viral suppression data derived before 2015 used a different data collection methodology and are not comparable to data collected using the current methodology.

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Status	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Target Not Met	Pending	Pending	Pending

In the United States, on average 5-20 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 vaccinations rates for adults ages 18 years old and over increased slightly by 2 percentage-points from FY 2013 (42 percent) to FY 2014 (44 percent), then varied from 42 percent in FY 2015 to 43 percent in FY 2016, and most recently decreased to 38 percent in FY 2017. 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. No decreases in flu vaccination coverage were seen in preliminary estimates from claims-based data systems. Four in ten adults report receiving a flu vaccination. In FY 2019 and 2020, CDC will continue to monitor the percentage of adults aged 18 and older who are vaccinated annually against seasonal influenza to inform its strategies for improving adult vaccination coverage rates.

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	Baseline	2	2	2
Result	N/A	N/A	N/A	N/A	2	7	12/31/19	12/31/20
Status	N/A	N/A	N/A	N/A	Historic Actual	Target Exceeded	Pending	Pending

It is estimated that a highly contagious and virulent airborne pathogen, such as a novel influenza virus, could kill tens of millions of people globally in less than a year. Influenza and other emerging infectious diseases with pandemic potential continue to mutate, evolve, spread geographically, and infect animals and humans. Effective treatments for those who are severely ill with influenza are a critical component of pandemic preparedness and response, with significant benefit for use in annual influenza epidemics. Despite this persistent need, there are no approved influenza antiviral drugs indicated for use in severely ill and hospitalized patients in the United States.

During 2018, BARDA supported manufacturing efficiency improvements to achieve a two-fold or more increase in the number of pandemic influenza vaccine doses produced, which led to the supplemental licensure of cell-based vaccine being incorporated into the national supplies for seasonal influenza. BARDA assisted two programs to support development of improved influenza vaccines or next generation vaccines. In addition, BARDA assisted four programs for late stage development of influenza antivirals and therapeutics. These programs include antiviral drugs with novel mechanisms of action, new therapeutics, and host-based therapeutics. Development of these candidate products will improve our pre-pandemic preparedness and also support use of the products to address seasonal influenza. In FY 2020, BARDA will continue to support advanced development of novel therapeutics and next generation vaccines to increase our pandemic response capability and improve products available for response to seasonal influenza.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, IOS, OCR, and SAMHSA.

Objective 2.3 Table of Related Performance Measures

Reduce the age-adjusted annual rate of overdose deaths involving prescription opioids per 100,000 population among states funded through Prescription Drug Overdose Prevention for States program (Lead Agency - CDC; Measure ID - 7.2.6) [22]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	11.9	Baseline	11.8	11.8	10.8	10.8
Result	N/A	13.3	N/A	15.0	12/31/18	12/31/19	12/31/20	12/31/21
Status	N/A	N/A	Not Collected	Historic Actual	Pending	Pending	Pending	Pending

CDC tracks the rise of opioid overdose deaths and uses the data to pivot to prevention activities to curb this alarming epidemic. Opioids were involved in over 42,249 deaths in 2016, and opioid overdoses were five times higher in 2016 than 1999. In response to this growing public health crisis, CDC has launched its Overdose Prevention in States (OPIS)[23] effort as means to equip states with resources and expertise needed to reverse this epidemic. As a part of OPIS, CDC's Prescription Drug Overdose Prevention for States (PfS) program funds 29 state health departments to advance and evaluate comprehensive state-level interventions for preventing opioid-related overdose, misuse, and abuse. This measure tracks progress in reducing overdose deaths involving all opioids among the 29 states funded specifically for PfS. In FY 2016 the baseline, age-adjusted annual rate of opioid overdoses was 15.0 per 100,000 residents among states funded for the PfS program. The PfS program will fund states through September 2019, at which point all the current OPIS programs will be replaced with one comprehensive new grant – Overdose Data to Action. Eligible entities include states, territories, and localities. CDC will continue to track the rise of opioid overdose deaths to monitor the impact of its prevention activities in FY 2020.

[22] This measure reports the number of overdose deaths involving prescription opioids per 100,000 residents. Targets and results have been adjusted for 2018 using data from the 29 funded states. The performance metrics reflect age-adjusted rates of overdose deaths involving all opioid analgesics per 100,000 population.

[23] https://www.cdc.gov/drugoverdose/states/index.html

Increase the number of substance abuse treatment admissions with Medication-Assisted Treatment (MAT) planned as part of Opioid Use Disorder Treatment (Lead Agency - SAMHSA; Measure ID - 2.3.19K) [24]

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Target	N/A	N/A	N/A	N/A	N/A	200,000	220,000	242,000
Result	N/A	N/A	223,407	217,626	8/31/19	8/31/20	8/31/21	8/31/22
Status	N/A	N/A	Historic Actual	Historic Actual	N/A	Pending	Pending	Pending

SAMHSA expects the number of people receiving MAT and the number of admissions to substance abuse treatment with MAT to increase. States are continuing to develop their systems with increased resources from grant programs, such as the State Opioid Response grants, Tribal Opioid Response grants, and Targeted Capacity Expansion: Medication-Assisted Treatment Prescription-Drug and Opioid Addiction grants. Medicaid systems have increased their focus on opioid-related technical assistance, and outreach efforts from across HHS promote the use of MAT. SAMHSA uses data from the Treatment Episode Dataset (TEDS) to track the provision of substance abuse treatment for opioid use disorders, which includes tracking the planned use of MAT at admission.[25] In CY 2015, 223,407 treatment admissions had MAT as a planned part of the treatment plan and 217,626 admissions had MAT planned in CY 2016. MAT data for CY 2017 will be made available in 2019. MAT data for CY 2018 will be available in CY 2020. SAMHSA will continue to monitor the use of MAT in CY 2019 and CY 2020.

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 2013	N/A	N/A	N/A
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	9/30/19	In Progress

[24] TEDS Annual Report, which is based on calendar year data, can be found at: https://www.samhsa.gov/data/sites/default/files/2016_Treatment_Episode_Data_Set_Annual.pdf

[25] 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. Generally, facilities that are required to report to the state substance abuse agency (SSA) are those that receive public funds and/or are licensed or certified by the SSA to provide substance use treatment (or are administratively tracked for other reasons). TEDS records do not represent individuals; rather, each record represents a treatment episode. Thus, an individual admitted to treatment twice within a calendar year is counted as two admissions. TEDS does not include all substance use treatments. It includes treatment admissions and discharges at facilities that are licensed or certified by a state substance abuse agency to provide care for people with a substance use disorder (or facilities that are administratively tracked for other reasons). In general, facilities reporting TEDS data are those that receive state alcohol and/or drug agency funds (including federal block grant funds) for the provision of alcohol and/or drug treatment services.

Fiscal Year	Target	Result	Status
	related to safe pain management and opioid prescribing and 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.		
FY 2020	Develop, test, and disseminate at least one electronic clinical decision support tool related to opioids or safe chronic pain management.	N/A	In Progress

Addressing the nation's opioid epidemic is an ongoing focus of AHRQ's Health Services Research, Data, and Dissemination portfolio. In FY 2017, AHRQ launched a new initiative to ensure that health care professionals have access to evidence supporting safe pain management and opioid prescribing at the point of care through electronic clinical decision support (CDS). CDS Connect is the infrastructure for developing and sharing these CDS tools.[26]

In FY 2018, AHRQ developed a dashboard that aggregates pain-related information from the Electronic Health Records (EHR) into one consolidated view for clinicians. The information includes data such as pain medications, pain assessments, relevant diagnoses, and lab test results. The dashboard was tested in partnership with Oregon Community Health Information Network, a network of community health centers, and uses the Health Level Seven Fast Healthcare Interoperability Resources standard, which allows for interoperability and implementation in different EHRs.

In FY 2018 and continuing in FY 2019, AHRQ will disseminate safe pain management and opioid-related CDS through CDS Connect. This includes the pain management dashboard developed in FY 2018. In addition, AHRQ will continue to work with its partners to disseminate safe pain management and opioid CDS tools. For example, CDC uses AHRQ's CDS Connect web platform as a dissemination mechanism for two opioid CDS tools that were developed by CDC and ONC. In FY 2019 and continuing in FY 2020, AHRQ will develop, test, and disseminate another electronic clinical decision support tool related to opioids or safe chronic pain management. AHRQ will continue to work with its partners and stakeholders on dissemination.

By 2020, 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 2013	N/A	N/A	N/A
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	Initiate at least one study to improve identification of OUD or evaluate the	A Phase 3 clinical trial to test a non-opioid medication for managing	Target Met

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

Fiscal Year	Target	Result	Status
	comparative effectiveness of available pharmacotherapies for OUD treatment.	symptoms of opioid withdrawal was completed.	
FY 2019	Conduct 1 preclinical study and 1 clinical trial to develop non-opioid based medications to treat OUD that may avoid the risks of opioid dependence and overdose.	12/31/19	In Progress
FY 2020	Conduct 1 pre-clinical and 1 clinical study of a longer acting formulation of a medication for the treatment of opioid use disorders or opioid overdose.	12/31/20	In Progress

The misuse of and addiction to opioids such as heroin and prescription pain medicines is a serious national problem. This issue has become a public health epidemic with devastating consequences, which include increases in opioid use disorders (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, which include 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 2018, an NIH-funded Phase 3 clinical trial of lofexidine was completed, and the results were submitted to FDA.

Lofexidine is the first non-opioid medication for managing symptoms of opioid withdrawal in the United States, and FDA approved its use in May 2018. The drug provides a new option to help patients manage the excruciating physical symptoms of opioid withdrawal, which can be a major cause of relapse for those undergoing detoxification. Although medications have been available to treat opioid addiction, none have been approved to treat the physical symptoms of withdrawal. Approval of lofexidine (Lucemyra) is expected to facilitate detoxification and improve the success of detoxification, which will make treatment and recovery possible for many patients with opioid use disorder. In FY 2019 and 2020, NIH will continue to support research that explores new strategies for treating opioid misuse and addiction.

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) [27]

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Target	N/A	N/A	N/A	N/A	N/A	48.0%	48.5%	50.0%
Result	N/A	N/A	N/A	46.7%	47.5%	12/31/19	12/31/20	12/31/21
Status	N/A	N/A	N/A	Historic Actual	Historic Actual	Pending	Pending	Pending

With states and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) driving efforts to address the needs of children and youth with serious emotional disturbances, SAMHSA expects to see increases in the percentage of youth with a past year major depressive episode who receive mental health treatment. The National Survey on Drug Use and Health (NSDUH) defines treatment for depression as 1) Seeing or talking to a health or alternative service professional, or 2) Using prescription medication for depression in the past year. The most recent data available show that in CY 2017, 47.5 percent of youth ages 12-17 who experienced major depressive episodes with severe impairment in the past year received mental health treatment. SAMHSA has funded a number of

[27] NSDUH full 2017 report available at https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH.

programs to increase access to treatment, which include Healthy Transitions continuation grants and contracts for technical assistance and evaluation. 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. In CY 2019 and 2020, SAMHSA will continue to monitor major depressive episodes in youth ages 12-17, and 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) [28]

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Target	N/A	N/A	N/A	N/A	N/A	67.0%	68.0%	71.0%
Result	N/A	N/A	N/A	64.8%	66.7%	12/31/19	12/31/20	12/31/21
Status	N/A	N/A	N/A	Historic Actual	Historic Actual	Pending	Pending	Pending

With states and ISMICC driving efforts to address the needs of individuals with serious mental illness (SMI), SAMHSA expects to see increases in the percentage of adults with SMI who receive mental health services.[29] The most recent NSDUH data available show that in CY 2017, 66.7 percent of adults with SMI received mental health services. In CY 2019 and 2020, SAMHSA will continue 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 will enable agencies to provide coordinated efforts and resources to individuals with SMI.

[28] Ibid.

[29] In NSDUH, SMI is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. SMI was assessed using the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID) which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). These mental illness estimates are based on a predictive model. Additionally, 'Mental Health Services' in the NSDUH is defined as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health.

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

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

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

The Office of the Secretary leads 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.

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) [30]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	94%	95%	95%	96%	96%	96%	96%	96%
Result	96%	96%	100%	95%	93%	2/28/20	2/28/21	2/28/22
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending	Pending

Public health agencies must be able to rapidly convene key management staff (within 60 minutes of notification) to appropriately respond to an emergency. This effort includes the integration of information and the prioritization of resources to ensure timely and effective coordination within the public health agency and key response partners. In FY 2017, 93 percent of PHEP-funded public health agencies convened trained staff within 60 minutes of notification to make decisions regarding partner engagement and incident response, slightly below the target of 96 percent. Some jurisdictions did not meet the target because they did not or could not submit adequate documentation to accompany staff assembly results. In FY 2019 and 2020, CDC will continue to work with awardees to improve results and achieve future targets.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	3	3	3	3	3
Result	N/A	N/A	N/A	3	5	9	12/31/19	12/31/20
Status	N/A	N/A	N/A	Target Met	Target Exceeded	Target Exceeded	Pending	Pending

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

BARDA's mission is to develop and make available medical countermeasures (MCMs) to address some of the most serious threats our nation could face. These include chemical, biological, radiological, and nuclear agents, pandemic influenza, and emerging (or re-emerging) infectious disease threats. In FY 2018, nine BARDA-supported programs achieved FDA licensure/approval/clearance. These products improve our nations' preparedness against these threats and supports ASPR's mission to protect American and save lives. BARDA worked with public and private partners to transition candidates for vaccines, antivirals, diagnostics, and medical devices – known collectively as MCMs – from early development into the advanced and late-stages of development and approval. BARDA's cost-efficient and innovative approach to MCM development is stimulating dormant industry sectors and revolutionizing the medical technology needed to protect communities from national health security threats and other public health emergencies.

BARDA's approach to advanced research and development has a proven track record of success due to continuous collaboration with NIH, CDC, FDA, and the Departments of Defense, Homeland Security, Veteran Affairs, and Agriculture. These agencies set research and development priorities under a five-year strategy and implementation plan. In FY 2019 and 2020, BARDA will continue to monitor progress towards an agile, robust and sustainable U.S. manufacturing infrastructure capable of rapidly producing vaccines and other biologics against pandemic influenza and other emerging threats.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, and CMS.

Objective 3.1 Table of Related Performance Measures

Increase the percentage of adult TANF recipients and former recipients who are newly employed (Lead Agency - ACF; Measure ID - 22B) [31, 32]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	30.7%	32.5%	N/A	N/A	Prior Result +0.1PP	Prior Result +0.1PP	Prior Result +0.1PP	Prior Result +0.1PP
Result	32.4%	31.4%	N/A	N/A	3/31/19	11/30/19	11/30/20	11/30/21
Status	Target Exceeded	Target Not Met	N/A	N/A	Pending	Pending	Pending	Pending

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

ACF is committed to providing innovative and effective employment information and strategies to the states and offering a range of targeted technical assistance efforts. In FY 2019 and 2020, ACF will continue to support state, tribal, and community partners' efforts to design and implement programs that focus simultaneously on adult employment and family well-being.

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) [33]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	71.77%	69.76%	76.84%	83.01%	85.26%	84.84%	82.88%	Prior Result +1%
Result	69.07%	76.08%	82.19%	84.42%	84%	82.06%	11/1/19	11/1/20

[31] These data exclude territories, but includes the District of Columbia.
[32] The actual results for fiscal years 2015 and 2016 cannot be reported due to technological constraints.
[33] In spite of generally robust economic conditions, grantees continue to note the difficulties inherent with decreasing and uneven arrival numbers and the corresponding adjustments in funding. Nonetheless, outcomes remain commendable and ACF expects positive growth to resume as the agency works towards achieving FY 2020 goals.

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Status	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

In FY 2018, 236 locations offered ACF Matching Grant Program services. This is a decrease from 250 locations in FY 2017, and ACF expects additional site consolidations in FY 2019. The program provides $2,500 in funds for each individual served and grantees must match those funds by at least 50 percent while providing services. ACF encourages grantees to experiment in the delivery of services at one or more sites to further improve efficiencies and outcomes. The number of refugees and other eligible individuals served is directly linked to the amount of money ACF awards grantees.

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

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

Injuries and violence affect all Americans regardless of an individual's age, race, or economic status. Preventable injuries and violence—such as falls, homicide stemming from domestic violence, and gang violence—kill more Americans ages 1 to 44 than any other cause, including cancer, HIV, or the flu.[34] Hospitalizations, emergency room visits, and lost productivity caused by injuries and violence cost Americans billions of dollars annually.

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, CDC, IHS, OASH, and SAMHSA.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	90%	90%	90%	90%	90%	90%	90%	90%
Result	92.3%	93%	91.9%	89.6%	92.8%	5/31/19	5/31/20	5/31/21
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending	Pending

Family Violence Prevention and Services Act grantee data for fiscal years 2012 through 2015 show that more than 90 percent of domestic violence program clients reported improved knowledge of safety planning as a result of grantee efforts. Since many program participants receive short-term crisis assistance and would not be expected to report significant change, the program's consistently achieving a higher than 90 percent benchmark is unrealistic. In FY 2020, ACF will continue to implement its improved data quality checks to ensure data accuracy as well as work with the grantees to identify ways to promote domestic violence safety.

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)[35]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	6.3%	6.1%	6.3%	6.2%	5.2%	6.74%	Prior Result - 0.2PP	Prior Result - 0.2PP
Result	6.3%	6.5%	6.4%	6.5%	6.9%	10/31/19	10/31/20	10/31/21

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

[35] 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 as a result of this change.

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Status	Target Met	Target Not Met	Target Not Met but Improved	Target Not Met	Target Not Met	Pending	Pending	Pending

In FY 2017, the rate of repeat child maltreatment increased from 6.5 percent to 6.9 percent. In FY 2019 and 2020, ACF will continue to identify and implement ways to support states in their efforts to care for children and families in crisis, which also ensures the safety of children. The renewed emphasis on prevention efforts may also assist 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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	41.6%	41.6%	TBD
Result	N/A	N/A	N/A	N/A	N/A	38.1%	1/31/20	1/31/21
Status	N/A	N/A	N/A	N/A	N/A	Target Not Met	Pending	Pending

Domestic and intimate partner violence has a disproportionately large 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. The Intimate Partner (Domestic) Violence screening measure is designed to support improved processes for identification, referral, and treatment for victims of domestic assault. In FY 2018, IHS began reporting the Intimate Partner (Domestic) Violence screening measure using the IHS Integrated Data Collection System Data Mart (IDCS DM). In FY 2019 and 2020, IHS will continue to support improvements in screening for female victims of domestic violence among the AI/AN community.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, CDC, HRSA, IHS, OASH, and SAMHSA.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	23%	27%	26%	25%	24%	15%	17%	Prior Result - 1PP
Result	31%	23%	22%	24%	16%	18%	1/31/20	1/31/21
Status	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

The ACF Office of Head Start (OHS) strives to increase the percentage of Head Start children in high-quality classrooms. ACF measures progress by reducing the proportion of Head Start grantees scoring in the low range (below 2.5) in any domain of the Classroom Assessment Scoring System (CLASS: Pre-K). This research-based tool measures teacher-child interaction on a seven-point scale in three broad domains: Emotional Support, Classroom Organization, and Instructional Support. Research findings underscore the importance of teacher-child interactions as a demonstrated measure of classroom quality. Now OHS assesses each Head Start grantee using the CLASS instrument during onsite monitoring reviews. The most recent data from FY 2018 CLASS reviews indicate that 18 percent of grantees scored in the low range. Although the target of 15 percent was not met, the proportion of low scoring grantees did remain relatively stable. In FY 2019 and 2020, ACF plans to reduce the proportion of grantees scoring in the low range by at least one percentage-point, year over year.

Reduce the proportion of children and adolescents ages 2 through 19 who are obese (Lead Agency - CDC; Measure ID - 4.11.10b)[36]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	15.7%	N/A	15.2%	N/A	14.7%
Result	N/A	17.2%	N/A	18.5%	N/A	10/31/19	N/A	10/31/21
Status	N/A	Historic Actual	N/A	Target Not Met	N/A	Pending	N/A	Pending

CDC funds a number of interventions that target obesity as well as related chronic diseases. The percentage of all children and adolescents (ages 2 to 19 years) that have obesity increased from 16.8

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

percent in FY 2008 to 18.5 percent in FY 2016. In children ages 2 to 5, the prevalence of obesity has fluctuated over time. Research shows behaviors that influence excess weight gain include eating high-calorie, low-nutrient foods and beverages and not getting enough physical activity. Public health practitioners can educate individuals about healthy lifestyle choices and ways to improve their diet and increase physical activity. Places such as child care centers, schools, or communities can affect diet and activity through the foods and drinks offered and the opportunities provided for physical activity. In FY 2019 and 2020, CDC will continue promoting good nutrition and physical activity in children and adolescents to help prevent childhood obesity.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	86%	86%	86%	86%	87%	90%	90%	90%
Result	87.7%	87.8%	88.2%	91.6%	90.7%	12/30/19	12/30/20	12/30/20
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

The Transitional Living Program (TLP) supports community-based, adult-supervised residences for youth ages 16 to under 22 who cannot safely live with their own families, or for whom living with their families provides undue hardships. This long-term shelter program offers otherwise homeless youth housing for up to 18 months and provides the educational, employment, health care and life skills necessary for youth to transition into self-sufficient living. The TLP safe and appropriate exit rate is the percentage of TLP youth discharged during the year who find immediate living situations that are consistent with independent living. The vast majority of youth (72 percent) were between the ages of 18 and 20 when they entered the program. Nearly 25 percent of these youth had been in the child welfare system and almost 12 percent had been involved in the juvenile justice system.

Because safe and stable housing is one of the core outcomes for the TLP program, ACF proposes to keep this performance standard and increase the annual target to 90 percent. In FY 2019 and 2020, ACF will continue to work with grantees to ensure that appropriate service delivery and technical assistance systems are in place to provide increased support to at-risk youth.

(For adult-serving programs) Increase the proportion of participants who, at program exit, express positive attitudes towards marriage (Lead Agency – ACF; Measure ID – 22F) [37]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	Baseline	TBD	TBD	TBD
Result	N/A	N/A	N/A	N/A	3/31/19	3/31/20	3/31/21	3/31/22
Status	N/A	N/A	N/A	N/A	Pending	Pending	Pending	Pending

(For adult-serving programs) Increase the proportion of married couples who, at program exit, view their marriage as lifelong (Lead Agency – ACF; Measure ID – 22G) [38]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	Baseline	TBD	TBD	TBD
Result	N/A	N/A	N/A	N/A	3/31/19	3/31/20	3/31/21	3/31/22
Status	N/A	N/A	N/A	N/A	Pending	Pending	Pending	Pending

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

(For youth-serving programs) Increase the proportion of youth who express attitudes supportive of the success sequence (Lead Agency – ACF; Measure ID – 22H) [39]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	Baseline	TBD	TBD	TBD
Result	N/A	N/A	N/A	N/A	3/31/19	3/31/20	3/31/21	3/31/22
Status	N/A	N/A	N/A	N/A	Pending	Pending	Pending	Pending

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

These are new measures for the Healthy Marriage program that better address the core goals of the program. ACF will establish future performance targets once trend data are established.

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

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

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, CDC, CMS, HRSA, IHS, OASH, and SAMHSA.

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 - QIO7.2) [40]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	Baseline	N/A	6.0%	5.0%	TBD
Result	N/A	N/A	N/A	8.0%	4.6%	10/31/19	10/31/20	10/31/21
Status	N/A	N/A	N/A	Historic Actual	Historic Actual	Pending	Pending	Pending

More than 3 million Americans rely on services provided by nursing homes each year. There are 1.4 million Americans who reside in the nation's 15,600 nursing homes on any given day. Those individuals and their family members, friends, and relatives, must be able to count on nursing homes to provide reliable, high-quality care. Current law requires CMS to develop a strategy that will guide local, state, and national efforts to improve the quality of care in nursing homes. The most effective approach to ensure quality is one that mobilizes and integrates all available tools and resources and aligns them with a comprehensive, actionable strategy.

In December 2008, CMS added a star rating system to the Nursing Home Compare website. This rating system serves three purposes: 1) to provide residents and their families with an assessment of nursing home quality, 2) to make a distinction 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. CMS tracks nursing home care quality using this rating system.

[40] The target for FY 2020 will be determined when the specific goals and aims of the 12th Statement of Work are finalized. These are still being developed at the time of publication of the FY 2020 Budget.

The Quality Innovation Network-Quality Improvement Organization (QIN-QIO), via recruitment of nursing homes and other activities, shall support the creation of a National Nursing Home Quality Care Collaborative (NNHQCC). The purpose of the NNHQCC is to ensure, along with its partners, that every nursing home resident receives the highest quality of care. The one-star recruitment measure assessed the ability of the QIN-QIO to gain participation in peer-to-peer quality improvement activities, measured by the percentage increase of one-star nursing homes participating in the NNHQCCs through 2018. Participation ensures safer care received by Medicare beneficiaries residing in the lowest performing nursing homes. Nursing homes participating in the NNHQCC focus on processes that improve their systems and measure individual tests of change. Specifically, nursing homes look at their Plan-Do-Study-Act improvement cycle results, clinical outcomes measures such as falls with major trauma, and measures of quality improvement. Nursing homes participating in the NNHQCC are encouraged to improve quality as a whole rather than focus on any one measure. Therefore, the 16 measure total quality score appropriately reflects general quality improvement. A reduction in the percentage of homes that receive the lowest quality score would indicate progress in the hardest-to-reach nursing homes.

Decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication (Lead Agency - CMS; Measure ID - MSC5)[41]

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Target	20.3%	19.1%	17.9%	16.7%	16%	16%	15.5%	15.4 %
Result	20.3%	19.1%	17.1%	16.7%	15.4%	4/30/19	4/30/20	4/30/21
Status	Target Met	Target Met	Target Exceeded	Target Met	Target Exceeded	Pending	Pending	Pending

Antipsychotic medications have common and dangerous side effects when used for the behavioral and psychological symptoms of dementia. A number of evidence-based non-pharmacological interventions and approaches have been reviewed by national scientists and thought leaders through the National Partnership to Improve Dementia Care. These have been incorporated into clinical practice guidelines and various tools and resources and are now posted on the Advancing Excellence website (in the public domain) at www.nhqualitycampaign.org. 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.

Success has varied by state and CMS region, with some states and regions seeing a reduction of greater than 40 percent. CMS continues to have quarterly national calls with the public on aspects of good dementia care and the use of non-pharmacological approaches. CMS is conducting focused dementia care surveys on those facilities that continue to have high rates of antipsychotic use, and has modified the regulations limiting the use of antipsychotic medications on an as needed basis.

[41] The purpose of including this measure as a CMS performance measure is to decrease the use of antipsychotic medications in nursing homes with emphasis on improving dementia care.

Improve dementia capability of long-term support systems to create dementia-friendly, livable communities (Lead Agency ACL; Measure ID – ALZ.3)[42,43]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	Baseline	28%	33%
Result	N/A	N/A	N/A	N/A	N/A	22%	1/31/21	1/31/22
Status	N/A	N/A	N/A	N/A	N/A	Historic Actual	Pending	Pending

Of the community dwelling individuals living with Alzheimer's Disease and Related Dementias (ADRD), approximately one-third live alone, exposing them to numerous risks, which include unmet needs, malnutrition and injury, and various forms of neglect and exploitation.[44] As the number of people living with ADRD in the United States is projected to grow by almost 300 percent by 2050[45], it is important to develop effective and coordinated service delivery and health care systems that are responsive to the needs of these individuals and their caregivers.

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

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

In FY 2019 and 2020, ACL will develop and implement a plan for continued improvement of assessment results.

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)[46]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	N/A	TBD	TBD
Result	N/A	N/A	N/A	N/A	78.1%	1/31/20	1/31/21	1/31/22

[42] 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.

[43] 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.

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

[45] 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

[46] 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.

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Status	N/A	N/A	N/A	N/A	Historic Actual	Historic Actual	Pending	Pending

Under the Developmental Disabilities Assistance and the Bill of Rights Act of 2000 (DD Act), each state and territory has a Developmental Disabilities Protection and Advocacy (P&A) program designated by the state's governor. The DD Act and other authorizing statutes give the P&A 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."[47] P&As provide a range of legal services and use a range of remedies, including self-advocacy assistance, negotiation, investigation, and litigation, to advocate for traditionally unserved or underserved individuals with developmental disabilities. P&A authorities are critical to preventing abuse and neglect of people with disabilities and safeguarding individuals' right to live with dignity and self-determination.

In FY 2019 and 2020, ACL will develop and implement a performance plan for improving results. The plan involves developing valid and reliable measures and a pilot to test the outcomes before full plan implementation. The plan also includes methods for analyzing the data to identify trends and results.

[47] 42 U.S.C. 15043

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ASPR, CDC, CMS, FDA, NIH, OCR, OGA, and SAMHSA.

Objective 4.1 Table of Related Performance Measures

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	Baseline	65%	70%	75%	80%	82%	90%	90%
Result	62%	69%	69%	75%	80%	86%	12/31/19	12/31/20
Status	Historic Actual	Target Exceeded	Target Not Met	Target Met	Target Met	Target Exceeded	Pending	Pending

Advancing national implementation of Electronic Laboratory Reporting (ELR) is a priority in CDC's efforts to protect the public's health. ELR replaces paper-based reporting, which accelerates reporting to public health labs; reduces the reporting burden on clinicians, hospitals, and commercial laboratories; and decreases errors and duplicate reporting. As of FY 2018, electronic laboratory reports accounted for nearly 80 percent of laboratory reports for reportable conditions received, which exceeds FY 2016 results and continues the upward trend since FY 2012.

Since there are diminishing returns after reaching an ELR volume higher than 90 percent, the program considers moving from 62 percent in 2013 to 90 percent a success. In FY 2019 and 2020, CDC will continue to monitor the implementation of ELR as part of its efforts to protect the public health.

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	Baseline	10%	40%	40%	40%	40%
Result	N/A	1%	1%	3%	5%	7%	12/31/19	12/31/20
Status	N/A	Historic Actual	Historic Actual	Target Not Met but Improved	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending

During FY 2018, CDC advanced the modernization of infectious disease surveillance by producing technology upgrades to the Message Validation, Processing and Provisioning System, which receives production data from the states using the new Health Level Seven (HL7) based messages. This system reduced development time to implement a new condition from months to weeks and ensures that CDC

programs can access their data within an hour of receipt at CDC. When new HL7 messages have been implemented for all diseases, the new strategy will allow the retirement of older, less efficient legacy systems, and will increase the number of HL7 messages received at CDC. Data transmissions continue to improve and remain stable, which indicates that CDC has achieved a more routine and reliable mode. The FY 2019 and FY 2020 focus will be on completion of the modernization process and transitioning to efficient long-term operations with continuous improvement and enhancement.

Increase the number of people for whom FDA is able to evaluate product safety through Mini-Sentinel/Sentinel system (Lead Agency – FDA; Measure ID – 292202)

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	
Target	100 million	150 million	180 million	185 million	195 million	233 million	Discontinued	
Result	149 million	178 million	182 million	193 million	223 million	292 million	N/A	
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	N/A	

FDA's Sentinel Initiative provides significant public health benefits by developing new approaches and methods to actively monitor the safety of marketed medical products to complement existing FDA surveillance capabilities. Through the Sentinel System, FDA evaluates drug safety issues that may require regulatory action. FDA held the 10th Annual Sentinel Initiative Public Workshop in February 2018 to bring together stakeholder communities to discuss a variety of topics on active medical product surveillance and emerging Sentinel projects. To date, the Sentinel Initiative has contributed to multiple safety communications and labeling changes to better inform patients and providers about safe use of drugs and vaccines. The Sentinel System ensures FDA will continue to have the tools necessary to conduct active safety surveillance work. In FY 2019 and 2020, FDA will continue to monitor the number of people for whom it is able to evaluate product safety using the Mini-Sentinel/Sentinel system.

Number of medical product analyses conducted through the FDA's Sentinel Active Risk Identification and Analysis (ARIA) system (Lead Agency – FDA; Measure ID – 292203)

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	N/A	50	55
Result	N/A	N/A	N/A	N/A	N/A	74	1/31/19	1/31/20
Status	N/A	N/A	N/A	N/A	N/A	Historic Actual	Pending	Pending

FDA has developed a new Sentinel performance measure that focuses on using the system to generate high quality evidence about the use of medical products and their risks and benefits. The new measure leverages Sentinel's Active Risk Identification and Analysis system, which is comprised of pre-defined, parameterized, and reusable routine querying tools. This enables FDA to conduct safety analyses more efficiently using a trusted distributed database that undergoes continuous quality checks and refreshes. FDA has used the results of these analyses to present at FDA Advisory Committee meetings, highlight potential ways to intervene in the opioid crisis, inform responses to Citizen Petitions, and influence numerous regulatory decisions.

FDA has framed the new goal as the number of analyses conducted using the ARIA system. Since this is a new goal and the analyses conducted each year can vary greatly in the number, timing, complexity, and character of the safety issues, FDA has set the initial targets at 50 and 55 analyses for FY 2019 and 2020 respectively. FDA will reassess these targets periodically. These targets reflect the trend toward more complex analyses that employ more sophisticated analytical methods, which yield more meaningful inputs to public health and regulatory decision making.

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

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, CDC, FDA, NIH, OASH, OGA, and SAMHSA.

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 2013	N/A	N/A	N/A
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 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 2 new therapeutic indications in humans through the BRAIN Public-Private Partnership.	12/31/19	In Progress
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.	12/31/20	In Progress

The Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative® was launched to accelerate 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 researchers have developed four innovative technological approaches to record brain activity at the cellular level. Overall, these advances allow us to record neural activity from deeper brain regions, with higher temporal resolution, and in more neurons simultaneously than ever before, which brings us closer to the ambitious goal of observing brain activity "at the speed of thought". These novel neurotechnological advances can be applied in future studies to enhance our ability to explore brain function at the cellular level. In FY 2019 and 2020, NIH plans to 1) test new and/or existing brain stimulation devices for 2 new therapeutic indications in humans through the BRAIN Public-Private Partnership and 2) provide broad access to new research approaches and techniques for acquiring fundamental insight about how the nervous system functions in health and disease.

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	50%	45%	40%	40%	40%	50%	50%	50%
Result	63%	78%	80%	81%	72%	53%	2/28/20	2/28/21
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

To support the Department's mission and FDA's scientific expertise, FDA is expanding its fellowship efforts by launching a new FDA Traineeship Program while continuing other Fellowship programs. This performance goal focuses on FDA's efforts to retain a targeted percentage of the scientists who complete these programs. The size and focus of the new agency-wide Traineeship Program will be greater in number and scope than the current Fellowship Program, and FDA will be resetting the retention target in FY 2020 when the new FDA Traineeship Program is launched. Additionally, whether "graduates" from these programs continue to work for FDA or choose to work in positions in related industry and academic fields, they are trained in an FDA-presented understanding of the complex scientific issues in emerging technologies and innovation, which furthers the purpose of HHS Strategic Objective 4.2: Expand the capacity of the scientific workforce and infrastructure to support innovative research. In FY 2019 and 2020, FDA will continue to monitor its ability to retain scientists who have participated in the Fellowship or Traineeship Programs.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, AHRQ, CDC, FDA, NIH, and OASH.

Objective 4.3 Table of Related Performance Measures

By 2023, develop, optimize, and evaluate the effectiveness of nano-enabled immunotherapy (nano-immunotherapy) for one cancer type (Lead Agency - NIH; Measure ID - SRO-2.1)

Fiscal Year	Target	Result	Status
FY 2013	N/A	N/A	N/A
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 3 nanoformulations for effective delivery and antigen-specific response in immune cells.	Researchers developed, tested, and optimized, in animal models, 3 unique nanodelivery systems for effective anti-cancer immunotherapeutics.	Target Met
FY 2019	Further optimize top 2 candidate nanoformulations for co-delivery of multiple antigens to enhance anti-tumor response in one animal model.	12/31/19	In Progress
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.	12/31/20	In Progress

Nanoparticles are extremely tiny particles that can coat, attach to, or encapsulate drugs. Nanoparticle drug delivery methods have been shown to alleviate some of the current limitations of and enhance the effectiveness of cancer drugs, which include immunotherapies. Therefore, NIH has launched several lines of research aiming to enhance existing immunotherapies with nanotechnologies or to facilitate the development of new, more efficacious nano-based immunotherapies.

In FY 2018, NIH-funded researchers developed and/or optimized delivery of nanoparticle-based drug formulations to cancer cells, which resulted in enhanced immune responses. One research team

developed and optimized two unique nanoparticle drug delivery platforms. Both drug delivery systems cause an immune response that boosts the effectiveness of the immunotherapy tested. Another research team used nanotechnology to improve the effectiveness of a treatment combination using immunotherapy and radiation to treat cancer. They engineered a number of antigen-capturing nanoparticles (AC-NPs) and found the AC-NPs significantly improved the efficacy of the immunotherapy tested in a model of melanoma. In FY 2019 and 2020, NIH will continue to support the optimization and evaluation of novel nanoparticle drug formulations to further the clinical translation of nano-based drugs into medicine for treating cancer.

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 2013	N/A	N/A	N/A
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	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: 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	12/31/19	In Progress
FY 2020	Strategy 1: Complete follow-up of participants in studies testing the safety, tolerability, and effectiveness of VRC01.	12/31/20	In Progress

NIH-funded research has led to the identification of highly effective, non-vaccine prevention strategies that have the potential to significantly reduce HIV infection rates around the world. However, adhering to daily or near-daily dosing has proved challenging for both HIV-infected and uninfected individuals. Cabotegravir, an investigational drug that is available in long-acting injectable form, has shown promise for HIV prevention. In FY 2018, an NIH-supported study investigating the safety and acceptability of cabotegravir completed enrollment of 200 HIV-uninfected men and women in 8 cities in the United States and abroad. The results of the primary analysis are in press (to be published in the open-access journal PLoS Medicine), and the results of the extended phase have been analyzed and were presented at the HIV Research for Prevention 2018 Conference. This study represents an important next step in determining whether additional research should be done to assess the effectiveness of cabotegravir in preventing HIV infection. In FY 2019 and 2020, NIH will continue support clinical studies that assess the effectiveness of long-acting prevention strategies.

By 2020, 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 2013	N/A	N/A	N/A
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. 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. 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. Continue harmonization of Discovery Phase and Replication Phase datasets. 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.	12/31/19	In Progress

Fiscal Year	Target	Result	Status
	Continue confirmation of genomic regions of interest in the Discovery Phase using samples from the Follow-Up phase. Continue harmonization of Discovery Phase and Follow-Up Phase datasets.		
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.	12/31/20	In Progress

Effective interventions to prevent, delay, and treat Alzheimer's disease (AD) are urgently needed. It is estimated that as many as 5.5 million Americans age 65 and older are living with AD, and many more under age 65 are also affected. Available treatments provide symptomatic relief and may slow symptoms of cognitive decline in some people for a limited time. However, they do not target the underlying molecular pathways believed to be involved in AD's development; thus, they neither halt nor reverse disease progression.

In FY 2018, the NIH-supported Alzheimer's Disease Sequencing Project (ADSP), the overall goal of which is to identify genetic variants associated with risk of and protection from AD, continued to confirm the involvement of previously-implicated genomic regions of interest in development of the disease. In addition, ADSP initiated additional genomic analysis to include racial and ethnic minority participants in the hopes of identifying risk factors that are associated with those groups. Using a combination of technologies, ADSP has identified a number of genetic "hubs" that may explain some of the basis for the development of AD. In FY 2019 and 2020, NIH will continue its efforts to identify risk factor genes associated with the disease.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, AHRQ, CDC, FDA, HRSA, NIH, OASH, and SAMHSA.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	76.7 %	71.4 %	64.1 %	62.4 %	57.3%	56.4%	Prior Result +3PP	Prior Result +3PP
Result	68.4 %	61.1 %	59.4 %	53.4%	53.4%	10/31/19	10/31/20	10/30/21
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Pending	Pending	Pending

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

Although this measure shows a downward trend, ACF anticipates a year-over-year increase of 3 percent through FY 2020. In FY 2019 and 2020, ACF is committed to continuing to work with CBCAP grantees to invest in known evidence-based practices, while continuing to promote evaluation and innovation, so as to expand the availability of evidence-informed and evidence-based practice over time. In addition, ACF continues to focus one-on-one and peer learning technical assistance on increased accuracy of data reporting for this measure.

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

Fiscal Year	Target	Result	Status
FY 2013	N/A	N/A	N/A

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 2 strategies for translating validated basic knowledge, clinical interventions, or behavioral interventions to diverse communities and clinical practice through establishing the Partnerships to Advance Cancer Health Equity (PACHE) program between Minority Serving Institutions (MSI) and NCI-designated Cancer Centers (CC).	Several U54 PACHE Partnerships have developed and/or validated evidence-based interventions and tools to help reduce the burden of cancer disparities in underserved communities across the United States. They are working with various community-based organizations (including faith-based organizations and community-based clinical practices and organizations) to disseminate/translate the interventions and tools in the diverse communities.	Target Met
FY 2018	Develop and support 2 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.	12/31/19	In Progress
FY 2020	Finalize testing and validating the strategies to translate basic cancer knowledge, clinical or behavioral interventions to underserved communities and into clinical practice.	12/31/20	In Progress

NIH's Partnerships to Advance Cancer Health Equity (PACHE) is a program that enables institutions serving underserved health disparity populations and underrepresented students and National Cancer Institute-designated Cancer Centers to train scientists from diverse backgrounds in cancer research and to effectively deliver cancer advances to underserved communities. In FY 2018, PACHE partnerships have developed and/or validated evidence-based interventions and tools to help reduce the burden of cancer disparities in underserved communities across the United States. These partnerships continue to work with various community-based organizations, which include faith-based organizations and community-based clinical practices and organizations, to disseminate and/or translate the interventions and tools for use in diverse communities. The work of these partnerships resulted in raised awareness about cancer and cancer prevention topics of regional relevance, which include cervical cancer, HPV

vaccines in the pediatric setting, and betel nut chewing in these multiethnic communities.

In FY 2019 and 2020, NIH will continue to support projects to develop and test dissemination strategies that will shed light on how new interventions can be effectively adopted by communities and clinicians serving various populations with various cancer types.

Goal 5. Objective 1: Ensure responsible financial management

HHS is responsible for almost a quarter of federal outlays and administers more grant dollars than all other federal agencies combined. Ensuring the integrity of direct payments, grants, contracts, and other financial transactions requires strong business processes, effective risk management, and a financial management workforce with the expertise to comply with legislative mandates, which include the Federal Managers' Financial Integrity Act of 1982 (Pub. L. 97–255), the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), and the Improper Payments Elimination and Recovery Improvement Act of 2012 (Pub. L. 112–248).

All divisions contribute to the achievement of this objective. The Office of the Secretary leads this objective.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018 [48]	FY 2019	FY 2020
Target	10.9%	9%	8.5%	9.14 %	9.5 %	8.08%	7.9%	TBD
Result	9.5%	9%	9.5%	10%	8.3%	8.10%	11/15/19	11/15/20
Status	Target Exceeded	Target Met	Target Not Met	Target Not Met	Target Exceeded	Target Met	Pending	Pending

The Part C Medicare Advantage (MA) program payment error estimate reflects the extent to which plan-submitted diagnoses for a national sample of enrollees are substantiated by medical records. Validation of diagnoses in medical records for sampled beneficiaries is performed 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 being measured.

In FY 2018, CMS reported an actual improper payment estimate of 8.10 percent, or $15.55 billion. The submission of more accurate diagnoses by MA organizations for payment drove the decrease from the prior year's estimate of 8.31 percent. The FY 2019 target is 7.90 percent. The FY 2020 target will be established in the FY 2019 Agency Financial Report (AFR). 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 2013	FY 2014	FY 2015	FY 2016 [49]	FY 2017	FY 2018	FY 2019	FY 2020
Target	3.1%	3.6%	3.5%	3.4%	3.3%	1.66%	1.65%	TBD
Result	3.7%	3.3%	3.6%	3.41%	1.67%	1.66%	11/15/19	11/15/20
Status	Target Not Met	Target Exceeded	Target Not Met	Target Met	Target Exceeded	Target Met	Pending	Pending

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

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 reflects the extent to which Prescription Drug Event (PDE) records submitted by Part D sponsors for a national sample of PDEs are substantiated by supporting documentation such as prescription record hardcopies, long-term care medication orders, and claims information from Part D sponsors. Validation of PDEs is performed during CMS's annual Payment Error Related to Prescription Drug Event Data Validation process, where two separate clinicians review supporting documentation. To calculate the Part D program's error estimate, divide the dollars in error by the overall Part D payments for the year being measured.

In FY 2018, CMS met its target of 1.66 percent, reporting an actual improper payment estimate of 1.66 percent, or $1.32 billion. Submission of more accurate payment data by Part D sponsors primarily drove the decrease from the prior year's estimate of 1.66 percent.

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

	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Target	8.3%	9.9%	12.5%	11.5%	10.4%	9.4%	8.0%	TBD
Result	10.1%	12.7%	12.1%	11.0%	9.5%	8.12%	11/15/19	11/15/20
Status	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The Medicare FFS improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) program and reported in the HHS AFR. The CERT program was initiated in FY 2003 and has produced a national Medicare FFS improper payment rate for each year since its inception. Information on the Medicare FFS improper payment methodology can be found in the FY 2018 HHS AFR.[50]

CMS exceeded its CY 2018 target. The Medicare FFS improper payment estimate for CY 2018 is 8.12 percent or $31.62 billion. The CY 2019 target is 8.00 percent and the CY 2020 target will be established in the FY 2019 AFR.

While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors. CMS believes implementing targeted corrective actions will continue to prevent and reduce improper payments in these areas and reduce the overall improper payment rate. Detailed information on corrective actions can be found in the FY 2018 HHS AFR.

Reduce the improper payment rate in the Medicaid Program (Lead Agency - CMS; Measure ID - MIP9.1)[51]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	6.4%	5.6%	6.70%	11.5 %	9.57%	7.93%	N/A	N/A
Result	5.8%	6.7%	9.78%	10.48%	10.10%	9.79%	N/A	N/A

[50] https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html

[51] 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. Reduction targets will be reported in FY 2021.

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Status	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	N/A	N/A

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	6.50%	6.81%	7.38%	8.20%	N/A	N/A
Result	N/A	N/A	6.80%	7.99%	8.64%	8.57%	N/A	N/A
Status	N/A	N/A	Target Not Met	Target Not Met	Target Not Met	Target Not Met but Improved	N/A	N/A

The Payment Error Rate Measurement program measures improper payments in 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 as a means to contain cost, reduce the burden on states, and make measurement manageable. In this way, states can plan for the reviews and CMS can complete the measurement on time for HHS and AFR reporting. At the end of a 3-year period, each state will have been measured once and will rotate in that cycle in future years, (e.g., the states measured in the 2015 AFR were also measured again in the 2018 AFR). Information on the Medicaid and CHIP statistical sampling process and review period can be found in the FY 2018 HHS AFR.

The national Medicaid improper payment rate (MIP9.1) reported in the 2018 HHS AFR is based on measurements that were conducted in fiscal years 2016, 2017, and 2018. HHS is not reporting FY 2019 improper payment targets for Medicaid and CHIP. The current national Medicaid improper payment rate is 9.79 percent. The national Medicaid component rates are 14.31 percent for Medicaid FFS and 0.22 percent for Medicaid managed care. The Medicaid eligibility component is held constant at the FY 2014 reported rate of 3.11 percent.

The national CHIP improper payment rate (MIP 9.2) reported in the 2018 AFR is based on measurements conducted in fiscal years 2016, 2017, and 2018. The current national CHIP improper payment rate is 8.57 percent. The national CHIP component rates are 12.55 percent for CHIP FFS and 1.24 percent for CHIP managed care. The CHIP eligibility component is held constant at the FY 2014 reported rate of 4.22 percent. Additional detail about Medicaid and CHIP improper payment rates and underlying components is available in the FY 2018 HHS AFR.

As described in Sections 11.4: Medicaid and 11.5: CHIP of the FY 2018 HHS AFR, HHS will resume the Medicaid and CHIP eligibility component measurements and report updated national eligibility improper payment estimates in FY 2019. Reduction targets will be published once a full baseline, including eligibility, has been established and reported in FY 2021.

The factors contributing to improper payments are complex and vary from year to year. Each year CMS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. Detailed information on corrective actions can be found in the FY 2018 HHS AFR.

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

As the Department looks to FY 2020 and beyond, it imagines all the achievements that can be reached when workforce performance is heightened, efficiencies achieved, and accountability strengthened. The Department must continue to create a flexible and agile workforce that responds and adapts to change: change in technology, change in society, change in expectations, and change in scientific findings. HHS needs the leaders of tomorrow today. To this end, the Department will continue to build a world-class federal management team and a workforce ready to collaborate with colleagues within the Department, among other federal departments, and outside the federal government, to seek change that improves and enhances the health and well-being of Americans.

The Office of the Secretary leads this objective. All divisions contribute to the achievement of this objective.

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) [52]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	Baseline	67%	68%	69%	72.5%	75%	75%
Result	N/A	66%	68%	70%	72%	73%	12/31/19	12/31/20
Status	N/A	Historic Actual	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Among very large federal agencies (greater than 75,000 employees), HHS had the highest employee engagement score for FY 2017 (72 percent). In FY 2017, HHS senior executives focused on achieving a minimum of 70 percent in each of the 5 areas of HHS FEVS performance: participation, employee engagement, satisfaction, belief that action will be taken based on survey results, and effective communication. The FEVS places emphasis on organizations taking local action to support enterprise improvement in the above 5 areas of focus, as well as other areas for improvement as appropriate. In FY 2019 and 2020, HHS will continue to use FEVS data to monitor the impact of its efforts to support enterprise improvement.

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	80 days	80 days	80 days
Result	N/A	N/A	N/A	108 days	101 days	94 days	12/31/19	12/31/20
Status	N/A	N/A	N/A	Historic Actual	Historic Actual	Target Not Met but Improved	Pending	Pending

HHS has engaged its Human Resources Center Subject Matter Experts as well as our program area customers to try to identify ways to streamline the hiring process via the HHS ReImagine Maximize Talent initiative. The Department determined that it can reduce some duplicative effort through standardization and sharing of efforts across staffing organizations. ReImagine projects are building the capacity to share certificates, build and share standard recruitment packages, and eventually share recruitments. These enhanced business practices are still emerging and so their impact will not be fully

[52] This measure reports employee engagement index results collected through the FEVS.

felt until next year. In FY 2019 and FY 2020, ASA will continue using this process to identify and implement ways to streamline the time-to-hire cycle. More about the ReImagine Maximize Talent initiative can be found in the Major Management Priorities section of this report (page 58).

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

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

The Office of the Secretary leads this objective. All divisions contribute to the achievement of this objective.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	Baseline	96.5%	97%
Result	N/A	N/A	N/A	N/A	N/A	96%	9/30/19	9/30/20
Status	N/A	N/A	N/A	N/A	N/A	Historic Actual	Pending	Pending

The purpose of this measure is to increase the total percentage of identified systems that have a formal authorization to operate on HHS networks. This measure links directly to measure 3.4.

Improve the score to an "A" in each of the FITARA-related Scorecard Metrics, per GAO and the House Oversight and Government Reform Committee (Lead Agency - ASA; Measure ID - 3.4)

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	90%	90%	90%
Result	N/A	N/A	N/A	64%	64%	89%	12/31/19	12/31/20
Status	N/A	N/A	N/A	Historic Actual	Historic Actual	Target Not Met but Improved	Pending	Pending

HHS has 100 out of 103 software projects on an incremental development methodology, giving the department an "A" grade. This builds on the department's score from May, when 82 out of 83 projects were on an incremental path. Under risk assessment transparency, HHS categorized 92 percent of its major investments as at risk, a designation that the committee wants agencies to use. This puts HHS as the agency with the fifth most investments at risk, maintaining the department's "A" grade in the category. Under the IT portfolio category, the department reported $4.378 billion in savings and avoidance since 2012. Compared to the IT budget of $17.04 billion for the last 3 years, HHS had a savings ratio of 25.7 percent, the highest out of all reviewed agencies, and a slight improvement over May's 25.3 percent. With exceptional results, HHS maintained an A grade. HHS also maintained its inventory of software licenses and used it to make management decisions, which helped to maintain the department's "A" grade in the category.

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

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

The Office of the Secretary leads this objective. All divisions contribute to the achievement of this objective.

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 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	Baseline	6.8%	6.5%
Result	N/A	N/A	N/A	N/A	N/A	7%	9/30/19	9/30/20
Status	N/A	N/A	N/A	N/A	N/A	Historic Actual	Pending	Pending

Through the combination or training, education, and tools (e.g., email add-in), the purpose of the measure is to reduce the likelihood of staff falling for fake email attempts over time. HHS will establish a baseline from data collected through Office of the Chief Information Officer's enterprise Phishme solution and set a target with a goal of negative responses decreasing over time.

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	Baseline	365	365
Result	N/A	N/A	N/A	N/A	N/A	365	9/30/19	9/20/20
Status	N/A	N/A	N/A	N/A	N/A	Historic Actual	Pending	Pending

This measure serves as an enterprise-wide countdown measure since the last day of a major PII incident in the Department as well as a gauge for the number of major PII incidents. The number of days will continue to increase unless there is a major incident, at which point the count resets.

Evidence Building Efforts

OMB Circular A-11, Section 210.11 requires that Annual Performance Reports 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 budget, legislative, regulatory, strategic planning, program, and policy arenas. Given the breadth of work supported by HHS, many evaluations and analyses are conducted each year. These efforts range in scope, scale, design, and methodology, but all aim to understand the effects of programs and policies and how they can be improved.

Evaluation at HHS: Across HHS, evaluation comes in many forms including 1) formal program evaluations using the most rigorous designs appropriate; 2) capacity-building initiatives to improve administrative data collection, accessibility, and use for management; 3) exploratory quantitative and qualitative analysis to build preliminary evidence; 4) pilots and demonstrations; and 5) statistical analysis of factors related to the implementation, performance, and outcomes of health and human services programs and policies. Findings from a variety of evaluations and analyses are disseminated to the public on HHS agency websites such as Office of Planning, Research, and Evaluation (ACF) and the Innovation Center at the Centers for Medicare & Medicaid (CMS). HHS coordinates its evaluation community by regularly convening the HHS Evaluation & Evidence Policy 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 such as the ACF Research and Evaluation Clearinghouses on Self-Sufficiency, Employment Strategies, Strengthening Families, Home Visiting, and Child Care and Early Education; the AHRQ United States Preventive Services Task Force; the CDC Community Guide; or 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.

Regulatory Reform

On April 28, 2017, the Administration published OMB Memorandum M-17-23, *Regulatory Reform Officers and Regulatory Policy Officers at Executive Departments and Agencies*. HHS currently tracks progress on six regulatory reform measures.

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	44	12	TBD
Result	N/A	N/A	N/A	N/A	111	10/31/19	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Pending	Pending

During FY 2017 and 2018, the Department worked to identify 155 deregulatory actions. For this reason, the number of evaluations has decreased from 1 to 2 new evaluations each month in FY 2019.

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	19	30	TBD
Result	N/A	N/A	N/A	N/A	61	10/31/19	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Pending	Pending

In FY 2017 and 2018, HHS Regulatory Reform Task Force working groups identified 155 deregulatory actions. The Task Force recommended 80 of those actions. Of the 75 remaining deregulatory actions, HHS predicts that the Task Force will approve 30 actions. Some of the submitted actions are not deregulatory based on EO definitions. Other deregulatory actions will require more detail before the Task Force can make a recommendation.

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	4	34	TBD
Result	N/A	N/A	N/A	N/A	25	10/31/19	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Pending	Pending

Based on the HHS FY 13771 Cost Allocation submitted to OMB, the Department expects to finalize 34 deregulatory actions in FY 2019. The Regulatory Reform Task Force recommended all deregulatory actions appearing on the HHS FY 2019 13771 Cost Allocation table.

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	6	15	TBD
Result	N/A	N/A	N/A	N/A	4	10/31/19	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Pending	Pending

Based on the HHS FY 13771 Cost Allocation table submitted, the Department expects to finalize 15 regulations in FY 2019.

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	16	34	TBD
Result	N/A	N/A	N/A	N/A	25	10/31/19	10/31/20

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Status	N/A	N/A	N/A	N/A	Target Exceeded	Pending	Pending

Based on the HHS FY 13771 Cost Allocation table submitted, the Department expects to finalize 34 deregulatory actions in FY 2019.

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	-$28.7 million	-$550 million	TBD
Result	N/A	N/A	N/A	N/A	-$763.48 million	10/31/19	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Pending	Pending

In FY 2019, the Department expects to decrease total incremental cost by $550 million in annualized dollars.

Major Management Priorities

The Department has identified 4 Major Management Priorities:

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

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

Moving to a 21st Century Workforce

Supporting Initiative: Maximize Talent

The Maximize Talent Initiative aims to transform our business processes and practices to meet modern-day human capital management and human resources operational challenges now and in the future. Through the Maximize Talent efforts, the Initiative will enhance the Department's most important resource – its people. We will achieve this transformation by focusing on three primary goals:

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

Designated Official: Bahar Niakan, Initiative Lead

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

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

Performance Indicator: FEVS Employee Engagement Index

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	70%	72.5%	73%	75%
Result	N/A	N/A	N/A	N/A	72.2%	72.8%	9/31/19	9/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Target Exceeded	Pending	Pending

Performance Indicator: FEVS Employee Participation

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	54%	56%	58%	60%
Result	N/A	N/A	N/A	N/A	58.5%	57.2%	9/31/19	9/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Target Exceeded	Pending	Pending

	Milestones	Planned Completion Date	Status
1.	2019 FEVS guidance from the ASA to OPDIV and STAFFDIV Heads and Executive Officers	10/31/2018	Completed
2.	Held Employee Engagement Forum Kickoff	10/17/2018	Completed
3.	Held FEVS Program Managers Best Practice Exchange	11/1/2018	Completed
4.	Provided pre-populated OPM reporting template to FEVS Program Managers	11/6/2018	Completed
5.	Compiled initial report of HHS 20 by 20 by 2020 data for submission to OPM	11/15/2018	Completed
6.	Submit HHS Report to OPM	11/23/2018	Completed
7.	ASA/CHCO Endorsement of “Sprint to 2019” and ”Marathon to 2020”	11/23/2018	Completed
8.	Set Up EVS ART Training for OpDiv/ StaffDiv	1/19/2018	Pending
9.	Leaders at all levels present FEVS data to work units and commit to action.	3/31/2019	Pending
10.	Collect insight on employee engagement from the employee perspective.	2/28/2019	In Progress
11.	Release a call for Organization Development services/providers to support SPRINT 2019	2/28/2018	In Progress
12.	Managers and supervisors lead work units in action planning for quick sprint improvement.	3/29/2019	Pending
13.	Active, visible, and meaningful action to improve employee engagement.	4/30/2019	Pending
14.	Encourage participation in the FEVS.	6/21/2019	Pending

15.	Employ long term strategies for success including FEVS Program Manager offsite, lessons learned from SPRINT to 2019, assessment of FEVS program metrics (leading and lag indicators), continued engagement of Employee Engagement Community of Practice, and other	6/21/2019 – 8/30/2020	Pending

Restoring Market Forces

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

Designated Official: Erik P. Mettler, Initiative Lead

Performance Goal: Create a more effective and efficient food safety system by increasing the role of the states in improving produce safety as measured by 85% of states and territories (out of 55 total, 50 states and 5 territories) participating in the Produce Safety Implementation Cooperative Agreement Program (State CAP) by September 30, 2019.

Data Source & Validation: FDA Produce Safety Implementation Cooperative Agreement Program (State CAP)

Performance Indicator: Number of States and Territories (Grantees) Participating in Produce Safety Implementation Cooperative Agreement Program (State CAP)*

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	Baseline	Baseline	47	47	47
Result	N/A	N/A	N/A	42	43	47	7/31/19	7/31/20
Status	N/A	N/A	N/A	Historic Actual	Historic Actual	Target Met	Pending	Pending

**State CAP year runs from July 1 – June 30. Data reported are from that timeframe.*

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

Data Source & Validation: State inspection reporting.

Performance Indicator: Number of Inspections being conducted by State Partners participating in the State Cooperative Agreement Program (State CAP)*

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	Baseline	Result +10%	Result +10%
Result	N/A	N/A	N/A	6/30/19	6/30/20	6/30/21
Status	N/A	N/A	N/A	Pending	Pending	Pending

**State CAP year runs from July 1 – June 30. Data reported are from that timeframe.*

	Milestones	Planned Completion Date	Status
1.	Complete detailed assessment of state produce regulatory programs, to include projected availability of resources and jurisdictional assessment.	6/2019	On-Track
2.	Develop detailed Implementation Plan which may include: potential funding sources; partners for leveraging; outreach opportunities; measures of success; for increasing the role of states in produce safety inspection.	12/2019	On-Track
3.	Execution of Implementation plan	6/2021	On-Track

Making HHS More Innovative and Responsive

Supporting Initiative: Optimize NIH

Designated Official: Janet Shorback, Initiative Lead

Performance Goal: Increase the efficiency and effectiveness of NIH administrative functions to better support the agency's mission while maintaining support of the workforce, increasing employee engagement, and overseeing the use of taxpayer dollars. HHS will pursue the following performance goal by 2020: Make management of Freedom of Information Act (FOIA) requests more efficient by reducing the number of systems used to track and submit FOIA requests by December 17, 2018.

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

Performance Indicator: Number of Systems Used to Track and Submit FOIA Reports[53]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	Baseline	1	Discontinued
Result	N/A	N/A	N/A	N/A	N/A	8	1	N/A
Status	N/A	N/A	N/A	N/A	N/A	Historic Actual	Target Met	N/A

	Milestones	Planned Completion Date	Status
1.	Due diligence to identify suitable FOIA platform	7/2018	Completed
2.	Finalize FOIA implementation plan	8/2018 - 9/2018	Completed: Refine on ongoing basis
3.	Begin implementing FOIA plan	9/2018	On schedule
4.	Selected platform for FOIA effort and began portal customization	10/2018	Completed

[53] The HHS target for FY 2019 was to reduce the number of systems from eight to one. HHS has achieved this target.

5.	Customize selected FOIA platform and perform user-acceptance testing	11/2018	Completed
6	Train all NIH FOIA staff on selected FOIA platform	12/2018	Completed
7.	Launch selected FOIA platform across NIH	12/2018	Completed
8.	Customize portal and launch customized portal to public	3/2019	Completion: End of March

Generating Efficiencies through Streamlined Services

Supporting Initiative: Buy Smarter

Designated Official: Lori Ruderman, Initiative Lead

Performance Goal: Achieve $720 million in cost savings[54] once fully implemented by September 30, 2025 by utilizing new and emerging technologies to leverage the enormous purchasing power of HHS ($24 billion per year) and enhance and streamline the end-to-end procurement process.

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

Performance Indicator: Overall HHS Spend Under Management. Spend Under Management is the percentage of an organization's spend that is actively managed according to category management principles.[55, 56, 57]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	N/A	NA	$8 million	$22 million
Result	N/A	N/A	N/A	N/A	N/A	NA	9/30/20	9/30/21
Status	N/A	N/A	N/A	N/A	N/A	N/A	Pending	Pending

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

[54] Percent of savings is in some part a cost avoidance and some savings will be reallocated back to primary missions.
[55] Government-Wide Category Management: Best-in-Class & Spend Under Management, 05 Feb 2018, https://www.gsa.gov/cdnstatic/BIC_%26_SUM_One-pager_252018.pdf
[56] The FY 2019 target of $8 million equals .03 percent and the FY 2020 target of $22 million equals .09 percent.
[57] HHS's spend is $24 billion per year. Over the next six years, HHS projects that it will be able actively manage a total of $720 million according to category management principles by September 30, 2025.

5.	Establish Category Collaborative Model to focus on GSA Categories of Spend	1/2019	Completed
6.	Leverage Accelerate block chain data layer for initial BUYSMARTER Operating Model.	3/2019	Ongoing
7.	Conducted initial business-case analysis to focus on understanding current purchasing fragmentation and potential inefficiencies of the current acquisition function (e.g., initial spend analysis, initial acquisition function review).	7/2019	Completed
8.	Conducted additional validation and implementation (e.g., detailed spend analysis, detailed acquisition function review).	10/2019	Completed
9.	Implement A.I. microservices for initial BUYSMARTER Operating Model.	1/2020	Ongoing
10.	Implement e-commerce platform.	12/2020	Pending
11.	Share contracts in place for 80 percent of A.I. identified common spend categories. The 80 percent metric covers the majority of HHS's spend while recognizing that there are unique requirements that may not fall under common spend categories.	10/2022	Pending

Lower-Priority Program Activities

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

Changed Performance Goals

Information on performance goal changes can be found at: https://www.hhs.gov/about/budget/fy2020/performance/performance-plan-changes-in-performance-measures/index.html?language=es.

Data Sources and Validation

Supporting information on HHS FY 2020 Annual Performance Plan and Report performance measures and data can be found at: https://www.hhs.gov/about/budget/fy2020/performance/performance-plan-data-sources-and-validation/index.html?language=es.