FISCAL YEAR 2016

Annual Performance Plan and Report

Released February 2015

PERFORMANCE

RESULTS

HITTING THE MARK

SUCCESS

U.S. Department of Health & Human Services

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Message from the HHS Performance Improvement Officer

The U.S. Department of Health and Human Services (HHS) supports and implements programs that contribute to the health, safety, and well-being of the American people and the world. Our Operating and Staff Divisions strive each day to help more Americans acquire affordable health care, to protect and enhance the health of the people of this country and the world, and to assist those who are least able to help themselves, often through the Department's state, local, and tribal partners. 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 2016 Annual Performance Plan and Report documenting the Department's performance during the past year and its plans for the future. Further information detailing HHS performance is available at Performance.gov.

In FY 2014, HHS monitored five new priority goals and over 1,000 performance measures to manage departmental programs and activities and improve the efficiency and effectiveness of these programs. Included in this report is a representative set of 137 performance measures that illustrate progress toward achieving the Department's strategic goals. The information provided spans many of HHS's eleven Operating Divisions and sixteen Staff Divisions and includes work across the country and throughout the world. Each HHS component has reviewed their submissions and I confirm, 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 Affordable Care Act is having a significant positive effect on Americans' lives. In 2014 the number of uninsured declined by approximately 10 million people. Millions signed up for health care coverage on Healthcare.gov and the state Marketplaces and paid their premiums. Millions more are receiving the care that they need through expanded Medicaid eligibility. Medicaid and the Children's Health Insurance Program enrollments are increasing, providing our youngest access to necessary healthcare. HHS is also working to keep America healthy, advance science and research, serve our citizens at key stages of life, and enhance the Department's administration and operations. The results presented here demonstrate that HHS is performing well across a wide range of activities and has plans in place to continue that success in the future.

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

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Overview

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

Eleven operating divisions, including eight agencies in the United States Public Health Service and three human service agencies, administer HHS's programs. In addition, sixteen staff divisions 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 a special trust obligation to provide services for American Indians and Alaska Natives (AI/ANs) based on this association. HHS works with tribal governments and with urban Indian and other organizations to facilitate greater consultation and coordination between state and tribal governments on health and human services.

HHS also has strong partnerships with the private sector and nongovernmental organizations. The Department works with partners in the private sector, such as regulated industries, academic institutions, trade organizations, and advocacy groups. The Department recognizes that leveraging resources from organizations and individuals with shared interests allows HHS to accomplish its mission in ways that are the least burdensome and most beneficial to the American public. Private sector grantees, such as academic institutions and faith-based and neighborhood partnerships, provide many HHS-funded services at the local level. In addition, HHS works closely with other federal departments and international partners to coordinate its efforts to ensure the maximum 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 Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

HHS Organizational Structure

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

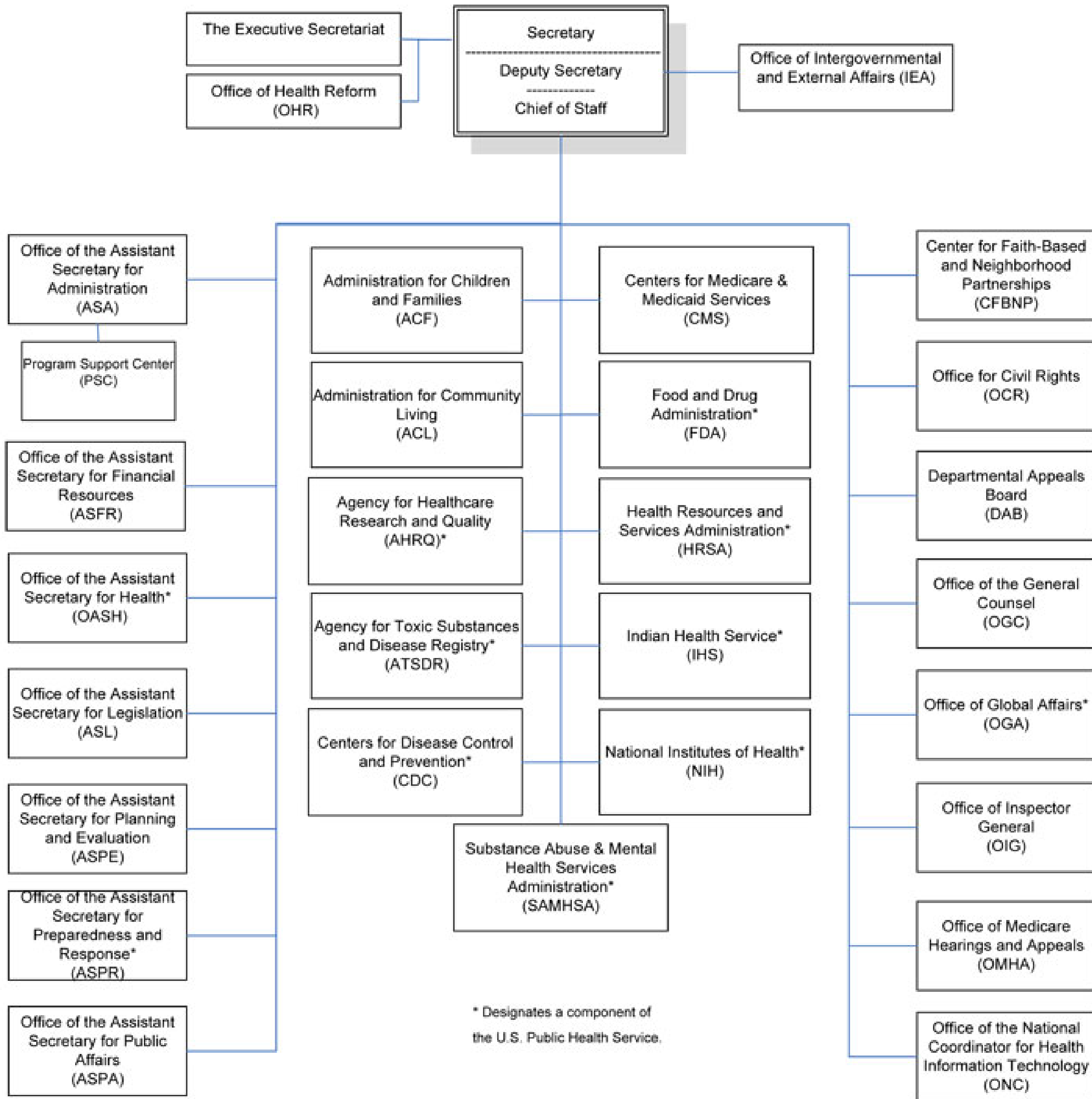
- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)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

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

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

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

Organizational Chart Department of Health and Human Services



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

Cross-Agency Priority Goals

Per the Government Performance and Results Modernization Act (GPRAMA) requirement to address Cross-Agency Priority (CAP) Goals in the agency strategic plan, the annual performance plan, and the annual performance report, please refer to www.Performance.gov for the agency's contributions to those goals and progress, where applicable. The Department of Health and Human Services currently contributes to the following CAP Goals: Customer Service, Benchmarking, Open Data, Lab-to-Market, and People and Culture.

Strategic Goals Overview

HHS developed a new strategic plan in 2013 to encompass the period from FY 2014 to 2018. This plan, available at http://www.hhs.gov/strategic-plan/priorities.html, identifies four strategic goals and 21 related objectives. The four strategic goals are:

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

Management Objectives and Priorities

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

Performance Management

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

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

- Developing, analyzing, reporting, and managing five Priority Goals for the period of FY 2014-2015 and conducting quarterly performance reviews between HHS component staff and HHS leadership to monitor progress toward achieving key performance objectives.
- Coordinating initial Strategic Reviews process supporting decision-making and performance improvement across the Department.
- Enhancing the coordination of performance measurement, budgeting, strategic planning, and program integrity activities within the Department.

- Continuing to foster a network of component Performance Officers who support, coordinate, and implement performance management efforts across HHS.
- Sharing of best practices in performance management at HHS through webinars and other media.

HHS Priority Goals

HHS, along with other federal agencies, uses Priority Goals to improve performance and accountability. HHS established a set of near-term (18 – 24 month) Priority Goals aligned to an HHS Strategic Plan Goal and began holding quarterly data-driven reviews to monitor progress towards these Priority Goals in FY 2014. The Department developed these Priority Goals by collaborating across the Department to identify those activities that would reflect HHS priorities and benefit from the focus and communication of the Priority Goal process. Some of these Goals are continuations from FY 2012-2013, reflecting their continued importance across the Department. These Priority Goals are largely cross-cutting in nature, requiring active management across HHS components for success. Priority Goals are included in the Strategic Plan and Annual Performance Plan with targets displayed until at least FY 2015. HHS will actively monitor progress and work towards the achievement of these goals through quarterly data-driven reviews and other mechanisms. Please refer to www.Performance.gov for additional information on Priority Goals and the HHS components' contributions to those goals.

HHS Priority Goals Progress Summary FY 2014 – FY 2015

Improve health care through meaningful use of health information technology: By the end of FY 2015, increase the number of eligible providers who receive incentive payments from the CMS Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for the successful adoption or demonstration of meaningful use of certified EHR technology to 450,000.

> **Results Reported:** As of September 2014 progress on stage 2 of this program showed more than 414,914 providers had received their first incentive payment or 83 percent of all registered providers. 74 percent of all eligible professionals and 94 percent of all eligible hospitals have received at least one incentive payment. As of October 2014, over 90 percent of attested providers were using an EHR vendor that had a 2014 certified EHR product available. This means, that while the provider may not have a 2014 certified EHR product/version currently installed, the vendor of their primary EHR does provide a 2014 certified EHR product option. Recognizing that many providers and vendors are facing difficulty transitioning to 2014 certified EHRs, CMS and ONC recently finalized the Flexibility Rule, which allows providers more flexibility in attestation options during 2014. While not all providers are eligible for the flexibility, those that are may defer progress to stage 2 requirements until after the end of FY 2015.

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

> **Results Reported:** CDC reported that the illness rate during the 12-month period ending June 30, 2014 was 2.8 illnesses per 100,000. This is a decrease from the 2010 rate (3.5 cases per 100,000) but is slightly higher than the 2007-2009 baseline rate of 2.6 cases per 100,000 population. In support of this reduction, as of September 30, 2014 FDA has conducted a total of

255 inspections or investigations of small and large registered egg producers, 168 and 87 respectively. Also, as of October 31, 2014, 9 of the 10 FoodNet sites were transmitting exposure information to CDC. Exploratory analyses of the 579 infections with exposure information are ongoing. CDC is evaluating this data to determine its usefulness in CDC's "exposure" model to estimate the proportion of total SE illnesses (foodborne, non-foodborne, and international travel-associated) attributable to shell eggs during 2014-2015.

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

Results Reported: Preliminary results show that OASH, FDA, NIH, and CDC face initial challenges on progress together toward this goal, reporting a rate of 1,277 cigarette equivalents per capita in FY 2013. This result does not quite meet the target, reflecting the many obstacles in place to effecting tangible change on smoking behavior. Supporting efforts around education about health effects, retail compliance and facility inspections, and cessation and prevention have all shown recent success, indicating that per capita smoking rates have the potential to decline.

Improve patient safety: To reduce the national rate of healthcare-associated infections (HAIs) by September 30, 2015 by demonstrating a 10 percent reduction in national hospital-acquired catheter-associated urinary tract infections (CAUTI) from the current standardized infection ration (SIR) of 1.03 to a target SIR of 0.92.

Results Reported: CMS, CDC, AHRQ, and OASH collaborated to coordinate programs across HHS, in addition to working closely with public and private partners, towards the goal to reduce the HAI CAUTI. The anticipated reduction of the CAUTI SIR by 20 percent has not yet been reached, and recent data trends from FY 2013 show an increase in CAUTI SIR by 12 percent. This represents an improvement over the prior year. HHS partners will continue to use a combination of programmatic levers and evidence-based infection control interventions in order to show substantial future reductions in CAUTI.

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

Results Reported: ACF continues to be on track to meet the key indicators associated with this Priority Goal, as we continue to make progress to improve the quality of Early Childhood Education programs. An analysis of CLASS: Pre-K scores for the most recent cohort of 404 Head Start grantees that received on-site monitoring in the 2013-2014 Head Start "school year" indicates that 23 percent of grantees scored in the low range, thus exceeding the target of 27 percent. All grantees scoring in the low range (below 2.5) in FY 2014 did so for the Instructional Support domain. ACF has also completed all implementation milestones in this goal in FY 2014.

Annual Performance Plan and Report

The Annual Performance Report provides information on HHS's progress toward achieving the goals and objectives described in the HHS Strategic Plan and Annual Performance Plan. This section is organized around the goals and objectives contained in the FY 2014 – 2018 HHS Strategic Plan. The information shown here reflects the most recent results available at the end of FY 2014 for HHS representative measures. The Goals and Objectives contained in this Strategic Plan can be found at http://www.hhs.gov/strategic-plan/priorities.html.

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

Before the Affordable Care Act, millions of Americans lacked access to affordable health insurance. Many who did have health insurance had gaps in coverage, such as exclusions for pre-existing conditions, or they were one step away from losing coverage because of a change in employment. Individuals with health insurance face increasingly high premiums and medical costs that drive some to bankruptcy or force choices between maintaining health insurance coverage and paying for other household essentials. HHS has been identified as the lead federal agency responsible for implementing the Affordable Care Act, which contains many new health insurance market reforms and programs to address these and other issues. The Affordable Care Act is making comprehensive health coverage available to millions of Americans who previously lacked access to or could not afford health insurance. As a result, about 10 million previously uninsured Americans gained health coverage in the first full year of Affordable Care Act implementation.

Starting in 2010 and continuing in 2014, HHS has implemented new regulations aimed at increasing consumer protections and at creating a more competitive insurance market to both lower cost and improve quality. These new protections and increased oversight of the insurance industry help ensure that consumers are receiving value for their premium dollars; this oversight will also make the healthcare system more responsive to the needs of its patients, providers, and other stakeholders.

Within HHS, divisions such as ACL, AHRQ, CDC, CMS, IHS, OASH and SAMHSA work to implement the reforms prescribed in the law to make affordable coverage more accessible. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 1.A Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	43,212,512 children	45,592,385 children	46,617,385 children	47,642,385 children	48,667,385 children[1]
Result	43,542,385 children	44,453,639 children	45,292,410 children	Mar 31, 2015	Mar 31, 2016	Mar 31, 2017
Status	Historical Actual	Target Exceeded	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	90 %	90 %	90 %	90 %	90 %	N/A[2]
Result	92 %	90 %	91 %	91 %	Dec 31, 2015	
Status	Target Exceeded	Target Met	Target Exceeded	Target Exceeded	Pending	

[1] Subject to an extension of CHIP. Under current law, FY 2015 is the final year of appropriations for CHIP and states have two years to spend their FY 2015 allotments.

[2] CMS will report MCR1.1a as a contextual measure with no target starting in FY 2016.

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	90 %	90 %	90 %	90 %	90 %	N/A[3]
Result	92 %	91 %	91 %	90 %	Dec 31, 2015	
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	58.0%	55.0%	53.0%	50.0%	48.0%
Result	57.0%	57.0%	Feb 28, 2015	Feb 28, 2016	Feb 28, 2017	Feb 28, 2018
Status	Historical Actual	Target Exceeded	Pending	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	6 months	6 months	6 months	6 months	6 months	6 months
Result	6 months	6 months	6 months	6 months	Oct 30, 2015	Sep 30, 2016
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	Set Baseline	5,911	5,911	8,850
Result	4,304	3,760	7,389	8,219	Dec 31, 2015	Dec 31, 2016
Status	Historical Actual	Historical Actual	Baseline	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	47 %	47 %	50 %	47 %	66 %	66 %
Result	40 %	66 %	66 %	Jul 31, 2015	Jul 31, 2016	Jul 31, 2017
Status	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[3] CMS will report MCR 1.1b as a contextual measure with no target starting in FY 2016.

Analysis of Results

CMS tracks combined Medicaid and Children's Health Insurance Program (CHIP) enrollment of children. The most recent results report more than 45 million children were enrolled in 2013, which missed the target but improved over the previous year's result. The Affordable Care Act requires maintenance of eligibility standards for children in Medicaid and CHIP through 2019.

Passage of the Medicare Modernization Act (MMA) prompted modifications in the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to include measurement of experience and beneficiary satisfaction with the care and services provided through the Medicare Prescription Drug Plans as well as Medicare Fee for Service (MFFS) and Medicare Advantage (MA). Since FY 2008, we have either met or exceeded the goal of 90 percent of beneficiaries who reported access to care.

The Affordable Care Act also included changes to Medicare to enhance the affordability of prescription drugs. Through the Coverage Gap Discount Program, CMS seeks to reduce the costs Medicare Part D enrollees are required to pay for their prescriptions once they reach the coverage gap (commonly known as the "donut hole"). The program will accomplish these reductions through significant manufacturer discounts and increased Medicare coverage according to a predetermined scale for FY 2011 through 2020. In FY 2012, CMS exceeded its target for reductions. In 2014, more than 5 million beneficiaries reached the coverage gap and saved more than $4.7 billion on their medications. These savings averaged about $941 per person. Cumulatively since enactment of the Affordable Care Act, 9.4 million beneficiaries have saved a total of $15 billion on prescription drugs.

The MEPS-Insurance Component provides annual national and state estimates of aggregate spending on employer-sponsored health insurance for the National Health Expenditure Accounts (NHEA) that are maintained by CMS and for the gross domestic product produced by the Bureau of Economic Analysis. In support of the Affordable Care Act, MEPS-IC state-level premium estimates are the basis for determining the average limits for the federal tax credit available to small businesses that provide health insurance to their employees. In FY 2010, a baseline of 6 months was established to make data available for use after data collection. Since baseline determination, AHRQ has been successful in maintaining the 6 months target.

SAMHSA recognizes that some populations have different needs for behavioral health services and is concerned about the needs of those with serious mental illness (SMI) and/or co-occurring substance use disorder who experience homelessness or are at risk of homelessness. It is common for those experiencing homelessness also to have a mental health issue(s) and/or substance use disorder(s). SAMHSA has committed to increase the percentage of homeless people served through its programs who receive behavioral health services. These include substance abuse and alcohol counseling, group supports, and treatments to reduce anxiety. In FY 2013, 66 percent of homeless enrolled in the Projects to Assist in the Transition from Homelessness (PATH) received mental health services. SAMHSA also focuses on suicide prevention and early intervention strategies for those at high risk of suicide, including youth. SAMHSA's State-Sponsored Youth Suicide Prevention and Early Intervention program is focused on individuals 10 to 24 years old who are at especially high risk of suicide. In FY 2014 SAMHSA planned to have at least 5,911 individuals receive direct treatment including outpatient, day treatment, intensive outpatient or residential programs in an effort to prevent suicide. For FY 2014, the program referred 8,219 youth for mental health services, well exceeding the target. Additional services are also available to participants including support service, wrap-around services, and outreach services.

Plans for the Future

The FY 2016 target is to increase CHIP and Medicaid enrollment to 48,667,385 children, (Medicaid: 39,758,322/CHIP: 8,909,063), over 30 percent more children than were covered in FY 2008. CMS will continue to aim outreach efforts to inform parents that they can enroll children in Medicaid and CHIP at any time of the year. In addition, CMS is working closely with states to implement Affordable Care Act provisions related to streamlining eligibility and enrollment processes in Medicaid and CHIP, as well as options to help children maintain coverage over time.

CMS will continue to monitor beneficiary satisfaction with access to care for Medicare Fee for Service (MFFS) and Medicare Advantage (MA) using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Medicare will also analyze data at the plan, enrollee subgroup, and geographic levels to assist plans in developing interventions that are both actionable and targeted to maintain or improve performance on measures through FY 2015, at which time the goal will be reported as a contextual indicator.

Between 2011 and 2020, CMS will work to reduce out of pocket costs for Medicare coverage for prescription drugs. Prior to the passage of the Affordable Care Act, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the catastrophic limit. By 2016, CMS will aim to reduce the coverage gap to 48 percent, using a combination of rebate checks, manufacturers' discounts, and enhanced Medicare benefits.

AHRQ plans to continue producing insurance component tables from the Medical Expenditure Panel Survey (MEPS) and be able to produce searchable tables within 6 months of the data collection. Schedules for data release will be maintained through FY 2016.

For the current reporting period, SAMHSA expects a slight decrease in the percentage of homeless assisted by the PATH program. This is due to a 10 percent reduction in funding in 2013. This small target decline is followed by a significantly increased target in FY 2015, which is maintained in FY 2016. Factors that influence performance include resources, changes in the collection methodology and the clarification of definitions for certain PATH data elements. The transient nature of the populations served by PATH increases the challenge for the program to meet its performance targets. SAMHSA expects to maintain the number of individuals referred to mental health or related services in FY 2015 and increase that number substantially in FY 2016.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- Over eight million people selected a health insurance plan through the Health Insurance Marketplace (including both state-based Marketplaces and the federally-facilitated Marketplace) through March 31, 2014 (including additional special enrollment period (SEP) activity reported through Saturday, April 19, 2014).[4] As of October 15, 2014, 6.7 million individuals were enrolled and paying for health coverage ("effectuated" enrollees) through the Marketplace.[5]

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[4] This included the special enrollment period extending through April 19, 2014 for consumers "in-line" to apply as of March 31, 2014.

[5] The source of this data is http://aspe.hhs.gov/health/reports/2014/Targets/ib_Targets.pdf

- Beginning in FY 2013, CMS began to track combined Medicaid and Children's Health Insurance Program (CHIP) enrollment. In 2013, 45,292,410 children were enrolled in Medicaid (37,198,483) and CHIP (8,093,927), falling short of our target of 45,592,385 children (Medicaid 37,246,233/CHIP 8,346,152). The results represent an increase in enrollment between 2012 and 2013.

- CMS met or exceeded FY 2014 targets reflecting beneficiary experience in fee-for-service and Medicare Advantage access to care in 2013.

- The Affordable Care Act Coverage Gap Discount Program reduces the amount Medicare Part D enrollees are required to pay for their prescriptions once they reach the coverage gap. CMS has succeeded in reducing the average out-of-pocket share of costs due to this gap and plans to build on this success with further reductions in the future.

- The Medical Expenditure Panel Survey, first funded in 1995, is the only national source for comprehensive annual data on how Americans use and pay for medical care. AHRQ has maintained a 6 month production cycle for the data table from this survey and plans to maintain that schedule in the future.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

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

CMS is transforming into an agency that positively promotes and incentivizes the quality of care for its beneficiaries through payment policy. Examples include continued development of physician, hospital, and post-acute care provider quality reporting systems that will link payments to the quality and efficiency of care, while also reducing healthcare-associated infections. In addition, CMS is promoting state efforts to report on quality metrics related to care in Medicaid and the Children's Health Insurance Program (CHIP). ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, OCR, ONC, and SAMHSA are working together to improve healthcare quality and patient safety for all Americans. Below are some key performance measures demonstrating HHS progress. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 1.B Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	0.7	0.6	0.5	0.4	0.35[6]	0.33
Result	0.59	0.56	0.54	Nov 30, 2015	Nov 30, 2016	Nov 30, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	5,000	6,500	12,000	13,500	17,000	19,000
Result	5,000	10,900	12,400	14,450	Jan 1, 2016	Jan 1, 2017
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

[6] New baseline will be established in 2015 per the updated HHS HAI Action Plan.

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	13%	25%	40%	60%	65%
Result	N/A	13%	33%	58%	Dec 31, 2015	Dec 31, 2016
Status		Target Met	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	10 %	20 %	5 %	10 %	TBD[8]
Result	N/A	-17 %	-12 %	Mar 31, 2015	Mar 31, 2016	N/A
Status		Target Not Met	Target Not Met but Improved	Pending	Pending	Target Not In Place

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Set Baseline	6.9 %	6.9 %	6.7 %[9]	5.7 %	5.5 %
Result	7.1 %	6.5 %	6.1 %	Feb 28, 2015	Feb 28, 2016	Feb 28, 2017
Status	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Decrease the Percentage of Long-Stay Nursing Home Residents Receiving an Antipsychotic Medication (Lead Agency - CMS; Measure ID - MSC5)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	N/A	19.1%[10]	17.9%[11]	16.7%
Result	23.87%	19.8%	20.3%	Jan 31, 2015	Jan 31, 2016	Jan 31, 2017
Status	Historical Actual	Historical Actual	Historical Actual	Pending	Pending	Pending

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

[8] There is no FY 2016 target for this goal at this time. The FY 2016 target will be dependent on whether this goal is renewed as an Agency Priority Goal (APG). Please see Performance.gov for further detail regarding this APG.

[9] FY 2014 Target was originally 6.9% in the CMS President's Budget. The target was reduced to 6.7% when 2012 results were received.

[10] This activity became high profile and changes were made to reflect modifications to the methodology and to be consistent with other public–facing reporting on this initiative. The original FY 2014 target was reduced from 20.3 percent to 19.1 percent.

[11] Due to the significant progress made toward achieving this measure, the FY 2015 target, as originally reported in the FY 2015 Congressional Justification, was reduced from 19 percent to 17.9 percent.

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Work with states to ensure that 70 percent of states report on at least one quality measure in the CHIPRA core set of quality measures.	Work with states to ensure that 80 percent of states report on at least five quality measures in the CHIPRA core set of quality measures	Work with states to ensure that 85 percent of states report on at least seven quality measures in the CHIPRA core set of quality measures.	Work with states to ensure that 90 percent of states report on at least eight quality measures in the CHIPRA core set of quality measures.	Work with states to ensure that 90 percent of states report on at least nine quality measures in the CHIPRA core set of quality measures.	Work with states to ensure that 90 percent of states report on at least ten quality measures in the CHIPRA core set of quality measures.
Result	84 percent of states reported on at least one quality measure.	92% of states reported on at least five quality measures	88% of states reported on at least seven quality measures[12]	Mar 31, 2015	Mar 31, 2016	Mar 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Publish recommended core set of adult quality measures in the Federal Register.	Publish initial core set of adult quality measures in the Federal Register.	Work with states to ensure that 60 percent of states report on at least three quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	Work with states to ensure that 65 percent of states report on at least five quality measures in the Affordable Care Act Adult Medicare core set of quality measures.	Work with states to ensure that 70 percent of states report on at least seven quality measures in the Affordable Care Act Adult Medicaid core set of quality measures	Work with states to ensure that 70 percent of states report on at least nine quality measures in the Affordable Care Act Adult Medicaid core set of quality measures
Result	Target Met	Target Met	59% of states reported on at least three quality measures.[13]	Mar 31, 2015	Mar 31, 2016	Mar 31, 2017
Status	Target Met	Target Met	Target Not Met	In Progress	Pending	Pending

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[12] "States" included in the denominator of this measure are the 50 States plus the District of Columbia. The FY 2013 result was 45/51 or 88%.

[13] "States" included in the denominator of this measure are the 50 States plus the District of Columbia. The FY 2013 result was 30/51 States or 58.8% – rounded to 59%.

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	2000	2000	2000	1350	Discontinued	
Result	2276	2313	1302	1521	N/A	
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Exceeded	Not Collected	

Review and act on original Abbreviated New Drug Application (ANDA) submissions within the established time frame. (Lead Agency - FDA; Measure ID - 223215)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	N/A	N/A	60% within 15 months	75% within 15 months
Result	N/A	N/A	N/A	N/A	Dec 30, 2017	Dec 30, 2018
Status					Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	100 percent	100 percent	100 percent	100 percent	100 percent	100 percent
Result	100 percent	100 percent	100 percent	Feb 15, 2015	Jan 15, 2016	Jan 15, 2017
Status	Target Met	Target Met	Target Met	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	900 users of research	1032 users of research	1300 users of research	1350 users of research	2050 users of research	2200 users of research
Result	1032 users of research	1128 users of research	1627 users of research	1851 users of research	Oct 30, 2015	Oct 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

Healthcare-associated infections (HAIs) are a significant cause of death in the United States. Of these, central line-associated bloodstream infections (CLABSI) have a strong potential to cause serious illness or death and catheter-associated urinary tract infections (CAUTI) are among the most common. The HHS *National Action Plan to Prevent Healthcare-Associated Infections* identified CLABSIs as a priority for prevention with national 5-year prevention targets and metrics proposed. Likewise, new Healthy People 2020 objectives have been proposed to address the substantial human suffering and financial burden attributable to healthcare-associated infections, one of which is to reduce CLABSIs. CDC's National Healthcare Safety Network (NHSN) is a surveillance system used for tracking and prevention of HAIs across healthcare settings, including hospitals in all 50 states, and non-hospital settings (e.g. hemodialysis and long-term acute care facilities). Exceeding its goal for FY 2013, CDC extended tracking capacity to more than 12,400 facilities. In FY 2013, CLABSIs decreased to 0.54 Standardized Infection

Ratio (SIR) nationally in U.S. hospitals. This represents an improvement over the prior year but misses the target.

The FY 2013 CAUTI SIR was 1.03, which reflects a 12 percent increase over its 2010 baseline, but an improvement over the previous year's result. There are a number of reasons for the increase, including the addition of new hospitals reporting into the National Healthcare Safety Network as part of CMS's Hospital Inpatient Quality Reporting Program. These new reporters were shown to have a consistently higher SIR than previous facilities. Also, better quality of reported data as a result of CDC outreach and education regarding reporting requirements in the Hospital Inpatient Quality Reporting program may have resulted in an increase in the number of CAUTIs reported, raising the SIR among this group of hospitals. In addition, ICUs have a higher prevalence of CAUTI and ICU reporting of CAUTI is incentivized by CMS' Hospital Inpatient Quality Reporting (HIQR) program, which is not the case for non-ICU reporting.

A Patient Centered Medical Home (PCMH) is a delivery model designed to improve the quality of care through enhanced access, planning, management and monitoring of patient care. In FY 2010 about 1 percent of HRSA-funded health centers had at least one site recognized as a PCMH. Through a series of quality improvement efforts, by the end of FY 2014 58 percent of HRSA health centers had at least one site recognized as a patient centered medical home, exceeding the target of 40 percent.

Pressure ulcers or "bed sores" can cause damage to a patient's tissues and other serious complications like infection. Since 2007 there has been a steady decrease in the reported prevalence in pressure ulcers. A decrease of even 0.1 percent represents more than 1,000 fewer nursing home residents with pressure ulcers, not only reducing the cost of care but also improving nursing home residents' quality of life. The FY 2013 result is 6.1 percent, which exceeds the target of 6.9 percent.

The National Partnership to Improve Dementia Care in Nursing Homes is committed to improving the quality of care for individuals with dementia living in nursing homes. The Partnership has a mission to deliver health care that is person-centered, comprehensive, and interdisciplinary with a specific focus on protecting residents from being prescribed antipsychotic medications unless there is a valid, clinical indication and a systematic process to evaluate each individual's need. CMS supports this effort and reports the percentage of long-stay nursing home residents that received an antipsychotic medication with a quality measure (QM) derived from the Minimum Data Set (MDS). CMS is currently reporting historical results and has set performance targets beginning in FY 2014. The FY 2013 result was 20.3 percent, which represented a slight increase over the previous year.

CMS continues to work closely with states to improve children's health care quality across Medicaid and CHIP, as required by the CHIP Reauthorization Act of 2009 (CHIPRA). In collaboration with states, CMS developed and published the Child Core Set of quality measures. CMS is encouraging all states to use and report on the Child Core Set to collect data that will lead to improved health outcomes and to enhance the accuracy and applicability of the pediatric quality measures program specific to the Medicaid and CHIP programs. In FY 2013, 88 percent of states reported on at least seven quality measures in the Child Core Set, exceeding the target. In addition, the Affordable Care Act requires that HHS develop a core set of adult quality performance measures for voluntary use by states to assess the care received by adults in the Medicaid program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid. With 59 percent of states reporting on at least three quality measures in FY 2013, CMS just missed its target of 60 percent.

Generics play an important and increasing role in providing safe, effective, and affordable drugs to the American public and thereby in controlling health care expenditures. FDA's Center for Drug Evaluation and Research has launched initiatives to streamline and modernize the generic review program. The growing capacity of the program is measured in total actions taken on generic drug applications. In FY 2014, the actual number of actions taken on applications was 1521, exceeding the FY 2014 target. FDA will be replacing this measure in FY 2015 with a new measure (223215) that better reflects the changes in methodology for counting the total actions required in the recent Generic Drug User Fee Act legislation.

IHS uses outside accrediting bodies, such as the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the Centers for Medicare & Medicaid Services, to develop national standards of quality of care and manages IHS-operated hospitals and ambulatory health centers to meet these standards. IHS has consistently maintained 100 percent accreditation of IHS-operated hospitals and outpatient clinics since 2007 that participate in accreditation visits. This is one of the most demanding measures to meet, given the growing clinical quality of care assessments that are required as well as issues related to health facilities maintenance and renovation that are critical to accreditation.

AHRQ developed the Hospital Survey on Patient Safety Culture so hospitals could determine how well they were doing in establishing a culture of safety in comparison to other similar hospitals. In FY 2014, 1,851 hospitals indicated in this survey that they use AHRQ-supported tools to improve patient safety, exceeding the target as the program has consistently for years. Interest in other AHRQ tools and resources has also remained strong, based on for example, on-going participation in webinars describing resources, electronic downloads, and orders placed for various products.

Plans for the Future

There have been significant investments in the expansion of the NHSN and HAI prevention by the CDC. CDC plans to increase the number of health care organizations reporting into the National Healthcare Safety Network to 19,000 facilities by FY 2016. That would be a more than four-fold increase from FY 2011 when only 5,000 hospitals were reporting. These investments should help facilitate the continued reduction of HAIs due to CLABSIs in FY 2014 and FY 2015 and, consequently, CDC's targets for FY 2014 and FY 2015 are 0.4 and 0.35, respectively.

HHS lowered its FY 2014 and 2015 targets to reflect significant challenges recently in CAUTI prevention. CMS projects a potential spike in the CAUTI SIR around January 2015 when hospitals begin reporting CAUTI data in non-ICUs as part of CMS' HIQR program. The need for continued widespread implementation of prevention strategies remains. Despite measurement-related factors that could be contributing to increasing SIRs, data from large prevention projects are showing that CAUTIs can be significantly decreased in US hospitals using the current interventions and metrics. For further information about plans to reduce CAUTI infection rates, please view this HHS Agency Priority Goal at performance.gov.

For HRSA's Patient-Centered Medical Home initiative, HRSA will continue to provide PCMH transformation technical assistance to health centers through national- and state-based webinars and practice coaching. Due to the success of this program, future targets show expectations of continued growth in the percentage of PCMHs.

CMS plans to continue its efforts to promote the reduction of pressure ulcers as an enhancement of the quality of healthcare throughout the nursing home community. The FY 2014, 2015, and 2016 target reflect an expectation of continued improvement in the incidence of ulcers.

CMS promotes a multidimensional approach to protecting residents from being prescribed antipsychotic medications unless there is a valid, clinical indication and a systematic process to evaluate each individual's need that includes; research, partnerships and state-based coalitions, revised surveyor guidance, training for providers and surveyors and public reporting. CMS's FY 2016 target for the percentage of long-stay nursing home residents that received an antipsychotic medication is 16.7 percent, which will reflect a reduction of 30 percent over the 2011 baseline.

CMS has goals to improve quality in both Medicaid and CHIP and has a phased in approach that allows states to take an iterative approach to quality improvement. CMS will continue to work closely with states to improve children's health care quality across Medicaid and CHIP, as required by the CHIP Reauthorization Act of 2009 (CHIPRA). In collaboration with states, CMS developed and published a Child Core Set of quality measures. CMS is encouraging all states to use and report on the Child Core Set to collect data that will lead to improved health outcomes and to enhance the accuracy and applicability of the pediatric quality measures program specific to the Medicaid and CHIP programs. In FY 2016 CMS will focus technical assistance efforts to ensure that 90 percent of states report on at least ten quality measures in the Child Core Set. In addition, as required by Affordable Care Act, HHS will encourage states to report on a core set of adult quality performance measures for Medicaid. Although state reporting is voluntary, CMS will use state reporting to assess the care received by adults in the Medicaid program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid. CMS will aim to have 70 percent of states report on at least nine adult quality measures by FY 2016.

FDA will retire its current abbreviated new drug applications measure (ID 223205) in FY 2015 due to a provision in the recent Generic Drug User Fee Act legislation, which changes the methodology for counting the total actions. The measure will be replaced with a new measure (223215) that better reflects the new methodology. FDA expects targets to continue to improve in the future.

IHS has committed to maintaining 100 percent accreditation of IHS-operated hospitals and outpatient clinics, using the standards and practices recommended by the Joint Commission, the Accreditation Association of Ambulatory Health-Care (AAAHC), or CMS. The Joint Commission, the AAAHC, and CMS continue to revise standards and have been increasing clinical quality of care assessments, which IHS plans to adapt to and continue to meet. The FY 2015 and 2016 targets are to maintain 100 percent accreditation at IHS-operated hospitals and outpatient clinics (excluding tribally operated facilities).

AHRQ continues to produce patient safety culture assessment tools for hospitals, medical offices, nursing homes, and pharmacies. One of these tools is a comparative database that healthcare providers can use as a benchmark for comparison on patient safety approaches. Information for this database report comes from the four patient safety culture survey tools: Hospital Survey on Patient Safety Culture (HSOPS), Medical Office Survey on Patient Safety Culture, Nursing Home Survey on Patient Safety Culture, and Pharmacy Survey on Patient Safety Culture. AHRQ is taking steps to update portfolio research topic areas and plans to continue to expand the number of research users through FY 2016.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- CDC's National Healthcare Safety Network (NHSN) is the nation's most widely used healthcare-associated infection (HAI) tracking system, with more than 13,000 healthcare facilities participating across all 50 states. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections. The use of NHSN allows facilities to monitor central line-associated bloodstream infections (CLABSI), surgical site infections (SSI), and Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia.

- The success of the efforts to reduce the prevalence of pressure ulcers in nursing homes can be attributed to greater collaboration between state survey agencies and Quality Improvement Organizations and the national Advancing Excellence in America's Nursing Homes campaign. In FY 2013, the actual reported prevalence of Stage 2 and greater pressure ulcers among high risk residents was 6.1 percent, better than the target of 6.9 percent.

- In FY 2013, 88 percent of states[14] reported on at least seven Children's Health Insurance Program Reauthorization Act (CHIPRA) quality measures, exceeding the target to work with states to ensure that 85 percent of states report on at least seven quality measures in the children's core set of measures. CMS has provided states with instructions for annual reporting to demonstrate how to submit data for this initiative and CMS will continue to evaluate options to improve state quality reporting as agency information systems are enhanced.

- In FY 2013, 59 percent of states[15] reported on at least three adult health care quality measures, falling just short of our target to have 60 percent of states reporting on at least three quality measures in the Adult Core Set. Although state reporting is voluntary, by encouraging states to report the core measures in a standardized manner, CMS is using technical support to create a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid.

- HRSA is implementing a Patient-Centered Medical Home (PCMH) initiative designed to improve the quality of care in health centers and support their efforts to achieve national PCMH recognition or accreditation. Data are collected on the percentage of health centers recognized as a patient centered medical home by national/state accrediting organizations. At the end of FY 2014, more than 55 percent of health centers had at least one site that was recognized as a PCMH.

- NIH-funded research is showing that tests for genes or other biological markers can help predict which treatments will work best for individuals. In one example, recent research has shown that genetics tests can be used to help identify which women with a high risk of developing breast cancer should take medicines to reduce their risk of developing cancer. On-going research will further assess and explore the promise of these findings.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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[14] "States" included in the denominator of this measure are the 50 States plus the District of Columbia. The FY 2013 result was 45/51 or 88%.

[15] "States" included in the denominator of this measure are the 50 States plus the District of Columbia. The FY 2013 result was 30/51 or 58.8 – rounded to 59%.

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

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

ACL, AHRQ, CDC, CMS, HRSA, IHS, OASH, ONC, and SAMHSA are committed to accelerating their emphasis on primary and preventive care, with a focus on community prevention services. HRSA programs deliver healthcare services to millions of Americans, especially vulnerable and underserved populations. CDC implements a number of programs promoting healthy behaviors, such as sustaining reducing obesity through physical activity and better nutrition.

The measures below demonstrate HHS's targets and results for primary and preventive care linked with community prevention services. Key features of the Affordable Care Act focus on preventive care. HHS and component managers use these and other related measures to focus attention on achieving positive preventive care results. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 1.C Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	64.2 %	68 %	68.3 %	71 %	72.5 %	73.2 %
Result	68.4 %	70.4 %[16]	69.7 %	Dec 30, 2015	Dec 30, 2016	Dec 30, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	61.3 %	64 %	64 %	65 %	66 %	67 %[17]
Result	70 %	70 %	72 %	Aug 31, 2015	Aug 31, 2016	Aug 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[16] Results prior to FY 2013 have been updated to reflect Healthy People data. Previous result estimates came from multiple annual reports released by CDC's National Center for Health Statistics

[17] The targets reflect performance expectations due to the significant expansion of the health center program over the indicated timeframe, and the potential impact on this measure of serving a significant increase in vulnerable populations.

Analysis of Results

The CDC is working on population-level approaches to address one of the America's most important problems - obesity. The prevalence of obesity among adults and children remains a public health concern. Obesity increases the risk of many health conditions, including heart disease, stroke, high blood pressure, and cancer. Reducing obesity prevalence, especially among population groups with the highest burden of disease, will improve health outcomes related to chronic diseases and conditions, lower morbidity rates, and reduce health care spending. The CDC exceeded its target in FY 2013 of increasing the proportion of adults that engage in at least some leisure-time physical activity.

Prenatal care is one of the most important interventions for ensuring the health of pregnant women and their newborn babies. Early high-quality prenatal care is critical to improving pregnancy outcomes. Monitoring timely entry into prenatal care assesses both quality of care as well as health center outreach efforts that are associated with improving birth outcomes. HRSA tracks the percentage of pregnant health center patients receiving prenatal care and in FY 2013, 72 percent of those patients began care in the first trimester, exceeding the target.

Plans for the Future

The CDC is working with communities, businesses, early child and education centers, and schools to increase the number of people 18 and older who are physically active. Creating more safe spaces to exercise in communities can improve individuals' overall health. CDC estimates 73.2 percent of adults will be participating in at least 150 minutes of physical activity a week by FY 2016 through its efforts to increase the availability of safe environments for physical activity.

HRSA projects that over the next few years the percentage of patients beginning prenatal care in the first trimester will progressively increase to 67 percent, given the changing mix of the pool of health centers. Health centers serve a higher risk prenatal population than the nation as a whole. HRSA will continue work to improve the percentage of pregnant health center patients that begin prenatal care in their first trimester.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- HRSA health centers continue to provide quality primary and related health care services, improving the health of the Nation's underserved communities and vulnerable populations. Results over the past few years demonstrate improved performance as the percentage of pregnant health center patients that began prenatal care in the first trimester grew from 57.8 percent in 2000 to 72 percent in 2013, exceeding the target of 64 percent.

- ACL's Chronic Disease Self-Management Education (CDSME) Programs provide older adults and adults with disabilities with education and tools to help them better manage chronic conditions. A process evaluation and retrospective outcome evaluation found positive results in terms of community based implementation and participant outcomes. Specifically, "Report to Congress: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act" (http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf) indicated that:

    - CDSME program participation was associated with an 8 percent increase in average adherence (proportion of days covered) to chronic obstructive pulmonary disease (COPD) combination regimens of long-acting anticholinergics (LAAC) and long-acting beta-agonists (LABA) over controls. This is important because, according to an article in the April 2011 issue of the journal Mayo Clinic Proceedings (available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3068890/), poor medication adherence is linked to increased hospital admissions resulting in $100 billion in costs annually.

- The Affordable Care Act added an important new preventive service in the Medicare program - an Annual Wellness Visit (AWV) with a health professional. In calendar year 2013, our most recent result, 4.1 million Medicare beneficiaries used this benefit.

- Hospitals are a primary source of data for public health agencies because they are often the first-line of support for patients seeking care and a key integrator of health data at the community level. As of December 2013, 87 percent of hospital attestations within the CMS Electronic Health Records Incentive Programs included the ability to report at least one public health measure.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

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

Objective 1.D Table of Related Performance Measures

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

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Target	N/A	N/A	Set Baseline	5,425,000.0 Medicare Beneficiaries	7,090,000.0 Medicare Beneficiaries	TBD[18]
Result	N/A	N/A	4,002,532.0 Medicare Beneficiaries[19]	Sep 30, 2015	Sep 30, 2016	Sep 30, 2017
Status			Baseline	Pending	Pending	Target Not In Place

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

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Target	N/A	N/A	Set Baseline	150,000.0 Physicians	178,000.0 Physicians	TBD[20]
Result	N/A	N/A	102,717.0 Physicians[21]	Sep 30, 2015	Sep 30, 2016	N/A
Status			Baseline	Pending	Pending	Target Not In Place

[18,20] TBD: Target set September 2015.

[19,21] CMS discovered an issue with what was reported for ACO measures 1.1 and 1.2 in December 2013 and April 2014. CMS reported projections, not actuals, for CY 2013 and CY 2014 and then estimated targets based on those projections for CY 2015 and CY 2016. The new reported numbers in the table are the actual results for CY 2013 (last quarter of FY 2014) for both the Pioneer and SSP initiatives. The new targets also reflect the new baselines.

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

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Target	N/A	N/A	Set Baseline	35%[22]	37%[23]	TBD[24]
Result	N/A	N/A	34%	Sep 30, 2015[25]	Sep 30, 2016	Sep 30, 2017
Status			Baseline	Pending	Pending	Target Not In Place

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	18.5% Percent[26]	18.3% Percent[27]	18.1% Percent[28]	17.9% Percent
Result	N/A	18.7% Percent[29]	18.6% Percent[30]	18.1% Percent	Mar 31, 2015	Mar 31, 2016
Status		Historical Actual	Target Not Met but Improved	Target Exceeded	Pending	Pending

Amount of savings by state AIDS Drug Assistance Programs (ADAPs) participation in cost savings strategies on medications. (Lead Agency - HRSA; Measure ID - 16.E)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	$551.3 million	$616.1 million	$989.8 million	Prior Result +0	Prior Result +0	Prior Result +0
Result	$616.1 million	$989.8 million	Apr 30, 2015	Apr 30, 2016	Apr 30, 2017	Apr 30, 2018
Status	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

Analysis of Results

As part of the delivery system reform process, we aim to increase the number of Medicare beneficiaries who have been aligned with ACOs, the number of physicians participating in ACOs, and the percentage of ACOs that share in savings (ACO measures 1.1-1.3). In 2013, more than 4 million beneficiaries were aligned to ACOs (3,394,587 Medicare SSP and 607,945 Pioneer), with the expectation of increasing alignment to more than 7 million beneficiaries during the 2015 performance year. Just over 100,000 physicians participated in an ACO in 2013 (83,877 Medicare SSP and 18,840 Pioneer). In the 2015 performance year, CMS expects physician participation to increase by almost 80 percent to 178,000 physicians. CMS also established a baseline for the percentage of ACOs that share in savings of 34 percent. Given this percentage will be limited in its second year ACO performance, and the fact that the

[22] CY 2014 result available September 2015

[23] CY 2015 result available September 2016

[24] TBD: Target set September 2015.

[25] The denominator for this measure was limited to the number of ACOs that share in savings after more than 1 year of participation. This change allows CMS to project modest growth in the targets year over year, given the rapid growth of the SSP program.

[26] Based on CY 2011 data.

[27] Based on CY 2012 data.

[28] Based on CY 2013 data.

[29] Based on CY 2010 data.

[30] Based on CY 2011 data.

Shared Savings Program expects ACO second year participation to nearly triple by the end of 2015 to 335 ACOs, we anticipate modest growth in the total number of ACOs that will share in savings at 35 percent in performance year 2014 and 37 percent in performance year 2015 respectively. The FY 2016 targets for ACO measures 1.1-1.3 are to be determined (TBD). We will determine new targets by September 30, 2015.

In order the reduce Medicare expenditures and improve patient quality, CMS tracks preventable Medicare inpatient hospital readmissions. A hospital readmission occurs when a patient who has recently been discharged from a hospital (within the last 30 days of the admission) is once again readmitted to a hospital. Discharge is a critical transition in a patient's care and incomplete handoffs at discharge can lead to costly adverse events and avoidable re-hospitalizations. In 2013 CMS established the Hospital Readmissions Reduction Program, which will reduce a portion of Medicare's payment to certain hospitals based on the hospital's excess Medicare readmissions for specific conditions. In addition, CMS leverages other efforts including Partnership for Patients to reduce preventable complications during a transition, as well as partnerships with the Community-Based Care Transitions Program and Quality Improvement Organizations. CMS exceeded the CY 2014 target for this goal, with readmission rates reduced to 18.1 percent.

HRSA supports state AIDS Drug Assistance Programs (ADAPs), through the Ryan White HIV/AIDS program, to provide assistance to low-income persons living with HIV/AIDS who have limited or no access to needed medications. State ADAPs use a variety of strategies to contain costs and achieved savings of more than $989.8 million in FY 2012 — an increase in drug cost savings of more than $373.7 million over the previous year.

Plans for the Future

Leveraging the innovative model of ACO is a key part of promoting healthcare cost savings through the Affordable Care Act. As part of the delivery system reform process, CMS will aim to increase the number of Medicare beneficiaries who have been aligned with ACOs and increase the number of physicians participating in ACOs. Given the percentage of ACOs sharing in savings is limited to second year ACO performance, and the fact that the Shared Savings Program expects ACO participation to nearly triple by the end of 2015 to 335 ACOs, CMS also expects the percentage of ACOs that share in saving will increase modestly in the coming years.

CMS uses a number of programs to reduce hospital readmissions, as described above. CMS's efforts to reduce readmissions also extend to ACOs, which must report on 33 quality measures if they wish to receive incentives under the Medicare FFS Shared Savings Program. CMS expects to meet or exceed the CY 2015 target for this goal. Data used to assess future targets will include admissions data that reflects hospitals' experiences under and resulting from CMS's efforts aimed at reducing hospital readmissions. The CY 2015 target is set at 18.1 percent, one percent under the CY 2014 target rate and for CY 2016 the target is set at 17.9 percent, once percent under the CY2015 target. The readmission rate will be updated annually. CMS will continue to improve hospital performance and reduce readmissions with the long-term aim to reduce the growth of health care costs, while promoting high-value, effective care.

State ADAPs will continue to use a variety of strategies to contain medication costs, potentially enabling ADAPs to serve more people. Moving forward, HRSA plans to use the previous year's result as the subsequent year's target.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- CMS' efforts to reduce readmissions also extend to Accountable Care Organizations (ACOs). ACOs must report on and meet targets for 33 quality measures in order to receive shared savings under the Medicare Fee-for-Service Shared Savings Program. Unlike most measures that only have a reporting requirement in year one, CMS targets reduction of all-cause Medicare hospital readmissions by one percent per year, beginning with a baseline of 18.7 percent on CY 2010 data set in FY 2012. Based on CY 2011 fee-for-service inpatient claims data, the Medicare all-cause hospital readmission rate is estimated to be 18.6 percent, which falls slightly above the 2013 target of 18.5 percent. The 2014 target was set at 18.3 percent. Despite not successfully achieving the 2013 target, CMS met the 2014 target for this goal, resulting in 18.1 percent reduction.

- In the Ryan White HIV/AIDS Program, state AIDS Drug Assistance Programs (ADAP) use a variety of strategies to maximize resources, which results in a more effective use of funding and enables ADAPs to serve more people. In 2012, state ADAPs participating in cost-savings strategies on medications saved $989.8 million, exceeding the FY 2012 target by $373.7 million. Since FY 2008, state ADAPs have saved over $3 billion on medications.

- The Community Preventive Services Task Force compiles systematic reviews of the evidence in The Community Guide (www.thecommunityguide.org). The Community Guide provides evidence-based recommendations and findings about community preventive services, programs, and policies to improve health. The Duval County Health Department in Jacksonville, Florida implemented Task Force Community Guide recommendations to improve appropriate vaccination and within one year saw the percentage of 2-year-olds with complete immunization records rise from 75 percent to the national target of 90 percent.

- Adoption of E-prescribing technologies has been an HHS priority because available evidence suggests positive impacts on reducing the growth of health care costs. HHS programs, such as the CMS Electronic Prescribing Incentive Program, the CMS Electronic Health Record (EHR) Incentive Programs, and the ONC state Health Information Exchange Program have brought focused attention to the issue and enabled federal leverage. Since December 2009, the rate of e-prescribing via an EHR among physicians increased from 16 to 65 percent. Since December 2009, the percent of community pharmacies actively e-prescribing increased from 80 to 96 percent.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

With the growing diversity of the U.S. population, healthcare providers are increasingly called on to address their patients' differing social and cultural experiences and language needs. Provision of culturally competent care can increase quality and effectiveness, increase patient satisfaction, improve patient compliance, and reduce racial and ethnic health disparities. A number of HHS programs help make health care more accessible to people whose circumstances call for special attention, including older adults, children, people with disabilities, uninsured populations, persons with limited English proficiency, low income individuals, and those who live in remote areas. The 2013 National Healthcare Disparities Report issued by AHRQ finds that many racial and ethnic minorities have more limited access to care and receive lower quality care.

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

ACF, ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, OASH, OCR, and SAMHSA have significant roles to play in realizing this objective. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 1.E Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	30.2 %	32.7 %	Set Baseline	48.3 %	47.7 %	49.5 %
Result	31.9 %	33.2 %	48.3 %[31]	48.6 %	Sep 30, 2015	Sep 30, 2016
Status	Target Exceeded	Target Exceeded	Baseline	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	51.9 %	56.5 %	58.6 %	66.9 %	64.3 %	67.2 %
Result	56.5 %	61.9 %	65.1 %	66 %	Sep 30, 2015	Sep 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met but Improved	Pending	Pending

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

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	3 recommendations	3 recommendations	3 recommendations	3 recommendations	3 recommendations	3 recommendations
Result	7 recommendations	4 recommendations	4 recommendations	9 recommendations	Sep 30, 2015	Sep 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	61 weighted average	62 weighted average	63 weighted average	62 weighted average	62.5 weighted average	63 weighted average
Result	62.8 weighted average	63 weighted average	64.2 weighted average	Dec 31, 2015	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	1,535[32]	1,535	5,734[33]	3,891[34]	3,000[35]	2,580[36]
Result	4,283[37]	6,593	6,437	Aug 31, 2015	Aug 31, 2016	Aug 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	66.1 %	63.1 %	64.2 %[38]	64.2 %	62.7 %	62.7 %
Result	63.1 %[39]	64.2 %	62.7 %	62.5 %	Dec 31, 2015	Dec 31, 2016
Status	Target Not Met	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

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

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

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

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

[36] Target has been reduced to reflect a decrease in number of grants in 2015 resulting in fewer participants.

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

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

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

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	19.7 million	20.6 million	22.2 million	28.6 million	27.5 million	28.6 million
Result	20.2 million	21.1 million	21.7 million	Aug 31, 2015	Aug 31, 2016	Aug 31, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	385,000 people	390,000 people	395,000 people	400,000 people	405,000 people	410,000 people
Result	615,849 people	747,952 people	703,070 people	Oct 31, 2015	Oct 31, 2016	Oct 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	9,203 persons	9,193 persons	7,128 persons[40]	7,520 persons	8,495 persons	15,159 persons
Result	10,279 persons	9,908 persons	8,899 persons	9,242 persons	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	2.48 Million	2.66 Million	2.85 Million	3.18 Million	3.26 Million	3.34 Million
Result	2.67 Million	2.88 Million	3.05 Million	3.25 Million	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	1,324,000	1,296,300	1,340,300	1,196,600	1,155,500	1,195,000
Result	1,333,149	1,247,525	1,164, 170	Oct 31, 2015	Oct 31, 2016	Oct 31, 2017
Status	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending	Pending

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

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	43 %	43 %[41]	43 %	33 %[42]	34 %[43]	34 %[44]
Result	33 %[45]	43 %[46]	43 %[47]	Dec 31, 2015	Dec 31, 2016	Dec 26, 2017
Status	Target Not Met	Target Met	Target Met	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	Within 3 percentage points of CDC.[48]	Within 3 percentage points of CDC data
Result	72.2% (CDC= 66.7%)	72.6% (CDC= 67.1%)	Oct 30, 2015	Oct 31, 2016	Oct 31, 2017	Oct 31, 2017
Status	Target Exceeded	In Progress	In Progress	In Progress	In Progress	In Progress

Analysis of Results

IHS, which incorporates tribal consultation to improve services for American Indians and Alaska Natives, has focused on some key health related issues for vulnerable tribal members. These include increasing the number of adults screened for depression when visiting IHS facilities and helping diabetic patients maintain good glycemic control. As a result of a more focused educational campaign conveying the benefits of early identification of depression, depression screening within IHS-operated facilities increased to 66 percent in FY 2014, missing its target by 0.9 percent but improving on the previous

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

[42] The change in target is the result of improved methodology, elimination of duplicate counting and a more accurate estimate of individuals who are serving in underserved areas. HRSA is only using counts from programs that are able to accurately track individuals that are being provided direct financial support from the HRSA program.

[43] The change in target is the result of improved methodology, elimination of duplicate counting and a more accurate estimate of individuals who are serving in underserved areas. HRSA is only using counts from programs that are able to accurately track individuals that are being provided direct financial support from the HRSA program.

[44] The change in target is the result of improved methodology, elimination of duplicate counting and a more accurate estimate of individuals who are serving in underserved areas. HRSA is only using counts from programs that are able to accurately track individuals that are being provided direct financial support from the HRSA program.

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

[46] Service location data are collected on students who have been out of the HRSA program for 1 year. The results are from programs that have ability to produce clinicians with one–year post program graduation. Results are from Academic Year 2012–2013.

[47] Service location data are collected on students who have been out of the HRSA program for 1 year. The results are from programs that have ability to produce clinicians with one–year post program graduation. Results are from Academic Year 2013–2014 based on graduates from Academic Year 2012–2013.

[48] This is a new target "Within 3 percentage points of CDC data" and it will be reported using national HIV/AIDS prevalence data provided to HRSA by CDC rather than previous target through FY 2014 of "5 percentage points above CDC data" as reported by national AIDS prevalence data reported in CDC's HIV Surveillance Report. HAB will report on this measure using the "5 percentage points above CDC data" as reported by national AIDS prevalence data from CDC's HIV Surveillance Report through FY 2014. The FY 2014 data from HAB's RSR will be available in October 2015 and the CDC comparison data from the HIV Surveillance Report may be available around July 2016.

year's result. During 2012-2013 and 2013-2014, the denominator increased 1.5 percent each year for a cumulative total of 16,490 new patients. The large increase in the denominator is one contributing factor to missing the FY 2014 target. Other contributing factors are a combination of staff turnover, recruitment of new staff unfamiliar with depression screening processes, and decreases in depression screening numbers among certain IHS Service Areas.

Good glycemic control among diabetic patients can help prevent associated health problems caused by diabetes. Glycemic control requires frequent medical visits, medications, and laboratory testing for blood sugar control. In FY 2013, IHS implemented new clinical standards of care, changing the glycemic control measure threshold. The FY 2014 result is 48.6 percent, exceeding the baseline target set in FY 2013. To strengthen the federal/tribal partnership, IHS engages American Indian and Alaska Native Tribes in open, continuous, and meaningful consultation. Out of this process in FY 2014, IHS implemented nine recommendations, exceeding the target. These included budgeting and contracting improvements and enhanced communication and deliberation opportunities. The substantial increases above the annual target in both FY 2011 and FY 2014 reflect the improvements made as a result of technology in communications with Tribes and the Agency's responsiveness to the implementation of the Affordable Care Act, the Indian Health Care Improvement Act reauthorization, and to congressional oversight.

Community based services and assistance to caregivers are crucial to enabling frail elderly clients to delay or defer nursing home placement. According to *Genworth 2014 Cost of Care Survey* the average cost in the US for a semi-private room in a nursing home is $77,380 per year. For many people, that level of annual expenditure for care cannot be obtained without spending down savings and liquidating other assets. Seeking alternatives to this level of costly care, while providing quality care in familiar surroundings for elderly individuals, is something that many senior citizens and family members prefer. ACL uses a "nursing home predictor" index which measures the prevalence of characteristics that frequently lead to nursing home placement. In FY 2013, the results showed continuous improvement with a resulting score of 64.2. Performance for FY 2013 shows a nearly 38 percent improvement over the FY 2003 baseline. As the score on the index increases it indicates an increase in the proportion of the high risk elderly population served through ACL funded services in the community. Since FY 2003, the index has increased substantially, demonstrating that in tight economic times ACL is succeeding in targeting community services and diverting individuals from more costly care.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA's Children's Mental Health Services program seeks to increase the percentage of children receiving systems of care mental health services who report positive functioning at 6 month follow-up. A "system of care" is a strategic approach to the delivery of services and supports that incorporates family-driven, youth-guided, strength-based, and culturally and linguistically competent care. This occurs through collaboration across agencies, families, and youth, while positive functioning relates to the general ability of the child to perform routine life activities. In FY 2014, the percentage of children reporting positive functioning declined slightly to 62.5 percent, missing the target due to reduced resources, attrition rates, and difficulties acquiring enrollees. Children's mental health experts consider a target performance level of approximately 60 percent to be appropriate, given the serious mental health issues of children served by this program.

Increased awareness of the consequences of substance abuse and risky sexual behaviors reduces the likelihood that those at highest risk and who are hardest to treat will engage in behaviors that place them at risk of HIV/AIDS transmission. The goal of the Minority AIDS Initiative (MAI) is to prevent and reduce the onset of substance abuse and transmission of HIV among at-risk minority populations by

delivering evidence-based substance abuse and HIV prevention interventions, including testing. SAMHSA monitors the numbers of individuals receiving education in the areas of substance abuse prevention and health promotion, thus enhancing protective factors against substance abuse, and transmission of HIV and other sexually transmitted diseases. In FY 2013, 6,437 program participants received substance abuse prevention education services, exceeding the target. This result reflects a slight decline from the previous year due to the transition of cohorts within the program.

HRSA plays a vital role in ensuring access to quality, culturally competent care for vulnerable populations through its mission to improve health and achieve health equity through access to quality services. Health centers are community-based, patient-directed organizations that serve populations lacking access to high quality, comprehensive, cost-effective primary health care. Health centers served 21.7 million patients in FY 2013. This is 0.6 million more than the patients served in FY 2012 and represents a greater than 75 percent increase within a ten year period. Through the Office of Rural Health Policy, HRSA improves access to care in rural communities by utilizing Outreach grants that focus on community coalitions and partnerships. In FY 2013, 703,070 persons received direct services supported by these grant programs, exceeding the target substantially.

The Nation's healthcare workforce is facing a number of significant challenges that are increasing demand, including changing population demographics, demand for health care services arising from increased health insurance coverage, and the imminent retirement of many Baby Boomer health professionals. HRSA's Bureau of Health Workforce programs are designed to improve the health of the Nation's communities, especially vulnerable populations, by supporting programs to augment the supply of health care providers who enter practice in underserved areas and increase access to quality health care. The overall percentage of graduates and completers who were directly supported by a Title VII or Title VIII program and went on to practice in a medically underserved community or health professional shortage area was 43 percent in FY 2013, meeting the target. Future targets are lower due to a change in estimation methodology.

The National Health Service Corps addresses the nationwide shortage of health care providers in areas of need by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. In FY 2014, the Corps field strength was 9,242, exceeding the target. Field strength is generally dependent upon variables such as the number of qualified applicants and the mix of scholarship and loan repayment support provided, among others.

HRSA manages the C.W. Bill Young Cell Transplantation Program to increase the number of unrelated blood stem cell transplants facilitated for patients in need. In FY 2014, 3.25 million persons on the donor registry self-identified as belonging to racial/ethnic minority populations, compared to 3.18 million in FY 2013.

More than 1.1 million people in the United States are living with HIV infection, and almost 1 in 6 (15.8 percent) are unaware of their infection. The CDC and HRSA are both striving to improve prevention and treatment results. Though new HIV infections among racial/ethnic minorities overall have been roughly stable, compared with non-racial/ethnic minorities, they continue to account for a higher proportion of cases at all stages of HIV – from new infections to death. The proportion of the Ryan White program's service population that comprises racial/ethnic minorities is an indicator of access to treatment for populations disproportionately impacted by HIV/AIDS. In FY 2012, 72.6 percent of Ryan White program clients were racial/ethnic minorities. This compares to 67.1 percent of CDC-reported AIDS cases among racial/ethnic minorities, exceeding the target.

Another example of HHS's support for providing care to a vulnerable population is evident through the provision of family planning and related preventive health services in Title X family planning clinics. Through these clinics, this Title X program implemented by OASH screens young women for Chlamydia as part of the full range of family planning and related preventative health services provided by Title X clinics. An untreated Chlamydia infection can lead to pelvic inflammatory disease and potential infertility. The number of screenings was 1,164,170 in FY 2013.

Plans for the Future

IHS will also meet depression screening goals through promoting increased accountability for achieving targets at the regional and local levels for IHS operated programs, and a more focused educational campaign will be undertaken for Tribally-operated programs to convey the benefits of depression screening. The screening tools and results are incorporated into the IHS Electronic Health Record. The system is now deployed and in operation in more than 250 clinical sites across the country. IHS will strive to maintain the FY 2014 baseline of patients with good glycemic control in FY 2015 and 2016; however targets have been reduced in 2015 to reflect current challenges. Another ongoing goal is to maintain an open, continuous, and meaningful Tribal consultation between American Indian and Alaska Native Tribes and IHS by implementing at least three process improvement recommendations per year.

ACL believes the composite measure of nursing home predictors, which gauges the prevalence of select characteristics of the service population, predictive of nursing home placement, will remain relatively stable or moderately improve over the next few years as the Aging Services Network has achieved very high levels of the targeted characteristics. Over 80 percent of home-delivered nutrition services participants have three or more limitations in Instruments Activities of Daily Living (IADLS) such as shopping for groceries and preparing meals. Nearly 80 percent of caregivers report that the supportive services received have helped them provide care longer than would be possible without these services. ACL will continue to provide high quality technical assistance, work with program resource centers to support the Aging Network and has proposed initiatives and increased resources in the President's FY2016 budget to continue effective service delivery for caregivers and home and community-based services that are instrumental in the delay or deferral of nursing home placement of the elderly and persons with a disability.

SAMHSA will continue to support systems of care that supports children and youth (including their families) with SMI through collaboration across agencies and providers. A systems of care approach also promotes access and expands the array of coordinated community-based, culturally and linguistically competent services. Additional technical assistance is provided to promote improvements. Through a new implementation grant, new grantees are using a new automated system for reporting. Performance is expected to improve during FY 2015.

The MAI grantees employ a number of Evidence-Based Interventions (EBI) to address the complex substance abuse and risky behavioral issues associated with HIV/AIDS transmission. These interventions are of varied duration and intensity lasting from one day to multiple days. The target for 2014 was reduced because a cohort ended during 2013. This mature group of 55 grantees will no longer be serving participants. While a newer cohort of 29 grantees has been funded, they are in an early stage of the grant and are not initially serving as many participants. This is expected when cohorts end and others begin. Consequently, targets are reduced for FY 2014 - 2016.

HRSA expects the number of patients served by health centers will increase in the coming years. This is because success in increasing the number of patients served has been due in large part to the

development of new health centers, new satellite sites, and expanded capacity at existing clinics. The target for the number of people receiving direct services through Office of Rural Health Policy Outreach Grants are less than current performance given changes in the cohort of grantees. To maintain the quality of services provided, HRSA works with Outreach grantees to ensure they maintain the minimum required number of consortium members. The field strength of the NHSC fluctuates as it is dependent upon variables such as the level of available funding, the number of qualified applicants, and the mix of scholarship and loan repayment support provided. However, the NHSC field strength is expected to reach a historic high of more than 15,000 in FY 2016. Estimates of the percentage of individuals trained by Bureau of Health Workforce Programs working in underserved areas will remain static for the forthcoming years until new data become available that can help in refining targets to better reflect program performance in this area. The C.W. Bill Young Cell Transplantation Program will have an increasing number of racial/ethnic minorities on the donor registry. The Ryan White HIV/AIDS Program will continue its efforts to ensure that the proportion of racial and ethnic minorities served by Ryan White-funded programs exceeds their representation in national AIDS prevalence data.

The number of young women screened for Chlamydia is projected to decline over the coming years, primarily due to policy changes and funding assumptions occurring in some states resulting in shifting funds away from some major providers of family planning services.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- Early identification of depression allows providers to plan interventions and treatment to improve the mental health and well-being of American Indian and Alaska Native people who experience depression. Screening tools and results are incorporated into the IHS Electronic Health Record. The system is now deployed and in operation in over 250 clinical sites across the country. Depression screening for early detection, diagnosis, and treatment increased from 65.1 percent in FY 2013 to 66.0 percent in FY 2014.

- The ACF Office of Refugee Resettlement (ORR) oversees the Preventive Health program, which funds states to coordinate and promote refugee access to health screening, assessment, training, and medical follow-up services, recognizing that a refugee's medical condition may affect public health as well as prevent a refugee from achieving economic self-sufficiency. In FY 2013, a total of 77,445 health screenings were completed by the ORR Preventive Health program. In addition, the ORR Refugee Social Services program tracks the percentage of refugees entering full-time employment who receive health benefits. In FY 2013 (the most recent results available), nearly 61 percent of refugees entering full-time employment received health benefits.

- Tooth decay is one of the most common and preventable chronic diseases of children aged 6 to 11 years and adolescents aged 12 to 19. Approximately one-fourth of health expenses for children in the U.S. are dental related. CDC works with funded states to implement two evidence-based strategies that have been shown to prevent tooth decay- community water fluoridation and dental sealants. From 2008 to 2010, nine million additional people had access to fluoridated water, saving an estimated $250 million and from 2010 to 2012 an additional 6 million people had access. Evidence shows that school-based dental sealant programs increase

the number of children who receive sealants at school, and that dental sealants result in a large reduction (80 percent after 2 years) in tooth decay among school-aged children (5 to 16 years of age). From 2003 to 2008, there was a 60 percent increase in the delivery of school-based sealants in states with CDC funding, which saved an estimated $1 million in Medicaid dental expenditures.

- CMS has launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents aimed at reducing avoidable hospitalizations, improving health outcomes, and reducing Medicare and Medicaid expenditures. Through this initiative, CMS has selected seven organizations who, starting in 2013, have implemented evidence-based interventions in over 140 nursing facilities and serving approximately 16,000 beneficiaries each day.

- HRSA researchers assessed racial/ethnic disparities in clinical quality among US health centers, and whether quality measures vary across certain types of health centers. Outcomes of interest included: poor hypertension control among adult patients, poor diabetes control among adult patients, and low birth weight among newborns. Compared with national rates, health centers report minimal racial/ethnic disparities in clinical outcomes. More favorable outcomes are associated with larger patient volume, longer duration of funding, and at least some patients enrolled in managed care.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

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

Objective 1.F Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	80,000 eligible professionals and hospitals	230,000 eligible professionals and hospitals	375,000 eligible professionals and hospitals	450,000 eligible professionals and hospitals	455,000 eligible professionals and hospitals
Result	10,700 eligible professionals and hospitals	156,758 eligible professionals and hospitals	325,124 eligible professionals and hospitals	414,914 eligible professionals and hospitals	Dec 31, 2015	Dec 31, 2016
Status	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	35% of office-based primary care physicians	45% of office-based primary care physicians	55% of office-based primary care physicians	65% of office-based primary care physicians	TBD	TBD
Result	39% of office-based primary care physicians	49% of office-based primary care physicians	53% of office-based primary care physicians	Mar 31, 2015	TBD	TBD
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Pending		

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	Set Baseline	33 %	54 %	54 %	65 %
Result	9 %	18 %	46 %	Mar 31, 2015	Mar 31, 2016	Mar 31, 2017
Status	Historical Actual	Baseline	Target Exceeded	Pending	Pending	Pending

Analysis of Results

To promote the use of health IT, the Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals as they adopt, implement, upgrade, or demonstrate "meaningful use" of certified EHR technology. Because the EHR Incentive Program is seen as key to HHS's goal to strengthen healthcare, it has been chosen as one of HHS's five Priority Goals. This increased focus has led to the pursuit of coordinated strategies that have resulted in a dramatic increase in the number of eligible providers who received EHR incentive payments. ONC exceeded its target in FY 2014 of 375,000 providers who receive an incentive payment for successful adoption or meaningful use of certified EHRs. The Recovery Act helped to set the groundwork for the expansion of electronic health care records and HHS used a variety of strategies to increase the number of providers using electronic health care systems by funding Health IT Regional Extension Centers, by working with state Health Information Exchanges and with Beacon Communities. Since 2011 the number of providers who received an incentive payment from CMS for meaningful use of electronic healthcare records increased 40 fold to 414,914 providers.

The wide scale adoption of appropriate HIT will enable providers to communicate with fewer errors to pharmacies, better coordinate care across settings, alert physicians and caregivers of preventive care options that would benefit the patient, and reduce duplicative testing results—among many other potential benefits. HHS measures the percentage of office-based primary care physicians who have adopted electronic health records. A basic EHR system would be expected to include: patient demographics, patient problem lists, medications, clinical notes, prescriptions, ability to view laboratory results, and the ability to view imaging results. By FY 2013, 53 percent of office-based primary care physicians had systems that met the basic EHR standard, falling short of the target.

CDC tracks the contribution of the informatics program and CDC program partners through the Electronic Health Records Meaningful Use (EHR-MU) initiative. CDC works to assess and ensure readiness of three key systems in each state: Electronic Laboratory Reporting, Immunization Information Systems, and Syndromic Surveillance. Public health agencies will assess their capability to receive data in a Meaningful Use-compliant format (i.e., Health Level 7 (HL7) 2.5.1 standard) from eligible hospitals and providers, meaning those with certified EHRs participating in the Centers for Medicare and Medicaid Services' Meaningful Use program. In FY 2014, Meaningful Use stage two required eligible providers to use only the latest format (HL7 version 2.5.1). However, if the public health agency approves, providers currently using the older format (HL7 2.3.1) could be grandfathered in. In FY 2013, CDC demonstrated significant capability gains for Electronic Laboratory Reporting as healthcare and public health agencies strove to meet Meaningful Use stage one and two requirements. Electronic Laboratory Reporting capability more than doubled from the 2012 baseline, exceeding the FY 2013 target by 39 percent.

Plans for the Future

ONC, CMS, CDC, AHRQ and their partners will to promote the meaningful use of technology and the development of health IT standards designed to improve quality and lower health care costs. More specifically, ONC and its partners will continue to analyze EHR Incentive Program registration, attestation, and payment data to evaluate the characteristics of providers at each of the different program milestones. Analysis of the program data will enable states and Health Information Technology for Economic and Clinical Health (HITECH) Act grantees to establish goals and accelerate progress to meaningful use of electronic health records and health IT. Monthly analyses of program participation and related policy-relevant data are available in the following internet locations: CMS EHR Incentive Program data and reports - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html; Health IT Policy Committee Meeting Archive - http://www.healthit.gov/facas/FACAS/health-it-policy-committee.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- The Electronic Health Record (EHR) Incentive Programs gained significant momentum in 2014, and as of September 2014, eligible providers received an incentive for adopting, implementing, or upgrading their certified electronic health record technology (CEHRT) or for successfully demonstrating Stage 1 of meaningful use. Also, 4,674 eligible hospitals and critical access hospitals have received an incentive for adopting, implementing, or upgrading their CEHRT or for successfully demonstrating Stage I of Meaningful Use, totaling 414,914 providers. The progress has exceeded the HHS priority goal for FY 2014 that 375,000 providers would receive a payment from either the Medicare or Medicaid programs.

- In 2013, 46 percent of public health agencies received production electronic laboratory reporting (ELR) Meaningful Use compliant messages from certified EHR technology used by eligible hospitals, exceeding the target by 13 percent. An additional 21 public health agencies tested ELR messages from eligible hospitals; therefore, CDC expects significant capability gains in the percentage of public health agencies that receive production messages, as healthcare and public health agencies strive to meet Meaningful Use stage one and two requirements.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

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

Many HHS components, including AHRQ, ASPE, ASPR, CDC, NIH, and OASH support the Department's efforts toward scientific discovery. Below is a sample of performance measures that HHS will use to guide activities and achieve improved results for patient care. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 2.A Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N ≥ 12%	N ≥ 12%	N ≥ 10%	N ≥ 10%	N ≥10%	N ≥ 10%
Result	Award rate to comparison group reached 12%.	Award rate to comparison group reached 11%.	Award rate to comparison group reached 11%.	Award rate to comparison group reached 10%	Dec 31, 2015	Dec 31, 2016
Status	Target Met	Target Not Met	Target Met	Target Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N ≥ 12%	N ≥ 12%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%
Result	Award rate to comparison group reached 13% and exceeded the target by 1%.	Award rate to comparison group reached 13% and exceeded the target by 1%.	Award rate to comparison group reached 13% and exceeded the target by 3%.	Award rate to comparison group reached 14% and exceeded the target by 4%.	Dec 31, 2015	Dec 31, 2016
Status	Target Met	Target Met	Target Met	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Increase depositions of bioassays in PubChem to a rate of five (5) per month.	Deposit chemical structure and biological data for 200 new small molecule probes in PubChem.	Establish 400 primary biochemical, cell-based or protein-protein interaction assays that can be miniaturized and automated as high throughput screens in the Molecular Libraries Program (MLP) Portfolio.	Increase the Molecular Libraries Program (MLP) inventory to 375 small molecule probes that can be used in biological research to interrogate basic biological processes or disease.	Make freely available to researchers the results of 400 high-throughput biological assays screened against a library of 300,000 unique compounds, and the detailed information on the molecular probes that are developed through that screening process.	Discontinued
Result	NIH increased the assay deposition into PubMed to a rate greater than eight HTS assays per month, resulting in a total deposit of 103 assays.	The Molecular Libraries Program deposited chemical structure and biological data for 294 new small molecule probes in PubChem since the program began.	Established 570 primary biochemical, cell-based or protein-protein interaction assays that were miniaturized and automated as high throughput screens in the Molecular Libraries Program (MLP) Portfolio.	Increased the Molecular Libraries Program (MLP) inventory to 375 small molecule probes that can be used in biological research to interrogate basic biological processes or disease.	Dec 31, 2015	N/A
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Complete phenotypic characterization of a patient cohort.	Complete genetic, biochemical, or cellular studies aimed at identifying a molecular pathway underlying the disease in the patient cohort.	Identify at least one molecular pathway suitable for targeting in the patient cohort by performing detailed genetic mapping and confirmatory analyses for markers and pathways identified through genome-wide association.	Design a clinical trial testing an agent for a disorder of the immune system in children (e.g., Still's disease).	Complete a clinical pilot study in a cohort of pediatric patients with a disorder of the immune system.	Identify at least one molecular pathway based on genetic analysis suitable for therapeutic targeting in a pediatric cohort of patients with an immune-mediated disease.
Result	NIH researchers completed recruitment of a cohort of well-characterized patients with systemic-onset juvenile idiopathic arthritis through an international consortium of investigators.	A genome-wide association study has been performed on the cohort of 982 systemic-onset juvenile idiopathic arthritis patients and over 7000 healthy controls for 1.4 million genetic markers.	Researchers have identified a genetic variant that confers an increased risk of developing systemic juvenile idiopathic arthritis (sJIA) and that indicates the CD4+ T cell activation pathway as a therapeutic target.	Researchers have designed a compassionate use study to evaluate a novel class of drugs Janus Kinase (JAK) inhibitors in pediatric patients with the immune disorder, Chronic Atypical Neutrophilic Dermatosis with lipodystrophy and elevated temperature (CANDLE).	Dec 31, 2015	Dec 31, 2016
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Characterize cellular and molecular inflammation in the distal lung that may contribute to severe disease with frequent exacerbations.	Investigate the role of mucus gel formation in healthy controls and asthma patients.	Conduct investigations to elucidate the dynamic, pathophysiologic phenotypes of severe asthma.	Investigate the disease processes involved in asthma exacerbations and/or severe asthma using state-of-the-art pulmonary imaging techniques.	Identify and characterize two molecular pathways of potential clinical significance that may serve as the basis for discovering new medications for preventing and treating asthma exacerbations.	Discontinued
Result	Scientists characterized the molecular pathways in fibroblasts (the principal active cells of connective tissue) from two regions of the lung. Their findings suggest that fibroblasts from the distal lung may be the more important fibroblast cell type in processes that contribute to disease progression and severity in asthma.	Researchers investigated two proteins associated with mucus formation, CLCA1 and TMEM16A that may serve as potential targets for treating asthma.	The Severe Asthma Research Program is conducting investigations.	The Severe Asthma Research Program (SARP) is using state of the art imaging techniques to help define disease phenotypes and endotypes, which will enable the development of tailored interventions for the appropriate patient populations.	Dec 31, 2015	N/A
Status	Target Met	Target Met	Target Met	Target Met	Pending	

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Identify an additional 3,000 compounds to the library for testing, complete compound analytical analysis, and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 50 qHTS and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 25 qHTS and test 180 compounds in densely sequenced human lymphoblastoid cell lines to assess genetic diversity in response to toxicants.	Test 10,000 compound main library in an additional 15 qHTS and test 20 subsets of possible high risk chemicals in high-content screens.	A formal process of prioritizing compounds for more extensive toxicological testing will be evaluated and used	Discontinued
Result	The 10K library was completed. Performance on mid- throughput assays surpassed the target. Analytical or chemical analysis is in progress but not yet completed.	The library containing 10,000 compounds was screened in 65 quantitative high throughput screens (qHTS) or assays. Fifty compounds were screened in approximately 600 mid-throughput assays.	The 10,000 compound library was screened in 33 qHTS assays and data was analyzed on 179 compounds screened for cytotoxicity across 1086 human lymphoblastoid cell lines representing 9 racial groups to assess genetic diversity in response to toxicants.	The 10,000 compound library was screened in 42 qHTS assays and 22 subsets of possible high risk chemicals were screened in high content screens using cells (e.g., cardiomyocytes, neuronal cells) and alternative organisms (zebrafish, *Caenorhabditis elegans*)	Dec 31, 2015	N/A
Status	Target Not Met	Target Met	Target Met	Target Met	Pending	

By 2018, (a) identify genetic factors that enhance or reduce the risk of development and progression of chronic obstructive pulmonary disease (COPD) and (b) validate new genetic and clinical criteria that may be added to COPD classification and contribute to better and/or earlier diagnosis or prognosis of the disease. (Lead Agency - NIH; Measure ID - SRO-5.2)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	N/A	Complete Genome-wide Association analysis of the original 10,000 subjects to discover 3 statistically significant genetic risk factors for COPD.	Using analysis of genetic and clinical data from the original 10,000 subjects, identify 1-3 COPD sub-classes that can then be tested for prognostic potential.	Analyze longitudinal for the first 1000 five year follow-up visits to identify 1-3 predictors of lung function decline.
Result	N/A	N/A	N/A	A meta-analysis was published in FY 2014 using COPDGene as well as other studies to identify three known loci and three new loci marking genetic risk factors.	Dec 31, 2015	Dec 31, 2016
Status				Target Met	Pending	Pending

By 2018, complete pre-commercial development of a point-of-care technology targeted for use in primary care setting. (Lead Agency - NIH; Measure ID - SRO-5.5)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	N/A	Identify 6 enabling technologies with potential clinical use in primary care setting.	Establish feasibility of use of 3 to 4 identified technologies through preliminary testing.	Complete pilot clinical studies on 1 to 2 prototype devices.
Result	N/A	N/A	N/A	Six technologies were identified that have potential for clinically focused solutions to improve primary care.	Dec 31, 2015	Dec 31, 2016
Status				Target Met	Pending	Pending

By 2017, identify circuits within the brain that mediate reward for 1) drugs, 2) non-drug rewards such as food or palatable substances, and 3) aversion to drug effects, and 4) determine the degree of overlap between these circuits. (Lead Agency - NIH; Measure ID - SRO-8.2)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	N/A	Identify drug-activated reward circuits	Identify non-drug activated reward circuits and compare with drug-activated reward circuits	Support research to compare and contrast rewarding versus aversive pathways in response to substances of abuse
Result	N/A	N/A	N/A	Classical and pharmacological dissection of the central drug reward system was confirmed, extended to demonstrate projections which had two or more transmitters with functional significance for drug reward, and identified the rostromedial tegmentem as a GABAergic nucleus which could functionally inhibit the dopaminergic pathway.	Dec 31, 2015	Dec 31, 2016
Status				Target Met	Pending	Pending

Analysis of Results

HHS recognizes that a high-quality workforce is crucial to the effective delivery of health and human services. The Department has a number of activities that focus on addressing current workforce issues and the strategic development of workforce capacity. For example, HHS seeks to ensure that our country not only maintains, but enhances its capacity for innovative health-related research. A critical part of the NIH mission is the education and training of the next generation of biomedical, behavioral, and clinical scientists. In FY 2014, NIH pre-doctoral Ruth L. Kirschstein National Research Service Award (NRSA) trainees and fellows were 10 percent more likely to remain active in biomedical research than non-NIH trainees and fellows; this result matched the annual target of 10 percent. Each year's target represents the proportion of NIH trainees and fellows who go on to apply for and receive subsequent NIH support in comparison to non-NIH trainees and fellows. Subsequent support is an indicator of retention success in the research arena, and reflects the impact of NIH-funded training on the ability of

trainees and fellows to be competitive and sustain a research career with independent funding. Annual targets were adjusted for FY 2013 and beyond in light of the general decline in NIH grant success rates over the past ten years. Despite this trend, former trainees and fellows have continued to outperform individuals who did not receive NRSA support.

NIH also routinely monitors the career outcomes of former postdoctoral fellows. In FY 2014, NIH postdoctoral fellows were 14 percent more likely to remain active in biomedical research than non-NIH fellows; this result exceeded the annual target of 10 percent. Despite the general decline in NIH grant success rates, former postdoctoral fellows have been more likely to receive subsequent NIH research grants than individuals who did not receive NRSA support.

Accelerating the process of scientific discovery for the purpose of improving health outcomes is important to Americans' well-being and health. The Molecular Libraries Program (MLP) made progress and met the FY 2014 target by increasing the inventory to 375 small molecule probes that can be used in biological research to interrogate basic biological processes or disease. By disseminating results in PubChem, the NIH enables one of the largest sets of publicly available chemical biology information to be used by researchers in the public and private sectors.

Advances in technology and reductions in cost have made it possible to identify the causes of certain genetically complex diseases. Chronic atypical neutrophilic dermatosis with lipodystrophy and elevated temperatures (CANDLE) is a novel rare pediatric autoinflammatory syndrome that is predominately characterized by inflammation, attacks of fever, skin lesions, and fat loss. NIH researchers, along with an international team of collaborators, identified in a group of affected patients mutations in a gene causing cells to be unable to recycle or remove waste products. During FY 2014, researchers designed a compassionate use study to evaluate a novel class of drugs Janus Kinase (JAK) inhibitors in pediatric patients with CANDLE.

Asthma attacks are a significant cause of morbidity in patients with asthma and represent a substantial public health burden. The Severe Asthma Research Program (SARP) unites transdisciplinary teams in a collaborative platform to foster an understanding of severe asthma and its phenotypes at genetic, molecular, cellular, and clinical levels over time. HHS is tracking SARP and other severe asthma research through a series of annual milestones. In FY 2014 NIH achieved its milestone, using state of the art imaging techniques to help define disease phenotypes and endotypes, which will enable the development of tailored interventions for the appropriate patient populations.

In addition to the cataloging of data about naturally occurring biological chemicals, NIH manages a program to investigate and catalog the potential health effects of many of the estimated 125,000 man-made chemicals in use commercially. NIH and the EPA began the program, titled Tox21, in early 2008 to collaborate on the research, development, validation, and translation of new and innovative test methods that characterize how chemicals interact with cellular pathways, determining chemical toxicity, as well as danger to human health. This is important for the development of prevention and mitigation strategies. Tox21 has a library of over 10,000 compounds. NIH exceeded expectations in FY 2014 by screening in 42 qHTS assays and 22 subsets of possible high risk chemicals in high content screens using cells (e.g., cardiomyocytes, neuronal cells) and alternative organisms (zebrafish, *Caenorhabditis elegans*).

COPD is characterized by airway obstruction and/or emphysema. COPD is known to have both environmental (e.g., tobacco smoke) and genetic risk components. Current and former smokers are at highest risk, although only a minority of smokers ever develops COPD. Why some smokers develop

COPD while others do not is unknown, as is why some non-smokers develop COPD. The COPDGene study, in which 10,000 current and former smokers with or without COPD were studied to identify clinical and genetic markers of the disease, was begun in 2008 to address some of these questions. A meta-analysis was published this year using COPDGene as well as other studies to identify three known loci and three new loci marking genetic risk factors for COPD.

As the number of primary care providers diminishes and the need for primary care increases, there is an urgent need to increase the capacity of providers to care for more patients without a decrease in the quality of care and without unduly burdening the providers. Primary care providers are also being tasked with providing increasingly complex care as the population ages and the burden of chronic disease grows. Point-of-care technologies have emerged as scientific knowledge has grown. An early example of a point-of-care technology is the home pregnancy test. More recent tests for diagnosing strep throat at the point-of-care have become available. Emerging microfluidic, nanotechnology, and sensor miniaturization technologies are making it possible to develop a new generation of point-of-care test systems designed to improve the efficiencies of primary care practices. NIH is supporting efforts to define and prioritize unmet clinical needs in primary care where technology-enabled solutions could be of benefit. In fiscal year 2014 NIH met its target by identifying and funding six promising point-of-care technology projects that aim to provide rapid testing in a clinic or doctor's office to enable the diagnosis of disease or illness where treatment can begin at the time of diagnosis.

Decades of neuroscience research have shown how substances of abuse impact the brain in many ways, with effects on reward pathways, motor function, cognitive abilities, etc., yet we still know very little about the specific brain circuits that signal rewarding effects in response to drugs vs other natural rewards (e.g., food, sweets, water). We also know that substances of abuse can have both rewarding and aversive effects, but the brain circuitry that signals one response vs. the other remains unclear. Recent advances in the development of tools to probe the central nervous system such as multi-array recording electrodes, in vivo fast scan electrochemical voltammetry, and optogenetics, stand to increase dramatically our understanding of this brain circuitry. These data will generate new scientific knowledge that may help to define the basis of individual differences in the responsiveness to reward/aversion-producing substances, including substances of abuse and may help to identify novel targets for the development of anti-addiction medications. Using genetically-defined reporter proteins has led to an explosion in the precise identification of neurons that are involved in the processing of reward by the brain. In FY 2014, NIH researchers confirmed classical and pharmacological dissection of the central drug reward system, extended to demonstrate projections which had two or more transmitters with functional significance for drug reward, and identified a drug-activated reward pathway in the brain.

Plans for the Future

NIH expects to maintain the retention targets of both pre- and post-doctoral trainees and fellows in FY 2015 and 2016, despite the challenges described above. It is taking a number of steps to bring this about, including encouraging the routine use of individual development plans to guide the career development of graduate students and post-doctorates supported by NIH, and establishing a new office to address biomedical workforce issues. To assess its performance, NIH routinely monitors degree completion by its pre-doctoral Kirschstein-NRSA trainees and fellows and tracks the extent to which the graduate students and post-doctorates it supports are subsequently involved in research, using data from the national Survey of Earned Doctorates and the NIH IMPAC II administrative database.

For its various milestone-based research goals, NIH expects to achieve each during the next few years. This includes: making more chemical biology information available to researchers; further examining

immune disorders; examining more compounds for toxicological effects; exploring molecular pathways that may lead to promising avenues for preventing and treating asthma; studying the genetic factors leading to COPD to enhance risk evaluation and diagnosis, exploring new point-of-care technologies; and understanding drug effects on the brain.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- The NIH performance measures reflect the Agency's overall goals to advance basic biomedical and behavioral science, support translational research, and enhance the development of human capital, and strengthen the scientific workforce. NIH has proposed 45 new measures to replace those that ended or will be ending soon. A multi-level review process, supported by two trans-NIH committees, was used to develop, refine, and select measures that best align with the Agency's performance priorities. All of these new measures are available publicly in the Fiscal Year 2016 NIH Congressional Budget Justification.

- ASPR has joined with select state and local partners to conduct innovative pilots to better understand whether limited federal data can inform and support state and local health department emergency planning for, and outreach and assistance to, individuals that rely upon life-saving and maintaining medical equipment and healthcare services prior to, during, and after an emergency or disaster.

- ASPR has conducted proof of concept research studies to characterize and assess disaster induced healthcare system stress and potential adverse outcomes on at-risk populations that rely upon life-maintaining healthcare services.

- In 2013, CDC released the results of its Dialysis Bloodstream Infection Prevention Collaborative showing a 32 percent decrease in overall bloodstream infections and a 54 percent decrease in vascular access-related bloodstream infections after CDC prevention guidelines were used. Vascular access-related bloodstream infections are those related to devices used to access the bloodstream for hemodialysis. With approximately 37,000 bloodstream infections occurring each year among dialysis patients with central lines, at an estimated cost of $23,000 per hospitalization, wider implementation of the practices in this study could help save lives and reduce excess health care spending.

- The Office for Human Research Protections worked with other HHS agencies to revise the regulations for the protection of human subjects in research. Those revisions, when implemented, will reduce the administrative burden and delays to the progress of research without lessening the protection of human subjects in research, accelerating the process of scientific discovery to improve patient care.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

Innovation is a key element of HHS's intra-agency Open Government initiative. Through this initiative, the administration is promoting agency transparency, public participation, and public-private collaboration across federal departments. Every part of the Department contributes to making HHS more open and innovative. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 2.B Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	317	340	346	500	Discontinued	
Result	334	343	496	747	N/A	
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Not Collected	

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	8	10	12	13	Discontinued	
Result	8	10	12	13	N/A	
Status	Target Met	Target Met	Target Met	Target Met	Not Collected	

Increase the number of opportunities for the public to co-create solutions through open innovation (Lead Agency - IOS; Measure ID - 1.4)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target				N/A	31.0	35.0
Result				16.0	Sep 30, 2015	Sep 30, 2016
Status				Historical Actual	Pending	Pending

Increase the number of innovative solutions developed across the Department (Lead Agency - IOS; Measure ID - 1.5)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target				N/A	180.0	210.0
Result				157.0	Sep 23, 2015	Sep 30, 2016
Status				Historical Actual	Pending	Pending

Analysis of Results

Enhancing opportunities for public participation and collaboration in HHS activities is a key priority for the HHS Open Government efforts. It is widely understood that to deliver effectively on our mission, we must leverage the collective creativity and wisdom of our stakeholders. Federal Advisory Committees are one key way of ensuring public and expert involvement and advice in federal decision-making. Another way to involve the public in helping HHS to solve pressing agency problems is through the use of challenges and competitions in which members of the public can participate. It is notable that some of the challenges issued over the course of FY 2014 have been very innovative. For example, the Breast Cancer Startup Challenge issued by that National Institutes of Health National Cancer Center has led to the creation of 11 new start-up companies and was recognized as a Secretary's Pick in the HHS Innovates competitions. An additional important vehicle to engage our stakeholders is through the development and release of application programming interfaces (API). APIs allow external websites and services to interface with HHS databases - thus allowing external partners to mix information and media from HHS services and datasets into their sites and applications. In FY 2014, HHS exceeded its targets, identifying 747 opportunities for engagement. In addition to the number of engagements secured, HHS enhanced its use of technology to facilitate public meetings, continued to grow and mature it challenges and competitions program, as well as added more than a hundred new APIs.

Developing new types of effective collaboration and participation initiatives at HHS often involves a focused effort by a select group of individuals. HHS's approach takes two forms: in some instances members of the HHS OS Innovations Team have seeded these new initiatives; and in others HHS operating and staff divisions have led. Each of the projects is labor-intensive, and thus only a few are selected in each year. In FY 2014, the HHS Innovations Staff and its agency collaborators (e.g. innovation staff from HHS operating and staff divisions who partner with OS on projects) successfully implemented 13 projects. Each of the projects is labor-intensive, and thus only a few projected are selected in a given year. These projects included: the second round of HHS Ignite, an innovation program that provides seed funding and mentoring to HHS employees for the purpose of incubating and testing new ideas; the seventh round of the HHS Innovates competition, a program that recognizes and shares promising new approaches developed by HHS employees; the third round of HHS Entrepreneurs, a program that pairs internal and external expertise to solve high priority problems; and the fifth annual HHS Datapalooza, an event that attracted over 2000 participants and showcased 250 exciting new health applications and products, among others.

Plans for the Future

HHS will be retiring measures 1.1 and 1.3 in FY 2015 and replacing them with two new measures (1.4 and 1.5) that better capture the environment of innovation the Department seeks to foster. A high priority for the Open Government Plan is to increase the public's capacity to co-create solutions through challenge competitions. Challenge competitions can provide a fresh approach to solving problems,

including implementing new methodologies and mechanisms for spurring innovation, helping agencies to advance their core missions, and providing new acquisition methods. Driven by the America COMPETES Act signed by President Obama in 2011, HHS has become one of the leading federal agencies to utilize the challenge mechanism to enable participation from innovators both within and outside of government. In recognition of the important role that challenges can play as an innovative mechanism for procuring new types of solutions from a broad range of solvers, the Department recently hired a Manager for Open Innovation to oversee the HHS challenge portfolio and established an HHS Competes Pathway. This quantitative measure will be based on metrics tracked in the Open Innovation Manager's database. Additional information which is relevant to understanding this metric is the types of challenges and number of solutions developed by HHS Operating divisions, the percentage of divisions utilizing challenges, and examples of successful challenges and results. In FY 2014, HHS issued 16 challenge competitions. We expect that number to nearly double in FY 2015. Some of initiatives being undertaken to increase the number of high-quality challenges issued by HHS include: 1) Launch of a new HHS Competes Ambassadors group that serve as points of contact within the HHS agencies, and steer the program forward by discussing policy and process issues, as well as effective prize design; 2) Development of a strategic sourcing mechanism and guidance for those who wish to hire a challenge management firm to assist with the running of challenges; and 3) a bi-weekly newsletter that highlights exciting new challenges being issued by HHS as well as non-HHS agencies. The bi-weekly newsletter has a readership of over 300 individuals, and is expected to grow during FY 2015.

In recognition of the important role that innovation plays within the Department of Health and Human Services, the Office of the Deputy Secretary has established the Innovation, Design, Entrepreneurship, and Action (IDEA) Lab to equip and empower HHS employees and members of the public who have an idea and want to act. This quantitative measure captures the number of submissions to HHS pathways. Current pathways include HHS Innovates (celebrating HHS trailblazers), HHS Entrepreneurs (pairing internal ideas with external expertise), HHS Innovator-in-Residence (solving shared problems through partnerships), HHS Ignite (incubating new ideas), and HHS Ventures (accelerating proven concepts). Over time additional pathways may be added. Additional information which is relevant to evaluating this metric is the percent of OPDIVs participating in the pathways and the number of projects selected within each pathway. A description of each of the pathways and examples of the resultant projects can be found on the IDEA Lab website. In FY 2014, there were 157 innovative projects submitted to the HHS IDEA Lab. We expect that number to grow in FY 2015. The HHS IDEA Lab is undertaking a number of initiatives to strengthen its various pathways and improve the types projects submitted. For example, The HHS Innovates Awards program has undergone restructuring to enhance the submission categories and mechanisms for rewarding innovative projects. The HHS Ignite program has moved to a bi-annual model, and now includes a training "bootcamp" for all participants. The HHS Innovator-in-Residence program now includes 2 external entrepreneurs working on distinct projects. The HHS IDEA Lab has hired a new Communications Director and expects to expand significantly its outreach about its pathways to HHS employees in FY2015.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- In November of 2012, ACF established an official Evaluation Policy. This Policy builds on ACF's strong history of evaluation work by outlining key principles to govern planning, conduct, and

use of evaluation. It reconfirms ACF's commitment to conducting rigorous, relevant evaluations and to using evidence from evaluations to inform policy and practice.

- AHRQ's TeamSTEPPS patient safety training program has spread to health care systems across all 50 states, now reaching an estimated 30 percent of U.S. hospitals, including small critical access hospitals. To date, over 8,000 master trainers have received TeamSTEPPS training through AHRQ and the Department of Defense. TeamSTEPPS master trainers have, on average, trained an additional 50 front line health care professionals each for an estimated national grand total of over 350,000 health care professionals. TeamSTEPPS is in use in over 1,500 hospitals in the United States and 156 military treatment facilities worldwide. To meet the growing demand for master trainers, AHRQ launched an online version of the TeamSTEPPS training in April 2014.

- ASPR is creating a dataset that will link, at the individual level, administrative claims data from Medicare & Medicaid with administrative claims data from the Federal Emergency Management Agency, the Department of Housing and Urban Development and the Department of Energy and data from the U.S. Census. This dataset will facilitate and speed research by providing a critical research resource both for this event and for future events; promote efficiency by eliminating duplicative investigator efforts to link relevant databases, or request the same information from federal administrative claims offices; reduce research costs by funding a single resource that can be utilized by multiple investigators; and allow for multidisciplinary research teams to be developed with the data analytic capabilities necessary to perform this work and streamline use of data.

- MicrobeNet is a web-based microbial information platform designed by CDC as a modular system to incorporate multiple data types from laboratory and field testing of human, animal, and environmental samples to assist in the identification of biologic threats and zoonotic pathogens. MicrobeNet went live on January 1, 2013, and as of October 2013, the system processed approximately 1,000 searches for state health labs. Because MicrobeNet enables multiple analyses of a new or rapidly emerging pathogen to be performed in state and local labs, it dramatically decreases reporting time from weeks to days or hours. Laboratory scientists throughout the world can run diagnostic tests and match results against unique or rare isolates in CDC's reference collection through a single interactive portal curated by CDC.

- ONC continues to provide leadership to the health care industry through nation-wide strategic health IT planning, maintaining the Electronic Health Record Certification Program and Certified Health IT Product List, and through a robust portfolio of prizes and challenges designed to motivate development of innovative solutions to health care problems.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

Advancing regulatory science and innovation is an objective shared by a number of agencies within HHS. FDA and NIH are collaborating on an initiative to fast-track medical innovation to the public. Below are several performance measures that are indicative of the types of achievements that HHS and its components expect to achieve related to improving regulatory science and food and medical product safety. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 2.C Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	9.0 working days	6.0 working days	5.0 working days	4.0 working days	4.0 working days	3.0 working days
Result	7.0 working days	6.0 working days	5.0 working days	4.0 working days	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Met	Target Met	Target Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	90% w/in 180 days	90% w/in 180 days	90% w/in 180 days	90% w/in 180 days	90% w/in 180 days	90% w/in 180 days
Result	100% w/in 180 days	100% w/in 180 days	Jan 31, 2015	Jan 31, 2016	Jan 31, 2017	Jan 31, 2018
Status	Target Exceeded	Target Exceeded	In Progress	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Identify target genes that can predict potential for obesity and type 2 diabetes to provide individually tailored therapeutic treatment and dietary guidelines for use in improving health	1) Develop analytical methods to assess drug-induced heart damage 2) Identify target genes for obesity and the consequent development of metabolic syndrome diseases and heart disease	1) Analyze urine, blood, and tumor tissues samples to identity biomarkers that will facilitate early detection in new cases and in the reemergence of pancreatic cancer. 2) Develop a new targeted therapeutic approach to improve clinical management of breast cancer.	Determine if some drugs cause a higher incidence of liver toxicity in women than men	1) Complete pilot project that will promote women's health by facilitating the development of personalized approaches to treat breast cancer 2) Evaluate serum metabolic biomarkers to determine whether they are correlated to acute kidney illness diagnosis and prognosis	Identify potentially predictable drug/drug receptor combinations that can cause rare and unpredictable side effects
Result	Statistical analyses of gene-phenotype interactions and nutrient levels were conducted and target genes identified, further results are pending a final analysis and publication (Target Met)	1) A model of drug-induced heart damage was developed and is being used to identify new predictive biomarkers of early stages of drug-induced cardiac tissue injury. (Target Met) 2) Research experiments have been completed and preliminary results suggest the involvement of a number of genes involved in lipid metabolism and sugar transporters. (Target Met)	Published results that found potential for new breast cancer therapy using epigenetic approach (Target Met)	Researchers found that 18 out of 30 previously identified drug transporter genes exhibited sex differences in normal kidney tissue. Ethnicity and age also influenced gene expression levels in normal kidney tissue.	Dec 31, 2016	Dec 31, 2017
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

Analysis of Results

HHS supports an extensive set of efforts to protect and promote food and medical product safety. FDA Foods Program scientists are evaluating commercially available instrumentation that can be adapted to support the FDA mission to prevent foodborne illnesses. The Center for Food Safety and Applied Nutrition has advanced two of these technology platforms to Field laboratories. The instrumentation is laboratory-based and provides broad-range and strain-specific identification of infectious organisms for multiple applications (clinical and environmental). These detection platforms are enhancing FDA regulatory activities and shortening FDA response time during foodborne outbreaks involving Salmonella. In FY 2014, FDA met the target of reducing the average number of days to serotype priority pathogens in foods to four working days.

The Animal Drug User Fee Act (ADUFA) helps FDA ensure that new animal drug products are safe and effective for animals as well as for the public with respect to animals intended for food consumption. FDA pursues a comprehensive set of review performance goals and commitments that seek to improve the timeliness and predictability of the review of new animal drug applications (NADAs). In FY 2012 FDA exceeded its ADUFA performance goal for the tenth year in a row, completing review and action on 100 percent of original NADAs.

The National Center for Toxicological Research's goal is to define the correlations between an individual's nutrition, genetic profile, health, and susceptibility to chronic disease in support of personalized nutrition and health. This research will provide baseline data that supports the FDA goal of providing consumers clear and timely information to help promote personalized nutrition and health. Identifying biomarkers of health, susceptibility to chronic disease, and gene-micronutrient interactions is essential to gaining a more complete scientific understanding of health. NCTR is implementing a novel research program for personalized nutrition and health that relies on the "challenge homeostasis" concept for identifying markers of health and susceptibility. Since 2008, FDA/NCTR and USDA/ARS have had an ongoing partnership with a community development center in the Mississippi Delta region of Arkansas to conduct community-based participatory research (CBPR) that studies the effects of dietary intake and its influence on the development of obesity-associated diseases. This ongoing collaboration analyzes dietary intake patterns, micronutrient levels in the blood samples of children and adults, and calories expended. In FY 2014, the FDA met its goal as its researchers found that 18 out of 30 previously identified drug transporter genes exhibited sex differences in normal kidney tissue.

Plans for the Future

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

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- In 2013, the CDC's Outbreak Response and Prevention Branch monitored approximately 35 potential food poisoning or related clusters each week, and investigated more than 220 multistate clusters of illness. These investigations led to the identification of 50 confirmed or suspected vehicles of transmission, and with the support of the FDA, led to the recalls of a variety of foods including frozen pizza snacks, salads, chicken, ground beef, and tahini sesame paste.
- As part of an on-going interagency partnership, the NIH and the FDA have created 14 new Tobacco Centers of Regulatory Science (TCORS) designed to generate research to inform the regulation of tobacco products to protect public health. Taken together, the TCORS sites will increase knowledge across the full spectrum of basic and applied research on tobacco and addiction. The program also provides young investigators with training opportunities to ensure the development of the next generation of tobacco regulatory scientists.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

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

A number of HHS agencies promote the adoption of evidence-based programs and practices including ACF, ACL, AHRQ, CDC, HRSA, NIH, OASH, and SAMHSA. CDC conducts systematic reviews of scientific literature that form the basis for evidence-based Community Preventive Services Task Force recommendations about effective programs, services, and policies for improving health and preventing many chronic and infectious diseases and injuries. ACF and SAMHSA both maintain "What Works" clearinghouses of research in the areas of family and youth support and mental health and substance abuse services to facilitate evidence based decision making. Below are representative measures which HHS and its components will use to guide performance. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 2.D Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	60 %	65.3 %	76.7 %	71.4 %	Prior Result +3PP	Prior Result +3PP
Result	62.3 %	73.7 %	68.4 %	Oct 30, 2015	Oct 31, 2016	Oct 31, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Set Baseline	973,724	1,032,147	1,400,000	1,400,000	1,420,000
Result	927,357	1,220,956	1,359,772	1,339,561	Oct 31, 2015	Oct 31, 2016
Status	Baseline	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Identify at least 3 mechanisms for tracking successful implement-ation within studies to improve the uptake of research-tested interventions in health care settings.	Complete target by identifying three effective implement-ation strategies that enhance the uptake of research-tested interventions in service systems such as primary care, specialty care and community practice.	Identify three key factors influencing the sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice.	Identify three effective implementation strategies that enhance the sustainability of research-tested interventions in service systems such as primary care, specialty care and community practice.	Identify three key factors influencing the scaling up of research-tested interventions across large networks of services systems such as primary care, specialty care and community practice.	Initiate testing of hypothe-sized mechanism of treatment effect of one novel intervention, and determine whether the intervention should progress further to clinical testing.
Result	Three mechanisms for tracking successful implement-ation within studies were identified to improve the uptake of research-tested interventions in health care settings.	NIH identified three approaches that enhance the uptake of research-tested interventions in service delivery systems addressing child mental health, attention deficit hyperactivity disorder, and depression.	NIH researchers identified three influences on sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice: Community Development Teams in child mental health service systems; barriers and facilitators to evidence-based interventions to control blood pressure in community practice; and a set of factors to enhance sustainability of health care interventions across multiple settings.	NIH researchers identified three effective implement-ation strategies that enhance the sustain-ability of research-tested interventions in service systems such as primary care, specialty care, and community practice including: strategies to overcome these barriers and to enhance the sustain-ability of research-tested interventions; development of specific scales on sustainability as a strategy to identify factors affecting ongoing use as diagnostics for system action; and, strategies to scale-up and sustain HIV prevention interventions within low and middle income countries.	Dec 31, 2015	Dec 31, 2016

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

Analysis of Results

The most efficient and effective programs often use evidence-based and evidence-informed practices. Currently, ACF's Children's Bureau and its National Resource Center for the Community-Based Child Abuse Prevention (CBCAP) program are working closely with states to promote more rigorous evaluations of their funded programs. The CBCAP program developed an efficiency measure to gauge progress towards programs' use of these types of practices. For the purposes of this efficiency measure, the Children's Bureau defines evidence-based and evidence-informed programs and practices along a four level continuum (from least to most): Emerging and Evidence Informed; Promising; Supported; and Well-Supported. The funding directed towards these types of programs (weighted by "evidence-informed" or "evidence-based" practices level) will be calculated over the total amount of funding used for direct service programs to determine the percentage of total funding that supports evidence-based and evidence-informed programs and practices. HHS selected the target of a three percentage point annual increase in the amount of funds devoted to evidence-based practice as a meaningful increment of improvement through FY 2016. This performance expectation takes into account the fact that this is the first time that the program has required grantees to target their funding towards evidence-based and evidence-informed programs, and it will take time for states to adjust their funding priorities to meet these new requirements. ACF has made steady progress on this measure, with the percent of Community-Based Child Abuse Prevention funding directed toward evidence-based or evidence-informed practices exceeding targeted increases from FY 2010 to FY 2012. In FY 2013, the percent of funding dropped to 68.4 percent, missing the target. Although there was a drop in the reported percent of funds supporting evidence-based and evidence-informed practices, ACF has been providing more technical assistance to states to ensure that the data are accurate, which may have contributed to the change.

The Community Preventive Services Task Force (Task Force) is an independent, nonpartisan, nonfederal, unpaid panel of public health and prevention experts. The Task Force's mandate is to identify population-based programs, services, and policies that are effective in saving American lives and dollars, increasing longevity, and improving quality of life. Task Force recommendations provide information about evidence-based options that decision makers and stakeholders can consider when determining what best meets the specific needs, preferences, available resources, and constraints of their jurisdictions and constituents. Task Force recommendations are compiled in The Guide to Community Preventive Services (The Community Guide). The Community Guide website (http://www.thecommunityguide.org) is the primary dissemination tool used to 1) provide information about Task Force-recommended options to individuals, organizations, agencies, and communities who are making their own decisions about what is best for their circumstances, and 2) assist those who request help in implementing Task Force recommendations that best meet their needs. In FY 2014, CDC received 1,339,561 page views on the Community Guide website, an increase of 44 percent over the 2011 baseline, nearly achieving the FY 2014 target. CDC maintained the majority of expected page views by utilizing processes, strategies, and web-based products developed and tested during 2011-2013.

NIH has broadened its portfolio of implementation research by encouraging teams of scientists and practice stakeholders to work together to overcome barriers to implementing research-tested interventions. In FY 2014 NIH researchers met the target of identifying three effective implementation strategies that enhance the sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice including: strategies to overcome these barriers and to enhance the sustainability of research-tested interventions; development of specific scales on sustainability as a strategy to identify factors affecting ongoing use as diagnostics for system action; and, strategies to scale-up and sustain HIV prevention interventions within low and middle income countries.

Plans for the Future

Over time, the ACF CBCAP program expects to increase the number of effective programs and practices that are implemented, maximizing the impact and efficiency of CBCAP funds. ACF is committed to continuing to work with CBCAP grantees to invest in known evidence-based practices, while continuing to promote evaluation and innovation, so as to expand the availability of evidence-informed and evidence-based practice over time. ACF aims to increase each year the percentage of CBCAP funds directed to evidence-based and evidence-informed practices by at least 3 percentage points greater than the previous year's result through FY 2016.

CDC expects modest growth in page views of the Community Guide website in FY 2015 through FY 2016 due to the release and promotion of enhancements to the Community Guide website (developed in 2012-2014) that provide customized decision and implementation support for a range of user audiences.

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

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- ACL's Alzheimer's Supportive Services Program (ADSSP) grants are translating evidence-based interventions into community-based aging and disability networks. The September 2013 program report for completed grants reported a number of participant measures with statistical significance. Several ADSSP grantees reported that, as a result of program engagement, caregivers reported decreased depression and stress, improved coping, as well as increased knowledge and/or use of available services. The state of Georgia reported significant improvements in caregiver health. Grantees implementing the New York University Caregiver Intervention reported improved caregiver reaction to problem behaviors, reduced caregiver burden, and increase in social network, all with statistical significance. In addition to implementation of evidence-based interventions, the ADSSP has recently directed attention to the development of dementia capable networks/systems. In relation to dementia capability, the state of North Carolina's program has reported improvement in the ability of physicians to work with persons with dementia and their caregivers, as well as improvements in the area agencies on aging's understanding and response to the needs of individuals with early stage dementia and their caregivers.

- HRSA Special Projects of National Significance (SPNS) support the development and testing of innovative HIV service delivery models and promote the replication of successful models. A new SPNS project in FY 2013 supported 10 demonstration sites to design, implement, and evaluate innovative methods to identify Latinos/as at high risk or living with HIV, and improve their access, timely entry, and retention in quality HIV primary medical care. Continuing in FY 2013 were demonstration projects to test ways of addressing HIV-related care needs and retention in care of multiply diagnosed homeless populations, women of color, transgender women of color, individuals co-infected with HIV and Hepatitis, and hard-to reach populations.
- Despite strides in developing effective disease prevention and control programs, NIH recognizes there has been slow adoption of these programs into community, public health, and clinical practice settings. Current NIH-funded dissemination and implementation (D&I) projects support important public health issues such as reducing rates of smoking, increasing cancer screening, optimizing diabetes treatment and prevention of obesity. Training clinicians and scientists to implement, disseminate and evaluate effective programs of health care delivery in community settings shortens the time from scientific discovery to better population health by providing evidence of improved health outcomes. In 2013 NIH supported forty-five doctoral level trainees to participate in D&I research training. Thirty-four grant applications were directly attributable to the training. D&I working groups have produced 3 webinars for clinicians and researchers interested in D&I science, to make training more widely available.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

Three critical elements that underpin public health and regulatory practice — laboratory, surveillance, and epidemiological services — enable the public health field to detect emerging threats, monitor ongoing health issues and their risk factors, and identify and evaluate the impact of strategies to prevent disease and promote health. Carrying out these activities requires quality data and specimen collection, evidence-based epidemiology, and accurate and reliable laboratory services across the departments and organizations that make up the nation's public health infrastructure.

To this end, HHS is working to strengthen surveillance systems, including the monitoring of health care quality to ensure that best practices are used to prevent and treat the leading causes of death and disability. CDC works to ensure a prepared, diverse, sustainable public health workforce through experiential fellowships and high-quality training programs in many areas, including epidemiology, preventive medicine, and program management. This fills critical gaps in workforce needs at CDC and in the field, including global Ministries of Health (MOH).

HHS is building a robust data system that provides data, feedback, and tools directly to health agencies and health care facilities to improve practices and, ultimately, health. A data system for public reporting and using electronic data sources for data collection and prevention will enhance the nation's ability to monitor trends in critical health measures among priority populations; monitor health status, health care, and health policy concerns; and conduct in-depth studies of population health at the community level and for specific subpopulations.

ASPR, CDC, FDA, and SAMHSA will have roles in implementing the following strategies to achieve this objective. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 2.E Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	26	31	33	36	40[49]	42
Result	26[50]	33	36[51]	40[52]	Feb 1, 2016	Feb 1, 2017
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

[49] 36 Plus DC

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

[51] 36 Plus DC

[52] 40 + DC

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	198	237	248	401	430	487
Result	309	335	401	310	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	164	179	255	430	430	430[53]
Result	351	280	300	Jun 30, 2015	Jun 30, 2016	N/A
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Not Collected

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	2,486	2,660	2,846	3,101	3,500	3,700[54]
Result	2,658	2,881	3,130	Jun 30, 2015	Jun 30, 2016	N/A
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Not Collected

Analysis of Results

The spread of infectious diseases continue to be a national and international concern, requiring a robust system of detection, monitoring, and prevention. CD4 and viral load reporting provide the fundamental data for four of the National HIV/AIDS Strategy Goals. These goals are to increase the proportion of newly diagnosed persons linked to clinical care, and reduce the proportion of three populations diagnosed with HIV who have undetectable viral loads. Routine reporting of CD4 and Viral Load data to surveillance programs facilitates case finding and follow-up on new cases. These data help to ensure the timeliness, accuracy, and completeness of the national HIV surveillance system. As of FY 2014, 40 states and the District of Columbia reported all CD4 and viral load values for surveillance purposes, exceeding CDC's target of 36 states.

The detection and monitoring of pathogens and infections is a key component of HHS's strategic plan to enhance public health. State health departments report shortages of critical disciplines such as epidemiologists, public health nurses, managers, disease investigation specialists, laboratorians, environmental scientists, sanitarians, and informaticians. CDC's fellowship programs promote service while learning; fellows fill critical workforce needs at CDC and in the field while they are in-training for

[53,54] Given policy changes within agencies that support the FETPs and the increased FY 2016 funding request, CDC will assess the implications for its performance targets for FY 2016 and adjust as applicable.

careers in the field of public health. Targets are set based on the typical, annual class size for each of the fellowship programs included in the measure. In FY 2013, 83 percent of CDC's fellowship program graduates pursued careers in public health practice, while less than 25 percent of school of public health did so. Over the past three years, CDC exceeded its targets for training up the next generation of the public health workforce. In FY 2014, 310 fellows were placed in state, tribal, local, and territorial field assignments in 44 states, Washington D.C., American Samoa, Guam, Puerto Rico, and six tribal locations, falling short of the target. Results decreased in FY 2014 due to the Public Health Associates Program's (PHAP) transition to a new start-date for its incoming class. CDC's new class of 145 PHAP associates started in fall 2014 (FY 2015), as opposed to summer 2014 (FY 2014), and thus were not included in FY 2014 results. PHAP associates that began in the fall of 2014 will be included in FY 2015 results.

The current ease and frequency of long-range travel can make previously regional diseases and infections local risks. Therefore, HHS supports a number of initiatives to develop local and international workforce to improve public health both at home and abroad. Since 1980, CDC developed 50 international Field Epidemiology Training Programs (FETPs) serving 94 countries and graduated over 3,100 epidemiologists. On average, 80 percent of FETP graduates work within their Ministry of Health after graduation and many assume key leadership positions. Their presence enhances sustainable public health capacity in these countries, which is critical in transitioning U.S. government global health investments to long-term host-country ownership. In FY 2013, CDC exceeded its target for new residents and for total, cumulative graduates. In FY 2013, FETP graduates and residents led 345 outbreak investigations, over 200 planned investigations, and approximately 250 surveillance activities.

Plans for the Future

CDC will hold steady the number of states (including the District of Columbia) that report for HIV surveillance purposes in FY 2015 and slightly increase in FY 2016. CDC expects performance levels similar to previous years in FY 2015. CDC is planning for a level number of new residents in FY 2016 based on current participation and funding considerations. FETP activities are supported by funding from CDC appropriations and inter-agency agreements with the Department of Defense, Department of State, and USAID. Policy changes within those agencies may affect the number of FETPs supported. In light of this and the increased FY 2016 funding request, CDC will assess the implications for its performance targets for FY 2016 and adjust as applicable. CDC is working closely with Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET) to implement the accreditation process for the FETPs, which will help maintain the quality of FETPs globally.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- CDC is working in collaboration with state health departments to better monitor the effects of HIV medical care through expanded reporting of CD4 and viral load test results. For FY 2014, 40 states and the District of Columbia required reporting of all CD4 and viral load values, exceeding the target. CDC programs seek to reduce progression from HIV infection to AIDS and monitor disease progression using surveillance data.

- CDC has made efforts to strengthen informatics capacity at the state, tribal, local, and territorial (STLT) level. In FY 2013, CDC developed the Informatics Training-in-Place Program (I-TIPP) which

provides informatics training and guidance to current state and local health department staff who are working on Meaningful Use projects. This training program supplements the informatics training provided through the Public Health Informatics Fellowship (which places doctoral-level fellows at CDC for two years of intense informatics training) and the Applied Public Health Informatics Fellowship (which places masters-level fellows at STLT agencies for one year of applied public health informatics training).

- Since 1980, CDC has developed international Field Epidemiology Training Programs (FETPs) serving 94 countries that have graduated over 3,100 epidemiologists. In FY 2013, FETP graduates and residents led 345 outbreak investigations, over 200 planned investigations, and approximately 250 surveillance activities.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

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

A wide range of HHS agencies support these activities, including ACF, ACL, HRSA, NIH, OASH, and SAMHSA. Below are several performance measures used by HHS agencies to manage performance and ensure the safety and well-being of children and youth. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 3.A Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Set Baseline	20 states	25 states	29 states	32 states	35 states
Result	17 states	19 states	27 states	Jan 30, 2015	Jan 31, 2016	Jan 31, 2017
Status	Baseline	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target		Set Baseline	23 %	27 %	26 %	25 %
Result		25 %	31 %	23 %	Jan 31, 2016	Jan 31, 2017
Status		Baseline	Target Not Met	Target Exceeded	Pending	Pending

Maintain the proportion of youth living in safe and appropriate settings after exiting ACF-funded Transitional Living Program (TLP) services. [55] ***(Lead Agency - ACF; Measure ID - 4.1LT and 4A)***

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	85 %	86 %	86 %	86 %	86 %	87 %
Result	87 %	89.4 %	87.7 %	87.8 %	Dec 31, 2015	Dec 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	91.9 %	91.7 %	92.4 %	Prior Result +0.2PP	Prior Result +0.2PP
Result	91.7 %	91.5 %	92.2 %	Oct 30, 2015	Oct 31, 2016	Oct 31, 2017
Status	Historical Actual	Target Not Met	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	73.3 %	75.3 %	75.4 %	Prior Result +0.5PP	Prior Result +0.5PP
Result	72.8 %	74.8 %	74.9 %	Oct 30, 2015	Oct 31, 2016	Oct 31, 2017
Status	Historical Actual	Target Exceeded	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	80 %	80 %	80 %	80 %	84 %	84 %
Result	84.6 %	85.3 %	85.5 %	Oct 30, 2015	Oct 31, 2016	Oct 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[55] The language of this performance measure has been updated from "increase" to "maintain" to be consistent with future performance targets and the most recent data trend.

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	13,051	4,930	6,457	4,846[56]	6,610	6,610
Result	6,639	6,357	6,610	6,280	Dec 31, 2015	Dec 31, 2016
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	76.1%[57]	76.1%	65.9%	65.9%
Result	73.5%	76.1%	65.9%	77.9%	Dec 31, 2015	Dec 31, 2016
Status	Historical Actual	Historical Actual	Target Not Met	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	20.0 %	20.0 %	20.0 %[58]	20.0 %	Discontinued	Discontinued
Result	21.5 %	19.1 %	18.1 %	Results Unavailable	Discontinued	Discontinued
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Results Unavailable	Discontinued	Discontinued

Decrease the percentage of middle and high school students who report current alcohol use (Lead Agency - SAMHSA; Measure ID - 3.2.50)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target					18.1 %	18.1 %
Result					Dec 31, 2015	Dec 31, 2016
Status					Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	31 million	33 million	30 million	31 million	32 million	34 million
Result	37.4 million	35.9 million	34.3 million	Nov 30, 2015	Nov 1, 2016	Nov 30, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[56] Target has been revised from previous reported.

[57,58] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY 2013 performance targets reflect FY 2012 funding levels.

Analysis of Results

Strengthening the quality of early childhood education programs can provide a stronger foundation for each child's future. Because improving the quality of Head Start and Child Care programs will help achieve a more solid foundation for each child, HHS has made this initiative a Priority Goal - to improve the quality of early childhood programs for low-income children through implementation of the Quality Rating and Improvement Systems (QRIS) in the Child Care and Development Fund and through implementation of the Classroom Assessment Scoring System (CLASS: Pre-K) in the Head Start program. For the ACF Child Care program, the goal is to increase the number of states with a QRIS that meets the seven high quality benchmarks developed by HHS in coordination with the Department of Education for child care and other early childhood programs. ACF has provided ongoing training and technical assistance to at least 30 states/territories on QRIS implementation; as of FY 2013, a total of 27 states had a QRIS that met high quality benchmarks, exceeding the target of 25 states. Currently, many states meet some, but not all seven, of the outlined benchmarks – for example, as of FY 2013, at least five states have incorporated six quality benchmarks and at least seven states have incorporated five quality benchmarks. The ACF Office of Head Start completed a comprehensive data collection effort and analysis of a full program year of CLASS: Pre-K data as part of an ongoing effort to improve training and assistance, and thus enhance children's school readiness. In support of this effort, ACF is measuring the proportion of Head Start grantees that score in the low range on any of the three domains of the CLASS: Pre-K. An analysis of CLASS scores for FY 2014 indicates that 23 percent of grantees scored in the low range, exceeding the target of 27 percent. Seven of eight FY 2014 implementation milestones for this program are completed and one is ongoing.

ACF is committed to establishing permanency for some of our most vulnerable citizens—children who are in foster care and runaways. The Transitional Living Program (TLP) seeks to foster a safe and appropriate exit rate of children from the program, which is the percentage of TLP youth (aged 16-21) discharged during the year who find immediate living situations that are consistent with independent living. During FY 2014, TLPs exceeded the 86 percent target for this performance measure by attaining an 87.8 percent safe exit rate. Performance improvements were achieved through ACF's promotion and support of innovative strategies that help grantees: (1) encourage youth to complete the program and achieve their developmental goals instead of dropping out, (2) stay connected with youth as they transition out of program residencies and provide preventive, follow-up and after care services, (3) track exiting youth more closely and stay connected, (4) report accurate data and maintain updated youth records to reduce the number of youth whose exit situations are unknown, and (5) analyze data to discover patterns and opportunities.

ACF has a suite of performance measures focused on ensuring positive permanent living situations for children in foster care, while ensuring children are placed in safe living arrangements. Establishing permanency for children who are in foster care is a priority for ACF since children who remain in care for longer periods of time are less likely to exit to permanency and experience the benefits of stable living arrangements. ACF exceeded its ambitious target in FY 2013 for those children in care less than 24 months, finding permanency for 92.2 percent. Because of the challenges related to placing those children in established living situations after longer than 24 months, ACF fell slightly short of its target for FY 2013, realizing permanency in 74.9 percent of exits. Trauma can be aggravated further when a child is moved from one placement setting to another, therefore ACF strives to have no more than two placement settings during the first 12 months of foster care. In FY 2013, performance on this measure again improved from the previous year with 85.5 percent of children experiencing no more than two placements in the first year of foster care.

In support of individuals, families, schools, and other organizations throughout the community, SAMHSA is promoting emotional health and preventing mental illness and substance abuse in children and adolescents. The Child Mental Health Initiative (CMHI) is designed to promote the transformation of the national mental health care system that serves children and youth (aged 0 to 21 years) diagnosed with a serious emotional disturbance and their families. This occurs through the development of comprehensive, community-based services that target children and youth dealing with serious emotional disturbance (SED) and other issues. CMHI funds the development and implementation of comprehensive and coordinated — systems of care among states, local communities, United States territories, and American Indian/Alaska Native Tribal Nations. These family-driven systems of care build on the individual strengths of the children, youth, and families being served, and address their needs. Despite a decline of less than 10 percent from FY 2013, in FY 2014 the number of children with severe emotional disturbance that are receiving services from the CMHI exceeded the target.

SAMHSA's National Child Traumatic Stress Initiative (NCTSI) is designed to improve behavioral health treatment, services, and interventions for children and adolescents (as well as their families) who have been exposed to traumatic events. NCTSI provides training and technical support for interventions that reduce the mental, emotional, and behavioral effects of trauma. This program continues as a principal and long-standing source of child trauma training for our nation. In FY 2014, SAMHSA exceeded the performance target with 77.9 percent of children who received services showing positive functioning at 6 months follow-up. Positive functioning refers to an overall ability to perform routine life activities. Positive functioning associates psychological as well as social, emotional, and psychological well-being. As a growing number of service and clinical providers develop their capacity to provide trauma-informed services, the rate of positive functioning at 6 month follow-up is expected to increase.

The Youth Violence Prevention initiative implemented enhanced, coordinated, and comprehensive activities, programs, and services that contributed to healthy childhood development, as well as preventing violence and alcohol and drug abuse. Progress was measured in several ways, including tracking the reported rate of current substance abuse among middle and high school students. Performance for this activity was stable and the program was deemed successful. The Youth Violence Prevention initiative is being transitioned into a new coordinated effort to address these important and complex problems called the Safe Schools Healthy Students State and Tribal program. Due to this transition, the performance and accountability plan is being updated. Data is no longer available for the Youth Violence Prevention program but will be soon available for the Safe Schools Healthy Students State and Tribal program.

HRSA's contribution to this objective also includes the Maternal and Child Health (MCH) Block Grant Program, which serves vulnerable populations by seeking to improve the health of all mothers, children, and their families. In FY 2013, 34.3 million children were served by the Block Grant program.

Plans for the Future

ACF will continue to have aggressive targets and aim to improve results in order to lay a stronger foundation for each child's future through strengthening the quality of early childhood education programs. ACF continues to invest in building its CLASS-related resources and making those resources available to grantees. In response to the data from the FY 2013 CLASS reviews, ACF plans to provide more intentional targeted assistance to those grantees that score in the low range on CLASS, using a case management approach. ACF will conduct more analysis on the specific dimensions that are particularly challenging for those grantees and develop a process for working more directly with those grantees on strategies for improvement. States are also making significant progress toward

implementing a comprehensive QRIS that meets all outlined quality benchmarks; however, their progress is masked by the single figure reported. To provide a more complete picture of QRIS implementation and improvements across the country, OCC is closely tracking the progress of states that may not meet all quality benchmarks, but that have demonstrated improvements by increasing the number of benchmarks reached.

ACF will continue to support state agencies as they work to move children to permanent homes and anticipates that the FY 2016 performance for placement in less than 24 months will be 0.2 percentage points higher than the previous year's performance. Although there was a slight decrease in performance this fiscal year for placement of children who had been in foster care greater than 24 months, ACF anticipates improvement on this measure, and by FY 2016 expects that it will show an increase of 0.5 percentage points from the previous year's actual performance. Given the recent data trend, ACF increased the future year target for the percent of children experiencing no more than two placement settings in the first year of foster care to 84 percent in fiscal years 2015 and 2016. ACF is providing technical assistance to the states to improve placement stability for children in care, and states are employing a number of strategies, including increasing the use of relatives as placement resources and improving training and support for foster parents to improve retention and prevent placement disruptions.

SAMHSA continues to support the CMHI through grants to support states, regions within states, the District of Columbia, Territories, Native American Tribes and tribal organizations, in developing integrated home and community-based services for children and youth with serious emotional disturbances as well as support for their families. SAMHSA continues to encourage the development and expansion of the effective and enduring strategic approach to mental health care termed “systems of care.” SAMHSA expects high performance during FY 2015.

NCTSI grantees continue to implement Evidence Based Practices (EBPs) that improve behavioral health treatment, services, and interventions for children and adolescents exposed to traumatic events. The service providers of many grantees were trained in FY 2013 and are learning new interventions. As grantees continue to gain experience and knowledge and providers expand their capacity to provide trauma-informed services, the rate of positive functioning at 6 month follow-up will increase.

SAMHSA will continue to support healthy childhood development, prevent violence, and prevent alcohol and drug abuse through the Safe Schools Healthy Students (SS/HS) State and Tribal program. The SS/HS initiative works to decrease violence while increasing the number of students who receive mental health services. SS/HS supports school and community partnerships by encouraging integrated systems that promote students’ mental health, enhance their academic achievement, prevent violence and substance use, and create safe and respectful school climates. SAMHSA will be replacing measure 3.2.30 (Youth Violence Prevention) with measure 3.2.50 (SS/HS) in FY 2015. The new measure tracks the success of this program in part through the percentage of middle and high school students who report current alcohol use.

Improving the health of mothers, children, and their families is the mission of HRSA’s Maternal and Child Health Block Grant program. HRSA’s targets for FY 2014-2016 reflect expectations regarding service mix and state and federal funding levels.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- ACF tracks the developmental progress of successive cohorts of nationally representative samples of 3 to 4-year-old children newly entering Head Start in the fall of the program year. Data from the last cohort showed that children assessed in English demonstrate progress toward norms across all developmental areas assessed between the fall and spring. Children assessed in Spanish make progress towards norms in the area of letter-word knowledge. Children also demonstrated gains in executive functioning skills by the end of the program year, and both teachers and parents report that children show growth in their social skills during their first Head Start year. Teachers rate children as having fewer problem behaviors by the spring, including hyperactive behaviors, as well as more positive approaches to learning.

- An issue of paramount concern for the disability community and a focus for Protection and Advocacy Agencies (P&A) that receive ACL funding is the prevention, reduction, and ultimate elimination of the use of restraint and seclusion on school children. Over 62 percent of P&A clients are children or young adults between ages 5 and 22. In FY 2013, nearly 64 percent of all P&A cases addressed issues related to abuse and neglect and in the area of education. In FY 2013 nearly 78 percent of individuals' case files (for all issues) were closed due to the P&A resolving the issue in the individuals favor. Only 1 percent of cases were closed due to unsuccessful appeals.

- A 3-year study assessed the performance of training, research, and state systems grant programs in meeting the objectives of the Combating Autism Act Initiative. The study found increases in the number of children receiving diagnostic evaluations over the course of the grant period, thereby providing an early indication of progress toward reducing barriers to services.

- Spinal muscular atrophy (SMA) is a genetic disease that weakens muscles and can affect walking, crawling, breathing, swallowing and head and neck control. Early treatment is critical; however, the short window of opportunity often occurs before symptoms appear. NIH-supported researchers developed an inexpensive and quick DNA test that could be used shortly after birth to identify newborns at risk of developing SMA.

- SAMHSA's SS/HS initiative has successfully decreased violence and increased the number of students receiving mental health services. For elementary, middle, and high schools participating in the SS/HS grant program, there were significant increases in the proportion of students receiving school-based mental health services. Participating elementary and middle schools reported decreased problems with gang activity. Among students at participating high schools, there were significant reductions in 30-day alcohol use.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

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

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

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

Objective 3.B Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	89.4 %	89.7 %	90 %	90 %	90 %	90 %
Result	90.7 %	90.3 %	92.6 %[59]	May 30, 2015	May 31, 2016	Mar 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[59] The FY 2013 actual results includes corrected data from two grantees that may have been collecting/reporting data incorrectly for prior fiscal years.

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	75 targeting index score	80 targeting index score	85 targeting index score	84 targeting index score[60]	Maintain Prior Result	Maintain Prior Result
Result	78 targeting index score	83 targeting index score	84 targeting index score	Nov 30, 2015	Nov 30, 2016	Nov 30, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	110 targeting index score	124 targeting index score	116 targeting index score	117 targeting index score[61]	Maintain Prior Result	Maintain Prior Result
Result	122 targeting index score	114 targeting index score	117 targeting index score	Nov 30, 2015	Nov 30, 2016	Nov 30, 2017
Status	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	68.79 %	71.75 %	71.77 %	69.76 %	76.84 %	Prior Result +1%
Result	71.04 %	71.06 %	69.07 %	76.08 %	Nov 30, 2015	Nov 30, 2016
Status	Target Exceeded	Target Not Met but Improved	Target Not Met	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	42.97 %	51.02 %	52.5 %	54 %	54.5 %	54.75 %
Result	50.02 %	52.91 %	49.33 %	Dec 31, 2015	Dec 30, 2016	Dec 29, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

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

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

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	61 %	62 %	62 %	62 %	63 %	65 %
Result	62 %	63 %	64 %	Nov 30, 2015	Nov 30, 2016	Nov 30, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	27.5 %	30.6 %	30.7 %	32.5 %	Prior Result +0.1PP	Prior Result +0.1PP
Result	30.3 %	30.4 %[62]	32.4 %	Oct 31, 2015	Oct 30, 2016	Oct 31, 2017
Status	Target Exceeded	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

Increase the percentage of homeless clients receiving services who were currently employed or engaged in productive activities (Lead Agency - SAMHSA; Measure ID - 3.4.24)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	32.7 %	32.7 %	32.7 %	31.7 %	31.7 %	31.7 %
Result	32 %	32.7 %	31.7 %	31.7 %	Oct 31, 2015	Oct 31, 2016
Status	Target Not Met	Target Met	Target Not Met	Target Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	25.6 %	25.6 %	25.6 %[63]	24.6 %	33 %	33 %
Result	33 %	35.7 %	44.9 %	45.3 %	Oct 31, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	790,000 caregivers	792,000 caregivers	796,000 caregivers	790,000 caregivers	790,000 caregivers	825,000 caregivers
Result	819,598 caregivers	867,546 caregivers	1,046,159 caregivers	Dec 31, 2015	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

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

Analysis of Results

Providing the survivors of domestic violence with tools that will assist them to remain safe is important to social and community well-being. The percentage of clients who have improved knowledge of safety planning is correlated with other long-term client safety and well-being measures. ACF again exceeded its target on a measure of the percentage of clients who reported improved knowledge of safety planning with more than 90 percent of clients served through Family Violence Prevention services programs. In FY 2013, the result for this measure increased by 2.3 percentage points. Part of this increase may be attributed to a data quality check measure that identified two grantees that, in the past, had entered these data incorrectly and were unable to correct retroactively the prior years. This would create an artificially lower percentage for the prior years. ACF plans to continue to monitor data reporting with grantees and assess whether new targets should be set for subsequent years.

ACF also focuses on targeting services to populations in need with its recipiency targeting index for families that receive Low Income Home Energy Assistance Program (LIHEAP) funding. The recipiency targeting index scores are the national percentage of LIHEAP-eligible households that receive services and have either a senior citizen or a young child (under the age of five) in the household compared to the percentage of households estimated by the Census Bureau as being LIHEAP-income-eligible and having a senior citizen or young child in the household. If the recipiency score was 100, it would mean LIHEAP served these target populations at precisely the level they appear in the US population of eligible clients. Although the recipiency score for households with a senior citizen did increase to 84 in FY 2013, this result fell just short of the FY 2013 target of 85 percent. Overall, the targeting index scores indicate that elderly households faced increased difficulty in enrolling in LIHEAP as compared to families with young children; in FY 2013, the recipiency score for households with children resumed an upward trend to 117, surpassing the FY 2013 target of 116. A review of the literature indicates that other federal social programs also find it challenging to serve eligible elderly households, especially in comparison to households with young children. Program participation barriers appear to be most significant when elderly households have not made previous use of public assistance programs.

HHS has several measures related to economic well-being. Refugees are another vulnerable population targeted by ACF programming with economic well-being performance measures. In FY 2014, 76 percent of refugees served by the Matching Grant program were not dependent on any cash assistance within 180 days of arrival, exceeding the target of 70 percent. ACF has put processes in place to improve future achievement including requiring Performance Improvement Plans for grantees with at least 50 refugee clients and who are performing below average. These plans include increased monitoring, professional development training, reassignment of personnel, and potential funding reductions. Several grantees attributed the increased performance in FY 2014 to the ongoing focus on these performance improvement plans. In FY 2013, the percentage of refugees entering employment through ACF-funded refugee employment services fell to 49.33 percent, missing the target of 52.5 percent. ACF still faces challenges in terms of performance on this measure given the changing demographics of the U.S. Resettlement Program, as many populations require extended employment services in order to enter the U.S. labor market and integrate into U.S. society.

The ACF Office of Child Support Enforcement (OCSE) and state Child Support Enforcement programs implement a wide variety of strategies to increase current collections, including early intervention, caseload segmentation and data analysis, income withholding, unemployment compensation interception, state or federal tax refund offsets, new approaches to facilitate stable employment for non-custodial parents, and new strategies to strengthen parent engagement. As a result, the collection rate for FY 2013 of 64 percent exceeded the target for this measure for a third year in a row, a

significant accomplishment for states considering data for this measure is most influenced by economic factors beyond the control of the program.

The Temporary Assistance for Needy Families (TANF) measures, taken together, assess the extent to which recipients transition from cash assistance to employment. Full success requires not only that recipients get jobs, but also that they stay in employment and increase their earnings in order to reduce dependency and enable families to support themselves. In FY 2013, 32.4 percent of TANF adult recipients became newly employed, which was an improvement over the previous year's result and exceeded the FY 2013 target of 30.7 percent.

The Grants for the Benefits of Homeless Individuals Services in Supportive Housing (GBHI-SSH) seek to use a permanent supportive housing approach to expand and strengthen substance use treatment or co-occurring substance use and mental disorders treatment services for individuals who experience chronic homelessness and veterans who experience homelessness. GBHI-SSH supports innovative strategies and services that help integrate individuals who are experiencing or at risk of homelessness and who also have substance abuse and mental health disorders into the community. For example, GBHI-SSH assists providers in strengthening the infrastructure for delivering and sustaining housing to support recovery. The FY 2014 target for homeless clients receiving services who were currently employed or engaged in productive activities was met due to increased focus in case management associated with activities that led to (contributed to) stable employment. Homeless clients receiving services who had a permanent place to live in the community experienced consistent performance improvements, increasing from 23.6 percent in FY 2008 to 44.9 percent in FY 2013. In 2014, 45.3 percent of clients receiving services had a permanent place to live in the community, exceeding the target. The GBHI-SSH measures are sensitive to external factors, such as employment. When the percentage of those employed decreases nationally, fewer clients are able to afford housing and addressing housing issues potentially becomes more complicated.

The National Family Caregiver Support Program provides grants to states, territories and tribal organizations to fund a range of supports that assist family and informal caregivers in caring for their loved ones at home for as long as possible. ACL succeeds in serving community-based elderly individuals is to support family and friends who are caregivers of these frail individuals. Increasing the number of caregivers served is a critical component of ACL's efforts to prolong the ability of vulnerable elderly persons to live in their homes. In FY 2013, over 1 million caregivers received services exceeding the target of serving 792,600 caregivers. Performance has trended upward with year to year performance experiencing some variability. These fluctuations are likely due to yearly variation in the mix of five services delivered to meet the needs of the caregivers in the program (i.e. if caregiver needs result in a service mix with more of the expensive services, such as respite versus caregiver training, then fewer caregivers can be served with a given amount of resources).

Plans for the Future

From FY 2014-2016, ACF aims to maintain the target rate of 90 percent of domestic violence program clients reporting improved knowledge of safety planning. This target rate is a realistic expectation of client assessment of their increase in knowledge due to services received. A higher number of clients responding that they increased their knowledge is unrealistic because many program participants receive short term crisis assistance and would not be expected to report significant change. ACF will coordinate with ACF-funded National Resource Centers and state Domestic Violence Coalitions to provide ongoing technical assistance in order to assure accurate data collection methods.

ACF plans to maintain the recipiency index score each year for the Low Income Home Energy Assistance program in fiscal years 2014-2016 for households with older members and young children. LIHEAP is one of five federal benefit programs for which the National Center for Outreach and Benefit Enrollment is seeking to develop innovative ways to increase enrollment of the elderly.

In the area of refugee self-sufficiency, ACF seeks to continue to make progress despite a challenging job market and a population of refugees who may face significant cultural and language barriers. By FY 2016, the goal is to improve by at least 1 percent over the prior year's actual result for measures of cash assistance dependency and by more than 1.5 percent in employment. ACF intends to increase its monitoring activities to enhance program performance.

Continued success in child support collections will depend, to some degree, on the extent to which states continue to implement policies and programs to ensure that child support orders reflect current earnings at establishment and are modified when earnings change given the explicit link of this measure to economic conditions. ACF also aims to maintain the child support percent collection rate target at 62 percent for FY 2014 and increase to 63 percent in FY 2015 and 65 percent in FY 2016 in anticipation of more modest improvements in economic conditions in the near term.

States continue to help TANF adult recipients enter employment, and ACF is committed to finding innovative and effective employment strategies through research, identifying and disseminating information on promising employment and skill-building strategies, and providing a range of targeted technical assistance efforts to states. Annual measure 22B and long-term objective 22.2LT have the goal of increasing the rate in FY 2016 by 0.1 percentage points above the prior year's result.

SAMHSA assists homeless individuals to sustain employment and engage in productive activities. SAMHSA will continue to provide targeted technical assistance to grantees and use strategies to improve the percentage of adult clients who have a permanent place to live in the community. The data shows the program has exceeded the targets for the percentage of clients reporting that they have a permanent place to live in the community. Through 2014, performance is stable. Consequently, the targets for FY 2015 and 2016 are increased.

The National Family Caregiver Support Program has achieved a significant upward trend in the number of caregivers served while federal funding has experienced periods of decline followed by stability and total expenditures for the program have increased slightly due to support from the state and local levels. Targets were set at lower levels for FY2014 and FY2015 due to the expectation of a delayed and lingering effect of sequestration and the FY2016 target was increased due to the increased President's budget request for the program and additional investments in family support and innovations. While the targets are lower than the FY 2013 result, the overall trend is predicted to be positive.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- An ACF study found that earnings supplements (such as the Earned Income Tax Credit, SNAP, and child care and transportation assistance) can substantially increase employment and income and, in many cases, employment retention, but have limited effects on employment advancement.

- An ACF study found that transitional jobs programs (such as the Center for Employment Opportunities (CEO) Prisoner Reentry Program) for ex-offenders can substantially increase employment in the short term and significantly reduce recidivism among former prisoners who enrolled in the program shortly after release from prison.
- A survey of Racial and Ethnic Approaches to Community Health (REACH) programs by CDC found that:
    - Over the 3-year intervention period, smoking prevalence decreased on average 7.5 percent (or an average of 2.5 percent per year) among African Americans and 4.5 percent among Hispanics.
    - In REACH communities that focused on cardiovascular disease or diabetes during this time, the percentage of adults who reported eating five or more fruits and vegetables daily increased 3.9 percent among African Americans and 9.3 percent among Hispanics.
    - The percentage of adults aged 65 years or older who had an influenza shot in the past year increased on average 11.1 percent across the 3-year intervention period.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

Among the agencies and offices contributing to the achievement of this objective are ACL, AHRQ, ASPE, CDC, CMS, OCR, OASH, and SAMHSA. The following performance measures exemplify how HHS is improving the quality and accessibility of supportive services for seniors and people with disabilities. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 3.C Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	30% percent	28% percent	28% percent	28% percent	27% percent	27% percent
Result	30% percent	26% percent	31.6% percent	Dec 31, 2015	Dec 31, 2016	Dec 31, 2017
Status	Target Met	Target Exceeded	Target Not Met	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	90%	90%	90%	90%	90%	90%
Result	90%	88%	89%	Dec 31, 2015	Dec 31, 2016	Dec 31, 2017
Status	Target Met	Target Not Met	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	90% percent	90% percent	90% percent	90% percent	90% percent	90% percent
Result	97% percent	98.5% percent	97% percent	Dec 31, 2015	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	90%	90%	90%	90%	90%	90%
Result	96%	93.8%	94.6%	Dec 31, 2015	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	39% percent	44.3% percent	44.8% percent	45% percent
Result	41.8% percent	43.5% percent	43.5% percent	Dec 31, 2015	Dec 31, 2016	Dec 31, 2017
Status	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	87.0 %	87.0 %	87.0 %[64]	87.0 %	87.0 %	87.0 %
Result	92.0 %	87.0 %	88.3 %	Jul 31, 2015	Jul 31, 2016	Jul 31, 2017
Status	Target Exceeded	Target Met	Target Exceeded	Pending	Pending	Pending

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

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	5,420	5,420	5,420[65]	4,591[66]	4,360	2,296
Result	4,459	4,781	4,360	2,296	Dec 31, 2015	Dec 31, 2016
Status	Target Not Met	Target Not Met but Improved	Target Not Met	Target Not Met	Pending	Pending

Analysis of Results

The National Family Caregiver Support Program provides grants to states and territories to fund a range of supports that assist family and informal caregivers. Since 2003, ACL has been working to reduce the stress of caregivers and has set ambitious targets to reduce the number of caregivers who have had difficulty obtaining services from a high of 64 percent caregivers in 2003 to the current reported level of 31.6 percent of caregivers in FY 2013. This result missed the target by 3.6 percentage points. Performance for this measure had been consistently improving and this finding may be an anomaly. Sequestration is a factor that may have influenced this single year rise. If supportive services availability declined due to reduced funding then caregivers would likely report more difficulties obtaining needed services. FY 2008 was the last time that over 30 percent of caregivers reported difficulty a time in which appropriations and expenditures declined sharply.

ACL's Administration on Aging (AoA) funds home delivered meals for elderly individuals who are too ill or too frail to be able to prepare their own meals. Obtaining adequate nutrition is key to recovery from recent illness or hospitalization, and important in managing chronic conditions including diabetes and heart disease. Over 40 percent of home delivered meal clients have 3 or more Activity of Daily Living (ADL) limitations, the same level of disability that is required for nursing home placement. Ninety three percent of service participants report that the meals help them remain at home and live independently in the community. Performance for FY 2013 was 89 percent reporting “good” to “excellent” service quality, an improvement over the FY 2012 results. AoA expects the slight drop in positive rating of program quality in FY 2012 and FY 2013 to be temporary as specific indicators of program quality are all rated above 90 percent.

ACL has a number of performance measures related to maintaining high levels of service quality while also serving frail, elderly individuals most in need of assistance to remain in their own homes. In general, ACL strives for service quality that meets or exceeds 90 percent of consumers rating services “good” to “excellent.” ACL's AoA funds transportation services for elderly individuals who have mobility challenges including those who are no longer able to drive their own car or who do not have access to public transportation. The quality ratings by transportation consumers are exceptionally high with greater than 97 percent of consumers indicating the services are “good” to “excellent,” exceeding the target. ACL's National Family Caregiver Support Program enables family members who have a loved one with disabilities or conditions which require assistance to use an array of supportive services. Caregivers

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

[66] Target has been revised from previously reported.

served by the National Family Caregiver Support Program reported a 94.6 percent rating of services "good" to "excellent," also exceeding the target.

ACL's AoA provides home-delivered meal services to individuals who are too ill or frail to prepare their own meals. High level of limitations in Activities of Daily Living (ADLs), i.e. three or more, is a risk factor for nursing home entry and loss of independence. Increasing the percent of older persons with severe disabilities who receive home-delivered meals is a new measure created in FY 2014. Historical results indicate that while the overall number of people served by the program has been declining due to a stable budget and increasing costs related to food, fuel, and labor, the percentage of program participants at high risk for losing their independence has been increasing. The FY 2013 result is 43.5 percent, exceeding its target.

SAMHSA programs use different approaches to address the needs of individuals with serious mental illness and other behavioral health challenges. For example, the Protection and Advocacy for Individuals with Mental Illness (PAIMI) helps individuals with serious mental illness (adults) and serious emotional impairments (children/youth) who are at risk for abuse, neglect, and/or right's violations. Legal-based advocacy services are provided to vulnerable individuals with mental illness, including those residing in public and private residential care and treatment facilities. PAIMI advocates for the rights of vulnerable individuals so that they are free from abuse and placed in appropriate, least restrictive, community-based settings. Targets have been met or exceeded during FY 2013 and each preceding year.

SAMHSA strives to help those with serious mental illness maintain or restore their rights and concerns related to housing by assisting with complaints and working to resolve issues. This supports an individual's personal decision-making. The PATH program provides SOAR training to mental health professionals. Once trained, PATH providers are better able to assist PATH clients in applying for and receiving the income benefits for which they are eligible. This assists individuals who apply for Social Security (SSI) or Social Security Disability (SSDI) payments and related benefits including health insurance. There was a significant drop in the number of people trained in 2014 as a result of a transition to a standardized online training This change standardized high quality training. The use of technology may ultimately assist with access while managing costs. States were made aware of the pending availability of the new SOAR online curriculum approximately mid-way through FY 2013. Anticipation of its availability in the latter part of the year helps explain the drop in attendance at in-person trainings.

Plans for the Future

ACL plans to reduce the percentage of caregivers who report difficulty getting services to 28 percent for FY 2014 and 27 percent for FY 2015 and 2016. Program performance has reduced caregivers reporting difficulty to such a low level that further reductions are expected to be modest. Performance improvement will be achieved through ACL Central and Regional Office provision of technical assistance to state grantees; collaboration and sharing across caregiver programs (e.g. Lifespan Respite) including the proposed Family Support program in the President's FY 2016 budget request. Longer term efforts include dissemination of results from the National Family Caregiver Support Program's evaluation. The process evaluation component is underway and the outcome evaluation component data collection is to be complete in FY 2017.

ACL will continue its efforts to enhance support services for people with disabilities and older adults. ACL's AoA will continue to provide technical assistance to state grantees through individualized technical assistance and webinars conducted by OAA nutrition program staff and the National Resource Center on

Nutrition and Aging (established FY 2012) to insure meal delivery program quality remains high. The President's budget request for a Nutrition Innovation Demonstration is another mechanism whereby nutrition programs will be strengthened and improved. ACL has invested significant resources in program evaluations including an evaluation of the Title III-C Elderly Nutrition Services Program. In addition, ACL/AoA and CMS have entered into an inter-agency agreement that will enhance this evaluation to include prospective analysis of healthcare utilization and cost. Data collection for the process study is scheduled to be complete in Spring 2015, currently 100 percent of state Units on Aging and 80 percent of Area Agencies on Aging (AAAs) have completed both parts of their data request (92 percent responded to the survey and 83 percent responded to a separate data form). The outcome study data collection is expected to be complete in late FY 2016. The results of the evaluation will be disseminated to the National Aging Network and used for program improvement and planning.

ACL plans to maintain the current high performance for the measures of client satisfaction with the National Family Caregiver Support Program, transportation, and home delivered meals at current levels for FY 2014– 2016. The percentage of older persons with severe disabilities receiving home-delivered meals has increased year by year, despite stable funding and increased cost related to food, fuel, and labor. States have increased their targeting of these clients at high risk of nursing home entry. Consequently, ACL increased the FY 2014-2016 performance targets.

SAMHSA measures the percentage of complaints of alleged abuse, neglect, and rights violations not withdrawn by the client that resulted in positive change as a consequence of PAIMI involvement. A positive change is an improvement in the client's safety or welfare. Although business costs continue to rise, SAMHSA plans to maintain its current performance levels for substantiated and not withdrawn complaints due to PAIMI involvement.

SAMHSA has reduced its targets for the number of PATH providers trained in the SOAR process for FY 2015 and 2016 due to more stringent requirements for completion as part of the online program. With the full implementation of the new online curriculum in FY 2015, SAMHSA expects that the number of people trained at in-person venues will continue to trend downward. The completion requirements of the online curriculum are more stringent than the in-person training. While there will be smaller numbers trained, they will be better equipped and more likely to complete applications. It is expected that this will positively impact outcomes.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- An AHRQ study of the On-Time Pressure Ulcer Prevention Program produced evidence that nursing homes implementing the program saw a 60 percent reduction in pressure ulcers.
- In 2013, CDC published the first comprehensive, cross-agency children's mental health surveillance (MMWR) report and convened a Children's Mental Health Forum with stakeholders to determine core directions and the scope of work for children's mental health at CDC. The resulting report is helping guide programmatic plans.
- More than 240,000 people have participated in the ACL Chronic Disease Self-Management Program.

- The Office of Civil Rights has entered into significant case resolution agreements with major health care providers to ensure that people who are deaf or hard of hearing have equal access to the health program through the provision of accessible health information.
- In January 2014, CMS published a regulation ensuring that individuals receiving home and community-based services have full access to the community and the right to dignity, privacy and respect in their home, and that states provide a person-centered planning process focused on the requests and needs of the individual thereby facilitating the integration of the social, emotional and medical aspects of an individual's life. CMS expects these regulations to improve access to employment, access to services, and coordination of services while allowing states a five-year period to bring these settings into compliance.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

Goal 3. Objective D: Promote prevention and wellness across the lifespan

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

Across HHS agencies including ACF, ACL, AHRQ, CDC, FDA, HRSA, IHS, NIH, OASH and SAMHSA contribute to prevention and wellness. For example, FDA has committed to increasing compliance with tobacco products regulations. IHS is striving to reduce heart disease among American Indian and Alaska Native patients. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 3.D Table of Related Performance Measures

Reduce the annual adult combustible tobacco consumption in the United States (cigarette equivalents per capita) (Lead Agency - OASH; Measure ID - 1.5)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target		Set Baseline	1,259 per capita	1,212 per capita	1,174 per capita	N/A[67]
Result		1342 per capita	1,277 per capita	Jul 31, 2015	Jul 31, 2016	N/A
Status		Historical Actual	Target Not Met	Pending	Pending	N/A

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	20.5 %	20 %	19 %	18 %	17 %	16 %
Result	19 %	18.1 %	17.8 %	Nov 30, 2015	Nov 30, 2016	Nov 30, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	18.9 %	18.6 %	18.2 %	N/A	15.7 %	N/A
Result	18.1 %	14 %[68]	15.7 %[69]	N/A	Jun 30, 2016	N/A
Status	Target Exceeded	Target Exceeded	Target Exceeded		Pending	

[67] This measure is a FY 2014 – 20 15 Agency Priority Goal; consequently it is currently uncertain if it will be maintained beyond FY 20 15.

[68] NYTS data, which captures youth smoking prevalence in the interim years of YRBSS reporting.

[69] YRBS data. CDC discontinued use of NYTS data in FY 2014 for interim YRBS reporting years due to growing variance in data reported between the two data sets

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	84,000	75,000	100,000	105,000	110,000
Result	24,419	87,455	109,908	124,296	Jan 31, 2016	Jan 31, 2017
Status	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	50.4%[70]	55.9%	50%	50%	Discontinued	Discontinued
Result	85%[71]	88%	76%[72]	Dec 31, 2015	N/A	N/A
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Not Collected	Not Collected

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	555,132	555,132	555,132[73]	765,638[74]	989,994	1,308,825
Result	765,638	884,536	1,061,204	1,308,825	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	62.3 %	68.4 %	63.1 %	63.1 %	66.1 %	66.1 %
Result	67.4 %[75]	66.7 %	66.1 %	66.0 %	Dec 31, 2015	Dec 31, 2016
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending

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

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

[72] Includes Cohorts 4 and 5 state and DC grantees based on pooled 2011/2012–2012/2013 state estimates. Virginia was suppressed due to low precision.

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

[74] Target adjusted to reflect 2011 actual.

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

Increase the percentage of Early Head Start children completing all medical screenings. (Lead Agency - ACF; Measure ID - 3.6LT and 3B)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	92 %	93 %	93 %	93 %	93 %	93 %
Result	85.7 %	85.9 %	84.3 %	83.1 %	Jan 31, 2016	Jan 31, 2017
Status	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Target Not Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	N/A	32.3 %	51 %	47.3 %	53.3 %
Result	32.8 %	37.5 %	46.7 %	52.3 %	Sep 30, 2015	Sep 30, 2016
Status	Historical Actual	Historical Actual	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

Smoking and second hand smoke kills an estimated 480,000 people in the U.S. each year. For every smoker who dies from a smoking-attributable disease, another 30 live with a serious smoking-related disease. Smoking costs the U.S. $133 billion in direct medical costs and more than $156 billion in lost productivity each year. An estimated 88 million nonsmoking Americans are exposed to secondhand smoke, which causes an estimated 7,330 lung cancer deaths and more than 33,900 heart disease deaths in nonsmoking adults each year. The Department's comprehensive tobacco control strategy, *Ending the Epidemic – A Tobacco Control Strategic Action Plan*, is designed to mobilize HHS's expertise and resources in support of proven, pragmatic, achievable actions that can be aggressively implemented at the federal, state, and community levels to reduce the incidence of smoking. HHS experienced challenges in the first year of this new Priority Goal. The annual adult combustible tobacco consumption in the United States failed to meet the target of 1,259 cigarette equivalents per capita in FY 2013.

However, HHS did make positive progress in other related measures. Two complementary efforts by the CDC also target smoking reduction in two populations, adults (18 and over) and adolescents (grade 9 – 12). The percentage of current adult smokers decreased to 17.8 percent in FY 2013, exceeding the target. The FY 2013 result for teen smokers (15.7%) represents the lowest teen smoking rate ever recorded with the Youth Risk Behavior Surveillance System (YRBSS) since data collection began in 1991. Because YRBSS data is only available every other year, CDC sought to glean data in the interim years with data from the National Youth Tobacco Survey (NYTS). NYTS data tracked closely with YRBSS data until FY 2012 results showed an unacceptable variance. Therefore, the YRBSS will once again be the sole data source for CDC reporting of teen smoking rates as of FY 2014. FDA's fights adolescent smoking with its program to conduct compliance checks to assure that retailers refuse sales of tobacco to adolescents under the age of 18. In FY 2014, under contracts with 45 states and territories, FDA conducted 124,296 compliance check inspections of retail establishments, substantially exceeding its target. Although this was a much higher number than expected, it reflects the high level of variability inherent in this goal requiring the estimation of the number of compliance checks that each state will be able to conduct.

Underage drinking has been linked to a number of mental and physical health problems. The Strategic Prevention Framework State Incentive Grant (SPF SIG) program, managed by SAMHSA, provides funding to states, federally recognized tribes, and U.S. territories to support local communities in preventing the onset and progression of substance abuse and substance abuse-related problems including underage drinking. Targets have been exceeded each year. For FY 2013, 76 percent of the states in the program reduced their rates of underage drinking. This represents a decline from the previous year, possibly in part because Virginia was suppressed from the result due to low precision of data. This measure is being retired as an APP/R measure and discontinued in FY 2015.

Another significant cause of early death in the U.S. is suicide. The National Center for Health Statistics (CDC) reported in 2013 there were 41,149 suicides, ranking as the 10th leading cause of death among persons ages 10 years and older nationally. The National Suicide Prevention Lifeline (Lifeline), sponsored by SAMHSA, routes callers from anywhere in the U.S. to the closest certified crisis center within Lifeline's network of more than 150 centers. Trained counselors provide crisis counseling, link callers to emergency services, and offer behavioral health referrals. SAMHSA has increased efforts to promote Lifeline broadly to the public, in order to enhance awareness of this resource. The success of this outreach effort is reflected in the 1,308,825 calls answered in FY 2014, an increase of almost 250,000 over the previous year. Targets have been exceeded each year.

In addition to suicide prevention, SAMHSA works through multiple programs to support those adults who may be severely mentally ill and homeless. A significant portion of persons who are chronically homeless have mental and/or substance use disorders. Grants under the Homelessness Prevention and Housing Programs initiative are awarded to organizations that assist severely mentally ill adults who are homeless or at risk of becoming homeless in gaining access to sustainable permanent housing, treatment, and recovery support. A measure of the performance of these grantees is the self-reported sense of positive functioning by the individual 6 months after beginning to receive homeless support services. In FY 2014, 66 percent reported improved functioning, exceeding the target. This was a result of a combination of factors including, but not limited to, grantees engaging and providing services to the population of focus in collaboration with community consortia, improved reporting, and support to grantees via technical assistance on housing, evidence based practices and other relevant topics.

ACF, through the Early Head Start program, aims to promote prevention and wellness early in the life span. For the 2013-2014 program year, 83.1 percent of Early Head Start program children completed medical screenings expected for their age, missing the target of 93 percent. The Early Head Start program underwent a large expansion under the American Recovery and Reinvestment Act, which resulted in expanded enrollment and many new programs. However, in the FY 2013-2014 program year, many Head Start and Early Head Start programs were still experiencing the effects of cuts from sequestration. Depending on when during the year programs are funded, some programs experienced the impact of sequestration during the FY 2012-2013 program year while others experienced the most of the impact from the reductions during the FY 2013-2014 program year. Data from the FY 2014 Program Information Report shows that relative to the prior year, Head Start had fewer staff, teachers and volunteers, which compromises the program's ability to support families in a range of areas, including supporting them in their efforts to complete medical screenings.

HHS manages a number of programs to reduce health disparities for minorities, including prevention and wellness. Modifying the following risk factors offers the greatest potential for reducing CVD morbidity, disability, and mortality: high blood pressure, high cholesterol, smoking tobacco, excessive body weight, and physical activity. IHS seeks to address these risk factors in patients 22 and older diagnosed with coronary heart disease by assessing all five of these risk factors. In FY 2014 the target

was 51 percent of coronary heart disease patients receiving all 5 assessments, a substantial increase over the previous year, and the result was 52.3 percent, exceeding that target.

Plans for the Future

In FY 2015 and beyond the Department will continue its efforts coordinated across a number of agencies to reduce smoking among all ages and populations. The annual adult combustible tobacco consumption measure is a new Priority Goal for FY 2014–2015 and HHS continues its commitment to reducing tobacco consumption through 2015. The focus of this goal was changed from cigarettes to combustible tobacco due to consumer preferences shifting to other products such as cigars and cigarillos. The FDA contributes to this cause by contracting with 45 states and territories to conduct tobacco regulation compliance check inspections of retail establishments. Although the FY 2013 result was a much higher number than expected, it reflects the high level of variability inherent in this goal that requires estimating the number of compliance checks that each state will be able to conduct. In addition, some of expiring contracts will need to be renewed in the next year to continue these efforts. Most states are expected to renew, however there are always factors that may prohibit them from doing so. Accordingly, the FY 2014 and FY 2015 targets consider these challenges but have still been increased.

The CDC will continue to support the National Tobacco Control Program (NTCP) in 50 states and the District of Columbia, eight territories/jurisdictions, eight tribal support centers, and six national networks. NTCP grants support evidence-based efforts by state, tribal and territorial health department to prevent initiation of tobacco use among young adults, promote tobacco use cessation, eliminate exposure to secondhand smoke, and identify and eliminate tobacco-related disparities. It will also provide national leadership for a comprehensive, broad-based approach to reducing tobacco use which involves: preventing young people from starting to smoke; eliminating exposure to secondhand smoke; promoting quitting; and, identifying and eliminating disparities in tobacco use among population groups. These are some of the efforts the CDC will employ to meet the future target for reduction of adolescent and adult smoking.

The SPF SIG program is eliminated in FY 2015 and grantees are being transitioned to the Partnerships for Success program.

The suicide hotline (Lifeline) has seen a yearly increase in calls answered, a trend that SAMHSA projects to continue. During FY 2013, SAMHSA awarded a new 3-year cooperative agreement with a continued focus on serving callers in distress, as well as expanding capacity of the Crisis Chat service for individuals seeking help online. The growth in average quarterly Lifeline calls can likely be attributed to the following: continued outreach and marketing of the National Suicide Prevention Lifeline service; wide distribution of the Lifeline number by third party organizations seeking to provide their clients with a 24/7 emergency resources; heavy promotion of the Lifeline through social media outreach on Facebook and other social media sites; and significant marketing and outreach to veterans of the Veterans Crisis Line, which also uses the 1-800-273-TALK (8255) Lifeline number. These efforts are expected to increase the number of calls answered in FY 2015 and 2016.

Through different initiatives and approaches, SAMHSA will continue to support those adults who may be severely mentally ill and/or struggling with other behavioral health issues while facing or being at risk of homelessness. SAMHSA expects to maintain performance in FY 2015 and 2016.

Despite the challenges to the Early Head Start program described above, ACF aims to achieve a target rate of 93 percent in FY 2015 and FY 2016. The Office of Head Start is in the process of developing a toolkit for programs to assist them in the tailored use of an online, web-based Well Visit Planner, which is a free online pre-visit planning tool designed to engage parents in planning for and partnering more fully in their child's well visit. Studies continue to show gaps in the quality of well-child care. Improving care means improving communication and partnerships with parents and meeting the unique needs and priorities of each child and family.

The CVD Risk Assessment measure logic used in the IHS measure addressing coronary heart disease in American Indian and Alaska Native populations was revised in FY 2013. Performance for this program is expected to decline in FY 2015 and then increase in FY 2016 from continued efforts by IHS to promote the Million Hearts Initiative at the regional and local levels.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- ACL's Administration on Aging (AoA) developed a graduated set of criteria for evidence-based interventions. The goal has been for all OAA Title III-D activities to move toward the highest-level criteria. Beginning in October 2016, Title III-D funds will only be used on health promotion programs that meet AoA's highest-level criteria. Several states targeted having 100 percent of their Title III-D funding for programs meeting the highest-level criteria by 2015. As of March 2014, two states (Florida and Georgia) have certified that they are using 100 percent of their Title III-D funds for programs meeting only the highest-level criteria.

- In 2012, the CDC's Tips I campaign generated 365,194 calls (207,519 additional calls and a 132 percent increase) to 1-800-QUIT NOW compared to corresponding weeks in 2011, resulting in an estimated 1.6 million new quit attempts among U.S. adult smokers. More than 200,000 Americans had quit smoking immediately following the three-month campaign, of which more than 100,000 will likely quit permanently. A preliminary analysis of the Tips II campaign's impact showed that calls to the national quitline increased by 75 percent, and the number of unique visitors to the campaign website increased almost 40-fold. In 2014, CDC launched Tips III in two phases. The first nine week phase (February 3—April 6) generated more than 250 news stories in print, broadcast, and online media, reaching an audience of more than 276 million people and generating over $230,000 in advertising value. A second nine week broadcast was launched on July 7.

- The HRSA Health Center Program promotes prevention and wellness through education, counseling, and treatment. Tobacco use, the most preventable cause of death and disease in the United States, is a key focus of these efforts. The most recent national data (2012) show that among health center patients age 18 years and older who are tobacco users, 57.6 percent have received cessation advice or medication (compared to 52.7 percent in 2011).

- An evaluation was conducted of the SAMHSA Minority AIDS Initiative-Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services grants. The proportion of program participants across the different target populations that increased HIV knowledge from baseline to exit increased by 10.9 percentage points. Increases in HIV

knowledge was most common among adolescent participants ages 12-17 years with 13.2 percent increasing HIV knowledge from baseline to exit. Black, Latina, and Hispanic women showed the next highest increases with 11.4 and 12.2 percent of participants increasing HIV knowledge from baseline to exit, respectively.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

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

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

Within HHS, components such as CDC, FDA, and NIH lead efforts toward reducing the occurrence of infectious diseases. Other HHS components and offices that contribute to combatting infectious diseases include ASPR, HRSA, IHS, NIH, OASH, and OGA. HHS will use a variety of approaches to reduce the occurrence of infectious diseases. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 3.E Table of Related Performance Measures

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

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Target	2.3 cases/100,000	2.2 cases/100,000	2.1 cases/100,000[76]	2.0 cases/100,000	1.9 cases/100,000	1.9 cases/100,000
Result	3.0 cases/100,000	2.6 cases/100,000	2.6 cases/100,000	Jul 31, 2015	Jul 31, 2016	Jul 31, 2017
Status	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Pending	Pending	Pending

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

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	90 %	90 %	90 %	90 %	90 %	90 %
Result	92 %	91 %	92 %	Sep 30, 2015	Sep 30, 2016	Sep 30, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	Set Baseline	47 %	50 %	53 %	56 %
Result	41 %	39 %	42 %	Sep 30, 2015	Sep 30, 2016	Sep 30, 2017
Status	Historical Actual	Baseline	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	27.4 %	26.3 %	24.9 %	21 %	19.1 %	18.9 %
Result	24.9 %	24 %	Nov 30, 2015	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018
Status	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

Increase the number of adults and children internationally with advanced HIV infection receiving antiretroviral therapy (ART). (Lead Agency - CDC; Measure ID - 10.A.1.5)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Set Baseline	N/A	2,813,684	3,310,618	4,796,000[77]	5,287,000[78]
Result	1,941,177	2,620,177	3,623,255	4,292,400	Dec 31, 2015	Dec 31, 2016
Status	Baseline	Target Not In Place	Target Exceeded	Target Exceeded	Pending	Pending

[77,78] 2015 and 2016 targets and results reflect the revised PEPFAR definitions of support that were implemented in January 2014. The numbers include individuals who receive PEPFAR/CDC support at direct service delivery sites and technical assistance for service delivery improvement sites

Reduce the incidence (per 100,000 population) of healthcare-associated invasive Methicillin-resistant Staphylococcus aureus (MRSA) infections (Lead Agency - CDC; Measure ID - 3.3.2a)[79]

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	N/A	Set Baseline	13.53	12.18	10.83[80]	10.83
Result	20.06	18.74	18.34[81]	Nov 30, 2015	Nov 30, 2016	Nov 30, 2017
Status	Historical Actual	Baseline	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	1.8 per 100,000	1.7 per 100,000	1.7 per 100,000	1.5 per 100,000	1.2 per 100,000	1.2 per 100,000
Result	1.4 per 100,000	1.4 per 100,000[82]	1.2 per 100,000	Sep 30, 2015	Sep 30, 2016	Sep 30, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	74.6 %	77.8 %	Set Baseline	74.8 %	73.9 %	76.8 %
Result	75.9 %[83]	76.8 %	74.8 %[84]	75.4 %	Sep 30, 2015	Sep 30, 2016
Status	Target Exceeded	Target Not Met but Improved	Baseline	Target Exceeded	Pending	Pending

Analysis of Results

Salmonella is the leading known cause of bacterial foodborne illness and death in the United States. Each year, food contaminated with Salmonella causes an estimated 1.2 million illnesses and between 400 and 500 deaths. Salmonella Enteritidis (SE), a subtype of Salmonella, is the second most common type of Salmonella and accounts for approximately 20 percent of all Salmonella cases in humans. The most significant sources of foodborne SE infections are shell eggs (FDA-regulated) and broiler chickens (USDA-regulated). To significantly reduce foodborne illness and death, the FDA and CDC have joined

[79] The incidence is calculated by dividing the number of infections over the number in the surveillance population.

[80] New baseline will be established in 2015 per the updated HHS HAI Action Plan and measure methodology will be revised to be more nationally representative

[81] Final data will be available by January 31, 2015.

[82] Preliminary

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

[84] In FY 2013 this measure changed to match the revised CDC Immunization Schedule and Healthy People 2020 measures; therefore, results will differentiate the use of the 3 or 4 dose Hib vaccine for individual patients. CDC identifies the new measure as 4313*314 with the 3* representing the Hib vaccine. In previous years, CDC did not make a distinction between the 3 or 4 dose vaccine. Individual sites will continue to use their choice of 3 doses or 4 doses of Hib.

forces and made the reduction of SE infections attributable to shell eggs a Priority Goal for FY 2015. The illness rate from calendar year 2013 was 2.6 illnesses per 100,000. The rate has decreased over the last few years, but is still above the yearly targets. However, if the rate continues to decrease at the present rate, it is possible we could meet the target before 2015. Eggs are not the only source of SE illnesses; chicken is also a major source, and there are other sources as well.

CDC works to tackle the biggest health problems causing death and disability in America. For young children this means promoting immunization coverage for recommended vaccines. Prior to wide-spread immunization nearly all children in the U.S. came down with the measles and about 500 people a year would die, 48,000 would be hospitalized, 7,000 had seizures, and about 1,000 suffered permanent brain damage or deafness. CDC exceeded its target with 92 percent of children 19 to 35 months of age receiving MMR vaccination.

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

More than 1.1 million people in the United States are living with HIV infection, and almost 1 in 6 (15.8 percent) are unaware of their infection. Prior to 2012, CDC tracked the percentage of people diagnosed with HIV infection at earlier stages of disease (not CDC stage 3: AIDS). From 2007-2010, the percentage of people identified at earlier stages of disease steadily improved to almost 56 percent. Per the HHS Secretary's memo (April 2012) on implementing a common set of core indicators across federal agencies, CDC has revised this indicator definition to conform to a new cross–agency definition. FY 2012 data indicates that 24 percent of persons diagnosed with HIV were diagnosed late in the course of infection, an improvement over 2011 results and exceeding the target. CDC also tracks the number of adults and children internationally in 23 countries included in the President's Emergency Plan for AIDS Relief (PEPFAR) with advanced HIV infection receiving antiretroviral therapy (ART). In FY 2014, CDC and CDC-supported partners in the PEPFAR countries and the Asia and Central Asia regional offices, in close collaboration with the Ministry of Health in each country, provided life-saving antiretroviral therapy (ART) for 4,292,400 HIV-infected adults and children (of which, 2,995,300 are receiving direct support and an additional 1,297,100 are benefiting from essential technical support provided by CDC), an 18 percent increase compared to FY 2013 and a 63 percent increase compared to FY 2012, exceeding the target.

In alignment with HHS *National Action Plan to Prevent Healthcare-Associated Infections*, CDC has developed guidelines and plans to reduce infections associated with healthcare settings, including but not limited to invasive Methicillin-resistant Staphylococcus Aureayus (MRSA) infections. Preliminary data show that the national incidence of healthcare-associated invasive MRSA infections (hospital onset and invasive healthcare-associated MRSA in other healthcare settings, such as dialysis centers), decreased 32 percent between CY 2008 and CY 2013 (final data pending until January 31, 2015).

Another condition the CDC is actively addressing in a collaborative manner includes tuberculosis (TB). Effective control efforts by CDC and its 68 state and local partners contributed to the lowest number of U.S. Tuberculosis (TB) cases since national reporting began in 1953. Data indicate 9,582 cases in 2013,

or 3.0 per 100,000 population and 1.2 for U.S. born population. Reflecting program effectiveness, the United States consistently ranks among the lowest TB incidence countries in the world.

In other areas related to decreasing infectious diseases, IHS is measuring the percentage of American Indian and Alaska Native children 19 to 35 months of age receiving a combined series of immunizations consistent with the CDC's Advisory Committee on Immunization Practices standards and schedule that includes coverage for diphtheria, tetanus, whooping cough, polio, measles, mumps and rubella, Hepatitis B, influenza, chicken pox and pneumonia. The childhood combined immunization series was updated in FY 2013 in accordance with the revised *Healthy People 2020* and CDC childhood immunization guidelines; therefore, subsequent results will differentiate the use of the 3 or 4 dose Hib vaccine for individual patients. As a result of this change in immunization schedule, the FY 2013 result set a new baseline of 74.8 percent. The 2014 result of 75.4 percent exceeded the target by 0.6 percent.

Plans for the Future

Because the current Priority Goal measure for reducing Salmonella Enteritidis (SE) infections includes all infections related to chickens, determining which infections are attributable to shell eggs (as opposed to broiler chickens) makes it difficult to determine whether the FDA's egg rule is having the desired effect of reducing the likelihood that contaminated shell eggs are the cause for a particular infection. CDC is working with FDA to explore the use of multiple statistical approaches to estimate source attribution. In particular, CDC and FDA are working to obtain data suitable for a "food product" model used in other countries to link contamination rates in foods to illness incidence. The FDA will continue inspections of large and small egg producers, while continuing to refine its egg rule enforcement policies with straightforward inspection, re-inspection, and warning strategies, aiming to reduce Salmonella Enteritidis infections each year through 2015.

Immunization continues to be one of the most cost-effective public health interventions. CDC supports immunization efforts nationwide such as maintaining infant measles, mumps, and rubella immunization coverage at 90 percent. To combat influenza in FY 2014 - 2016, the CDC has set a target of increasing the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza to 56 percent. Consistent reductions year over year are expected in the proportion of persons with an HIV diagnosis at later stages of disease within three months of diagnosis, monitoring the effectiveness of efforts to decrease the number of domestic HIV infections diagnosed at later stages of disease. In addition, in FY 2015 and FY 2016 the number of adults and children internationally with advanced HIV infection receiving antiretroviral therapy is expected to increase. The CDC will continue to maintain effective control efforts with its 68 state and local partners contributing to the low and declining tuberculosis rates in the U.S. For other infectious diseases such as MRSA infections, CDC's FY 2016 targets are currently flat to FY 2015 targets since CDC is in the process of revising the MRSA measure to be more nationally representative.

IHS, beginning in FY 2013, updated its childhood combined immunizations series in accordance with the revised CDC Immunization Guidelines and Healthy People 2020. IHS expects performance to improve in FY 2016 setting a target of 76.8 percent. IHS works through the twelve Area Immunization Coordinators to ensure that IHS meets or exceeds the childhood combined immunizations measure.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- In 2013, NIH released a Strategic Plan that outlined several research activities to address a growing public health concern. The newly NIH-funded "Clinical Research Network on Antibacterial Resistance," a consortium of more than 20 investigators nationwide with experience in diverse areas related to antibacterial resistance, will conduct early-stage clinical evaluation of new antibacterial drugs, perform clinical trials to optimize currently licensed antibacterial drugs to reduce the risk of resistance, test diagnostics, and examine best practices in infection control programs to prevent the development and spread of resistant infections.

- In FY 2013, accomplishments of the CDC's Viral Hepatitis Action Plan included:

    - The release of new US Preventive Services Task Force hepatitis C testing recommendations with a grade B in alignment with CDC hepatitis C testing recommendations released in 2012

    - Renewed commitment and update of the Viral Hepatitis Action Plan for 2014-2016.

    - Hosting the launch of the Know Hepatitis B campaign in collaboration with the CDC and White House Initiative for AAPIs.

    - Dissemination of a letter from the Directors of Civil Rights from the Departments of Justice, Health, & Education to all schools of medicine, dentistry, nursing, and allied health professions regarding the updated CDC guidelines for the Updated CDC Recommendations for the Management of Hepatitis B Virus-Infected Health-Care Providers and Students in response to cases of discrimination against individuals with hepatitis B.

    - Conducting a multidisciplinary, technical consultation on HCV in Persons Who Inject Drugs (PWID), producing a report with recommendations for action, and increasing awareness and federal coordination.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

Goal 3. Objective F: Protect Americans' health and safety during emergencies, and foster resilience to withstand and respond to emergencies

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

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

Within HHS, improving health security is a shared responsibility. ASPR serves as the Secretary's principal advisor on matters related to bioterrorism, public health emergencies, and also coordinates interagency activities between HHS, other partners, and officials responsible for emergency preparedness and protection of the civilian population. ACF, ACL, AHRQ, ASA, ASPR, CDC, CMS, FDA, HRSA, NIH, OASH, OCR, and SAMHSA have a role in supporting emergency preparedness. The table below includes performance measures that are indicative of HHS activities to improve the health and safety of Americans during emergencies. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Goal 3.F: Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Awards contracts for advanced development of recombinant-based influenza vaccines. Initiate clinical study to determine the safety of an anthrax vaccine. Issue RFP to establish Centers of Innovation for Advanced Development and Manufacturing Issue RFP to establish a network of domestic vaccine and biologics manufacturers	CBRN Licensed= 0; EUA= +1; Pan Flu/EID Licensed= +1; EUA= 0	CBRN Licensed= +0; EUA= +3; Pan Flu/EID Licensed= +3; EUA= +0	CBRN Licensed= +2; EUA= +; Pan Flu/EID Licensed= +2; EUA= +0	Increase the number of new CBRN and emerging infectious disease medical counter-measure under EUA or licensed FY 2015 Target: CBRN: Licensed= +4; EUA= +2. Pan Flu/EID: Licensed= +5; EUA= +3	Increase the number of new CBRN, pan flu, and EID MCMs. CBRN Target: Licensed= +2; EUA= +5. Pan Flu/EID Target: Licensed= +2; EUA= +3

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Result	Awarded contract for Recombinant-based flu vaccines. Started large clinical studies to evaluate safety H5N1 vaccines. Issued RFP to establish Centers of Innovation for Advanced Development and Manufacturing. Proposals received and are under evaluation. Issued RFI to discern the capabilities of US vaccines and biologics manufacturing, which will inform the subsequent RFP.	**Target: EUAs= +1;** CBRN EUA= 1 anti-neutropenia cytokine drug for acute radiation treatment (Neupogen) Flu EUA = 4 Pre-EUA packages submitted to FDA by BARDA on H5N1 vaccines BLA Submissions= 3: (cell-based seasonal and H5N1 influenza vaccines – 2 and botulinum antitoxin - 1) **Pan Flu/EID Licensed= +1;** Licensures = 1: Influenza point-of-care diagnostic device (Simplexa) Awarded 3 contracts establishing the Centers for Innovation in Advanced Development	**CBRN EUA= 2;** ST-246 antiviral for smallpox approved by FDA for EUA and Neupogen an anti-neutropenia cytokine for radiation treatment. 2 other packages were submitted but not acted on during the performance period. **Pan Flu licensed=3**; Licensed by FDA are: 1) Flucelvax, the first cell0based seasonal influenza vaccine, 2) FluBlØk, the first recombinant-based seasonal influenza vaccine, and 3) Aura, a next generation portable ventilator for adults. While not part of the goal, BARDA saw the first anthrax	**CBRN EUA= 3;** ST-246 antiviral for smallpox became accessible and Neupogen and Leukine, anti-neutropenia cytokines for radiation treatment under EUA by FDA. Another package (Neulasta) was submitted but not acted on during the performance period. **CBRN licensed = 2;** Licensed by FDA are 1) Raxibacumab, the first anthrax antitoxin, and 2) HBAT, the first botulinum antitoxin. Both projects were supported by Project BioShield and approved under the FDA's Animal Efficacy Rule. **Pan Flu licensed=5**; Licensed by FDA are: 1) Flucelvax, the first cell-based seasonal influenza vaccine, 2)	Pending	Pending

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
		and Manufacturing (CIADM) Issued RFP to establish domestic network of fill finish manufacturers for pandemic influenza and drug shortages.	antitoxin and the first botulinum antitoxin licensed by FDA. Both projects were supported by Project BioShield and approved under the FDA's Animal Efficacy Rule.	FluBlØk, the first recombinant-based seasonal influenza vaccine, 3) QPAN H5N1 vaccine, the first adjuvanted pandemic influenza vaccine in the U.S. 4) Aura, a next generation portable ventilator for adults, 5) Simplexa, PCR-based point-of-care diagnostic for influenza and respiratory syncytial virus, and 6) Rapivab (peramivir), the first intravenously-administered single dose influenza antiviral drug; had been available under EUA previously		
Status	Target Met	Target Met	Target Not Met but Improved	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Apply novel technologies, including mass spectrometry, to quantify the absolute amount of hemagglutinin in the reference standards that are used to determine influenza vaccine potency.	Evaluate and compare new methods to determine the potency of influenza vaccines.	Develop and evaluate new methods to produce high-yield influenza vaccine reference strains	Continue evaluation of new methods to produce high-yield influenza vaccine reference strains	Continue evaluation of new methods to produce high-yield influenza vaccine reference strains.	Evaluate new methods to character-ize influenza vaccines.
Result	The studies were delayed in FY 2011 awaiting the delivery of required equipment. In FY 2011, CBER did complete preliminary studies to evaluate the use of mass spectrometry to determine the absolute amount of hemagglutinin in reference standards and define initial sample conditions. (Target not met but improved)	In FY 2012 CBER met the goal by evaluating three new methods for the determination of influenza vaccine potency. These methods (ELISA using monoclonal antibodies to capture antigen, Surface Plasmon Resonance, and label-free, antibody-free mass spectrometry) were used to measure the potency of inactivated influenza vaccines from several manufacturers. In each case, the results demonstrated the potential of each method and indicated that further development and evaluation was warranted.	In FY 2013, CBER met the target to develop and evaluate new methods to produce high-yield influenza vaccine reference strains. Activities to meet this target include: • Evaluated multiple assays to determine the best methods for assessing vaccine reference strain yield. • Further modifications were made to previously developed influenza vaccine reference strains for the 2009 H1N1 pandemic strain, which is now included in the seasonal vaccine. • Developed one new influenza reference strain as a possible vaccine candidate	In FY 2014, FDA met the target to develop, evaluate, and standardize new methods to produce high-yield influenza vaccine reference strains. Activities to meet this target include the following: • FDA continued evaluation and standardization of multiple assays, such as total viral protein yield and HA antigen by HPLC-based analysis. In addition, FDA included a new technology, Virus Counter platform, to quantify the virus particles in the virus preparation.	Dec 31, 2016	Dec 31, 2017

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
			for the H7N9 influenza virus that emerged in China during 2013.	• FDA developed a H7N9 influenza vaccine candidate virus. The vaccine candidate virus was optimized by introduction of targeted mutations in the viral genome to increase its protein yield, measured using the methods described above.		
Status	Target Not Met but Improved	Target Met	Target Met	Target Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem
Result	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	Dec 31, 2015	Dec 31, 2016
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	83 %	91 %	94 %	95 %	95 %	95 %
Result	87 %	89 %	98 %	Dec 31, 2015	Dec 31, 2016	Dec 31, 2016
Status	Target Exceeded	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

Analysis of Results

HHS is expanding diagnostic, preparation, response, and treatment options to deal with both natural and man-made disasters. To do this, both the FDA and ASPR are striving to have more options available

to handle a crisis. For example, through the Office of Biomedical Advanced Research and Development Authority (BARDA), ASPR is working to increase the development of medical countermeasures for pandemic influenza as well as chemical, biological, radiological, and nuclear agents through public-private partnerships. The intent is to develop countermeasures, facilitate licensure of these producers, and build domestic countermeasure manufacturing capacity to address these threats. The establishment of three Centers for Innovation in Advanced Development and Manufacturing in the U.S. in 2012 has greatly impacted the nation's ability to produce vaccine. A two-fold increase in our domestic pandemic influenza vaccine manufacturing surge capacity was realized in 2013 with the commercial scale production of H7N9 vaccines at Novartis' cell-based vaccine manufacturing facility in North Carolina, which became a CIADM in 2012. In FY 2014, the program exceeded its target its target, producing 3 EUA and 2 licensed medical countermeasures in the CBRN area and 5 licensed products in the pandemic influenza portfolio.

In March 2013, the first human cases of the novel avian influenza strain, H7N9, were reported in China. As of January 2014, 237 cases have been identified, including 58 deaths. Although H7N9 has not yet reached the United States, scientists have indicated that this strain poses a significant threat. Fortunately, lessons learned from the 2009 H1N1 pandemic have brought about improvements in response and coordination between agencies across the Department, including ASPR/BARDA, CDC, NIH, and FDA. For example, new cell- and recombinant-based influenza vaccines, generated by the need identified in the H1N1 response, have been licensed for use. Also technology improvements in vaccine development and manufacturing have streamlined vaccine seed production, which has provided the ability to develop influenza vaccines quicker. Partnerships with private industry, such as the Centers of Innovation and for Advanced Development and Manufacturing, allowed the Department to quickly pivot and expand capacity for the development and manufacturing of H7N9 vaccines for stockpiling. BARDA has also established the Fill-Finish Network, which is intended to boost the nation's ability to provide influenza vaccine domestically. Should large-scale distribution of a H7N9 vaccine be necessary, BARDA will be able to engage this network, which is anticipated to increase existing capacity by 20 percent.

The FDA is diversifying flu vaccine production and increasing laboratory surge capacity for testing potentially contaminated foods. The FDA seeks to ensure continued progress in preparation for new influenza strains, to strengthen vaccine safety monitoring, and to advance the detection of possible adverse events of new licensed vaccines through the use of large population databases. As a result, the FDA achieved its FY 2014 target to develop, evaluate, and standardize new methods to produce high-yield influenza vaccine reference strains. Activities to meet this target include the following: FDA continued evaluation and standardization of multiple assays; FDA included a new technology, Virus Counter platform, to quantify the virus particles in the virus preparation; and FDA developed a H7N9 influenza vaccine candidate virus. Also, in the event of a terrorist attack on the food supply, the FDA seeks to increase its ability to rapidly test large numbers of samples of potentially contaminated foods through a focus of laboratory capacity, achieving its target every year since 2010.

The CDC is helping public health agencies rapidly convene key management staff (within 60 minutes of being notified of an emergency) so that they can integrate information, prioritize resources, and effectively coordinate with key response partners. Since FY 2009, the CDC's 62 grantees (which include states, territories and four major metropolitan U.S. cities) that successfully convened key staff within 60 minutes of notification increased from 68 percent to 98 percent in FY 2013, exceeding the target. CDC will continue to work with grantees to improve results and achieve future targets.

Plans for the Future

For FY 2015, ASPR plans to continue manage the procurement and advanced development of medical countermeasures for chemical, biological, radiological, and nuclear agents (referred to as CBRN); Project BioShield procurements; and the advanced development and procurement of medical countermeasures for pandemic influenza and other emerging infectious diseases, with acquisitions to meet the requirements.

The FDA is planning to maintain laboratory surge capacity for potentially contaminated foods in FY 2015 to perform analysis on at least 2,500 radiological samples and 2,100 chemical samples per week. This effort will have public health value even in non-deliberate food contamination situations because contaminated food products will be identified and removed from the marketplace more quickly. The FDA will also continue to evaluate new methods to produce high-yield influenza vaccine reference strains, to build capacity to respond to seasonal influenza and potential pandemics.

The CDC will work to increase the percentage of public health agencies that can assemble, make key decisions, and quickly respond during an emergency. Because many emergencies provide little to no notice but still require a rapid response, the CDC will continue focusing on improving the percentage of grantees who can convene key staff within 60 minutes of notification, maintaining a goal of 95 percent in FY 2014 - 2016.

Objective Progress Update Summary

The U.S. Department of Health and Human Services, in consultation with the Office of Management and Budget, has determined that performance toward this objective is making noteworthy progress. This progress is demonstrated by the representative performance measures associated with this objective and described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- With the help of the Assistant Secretary for Preparedness and Response's (ASPR) Biomedical Advanced Research and Development Authority (BARDA) and Project BioShield, our nation has acquired 12 medical countermeasures (MCM) against chemical, biological, radiological, and nuclear (CBRN) threats; pandemic influenza; and emerging infectious diseases. Almost half of these MCMs have a "peacetime" public health use. In addition, when a worrisome new avian influenza strain (H7N9) emerged in China last year, ASPR and its HHS partners supported rapid research, development, and stockpiling of vaccine should the strain ever reach the United States.

- In November 2013, the Food and Drug Administration approved the first adjuvanted vaccine for the prevention of H5N1 influenza, commonly known as avian or bird flu, which has been included within the Strategic National Stockpile for distribution by public health officials as needed.

- In response to the Elk River methylcyclohexanemethanol (MCHM) chemical release in January 2014, West Virginia's Laboratory Response Network C Level-2 laboratory tested 581 drinking water samples in 30 days, mobilized its public health incident management system, and provided CDC Public Health Emergency Preparedness-funded epidemiology support to enhance public health security for West Virginia residents.

- HRSA, through its Office of Emergency Preparedness and Continuity of Operations and Bureaus/Offices, provided situational awareness and operational status information to federal and other entities related to the following: drought in the Midwest, tornado in Moore, OK, Hurricane Sandy, CDC influenza and immunizations alerts, and the Charleston, WV chemical release.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands. HHS evaluated the performance of this objective prior to recent notable events involving global health response (such as Ebola) and will reassess this objective as part of the next Strategic Review cycle. At that time subsequent performance will be taken into account and the performance rating will be reconsidered.

Goal 4. Objective A: Strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud, and integrating financial, performance, and risk management.

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

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

All agencies and offices in HHS are focused on ensuring the efficiency and integrity of HHS programs. In the table below are performance measures which focus on HHS plans for responsible stewardship. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 4.A Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	8,350 clients	8,600 clients	8,700 clients	8,600 clients	9,250 clients	8,700 clients
Result	8,881 clients	9,206 clients	9,753 clients	Dec 31, 2015	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	3.4	3.6	3.6	3.6	3.4	3.4
Result	4.2	4.1	4	3.9	Nov 9, 2015	Nov 8, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	0.6 %	0.7 %	0.7 %	0.6 %	0.8 %	Prior Result -0.1PP
Result	0.8 %	0.8 %	0.7 %	0.9 %	Jan 31, 2016	Jan 31, 2017
Status	Target Not Met	Target Not Met	Target Met	Target Not Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	4.7 %	4.5 %	6 %[85]	5.1 %[86]	5.3 %[87]	5.1 %[88]
Result	5.25 %	6.2 %	5.3 %	5.5 %	Oct 30, 2015	Oct 31, 2016
Status	Target Not Met	Target Not Met	Target Exceeded	Target Not Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	19 %	17 %	16 %	16 %	16 %	16 %
Result	16.23 %	16.07 %	15.85 %	Oct 30, 2015	Oct 31, 2016	Oct 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	13.7 %	10.4 %	10.9 %	9 %	8.5 %	8.1 %
Result	11 %	11.4 %	9.5 %	9 %	Nov 15, 2015	Nov 15, 2016
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Met	Pending	Pending

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

[86] The FY 2014 target for this performance measure has been revised in light of the most recent data trend.

[87] The FY 2015 target for this performance measure has been revised in light of the most recent data trend.

[88] The FY 2016 target for this performance measure has been revised in light of the most recent data trend.

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	8.5 %	5.4 %	8.3 %	9.9 %	12.5 %	11.5 %
Result	8.6 %[89]	8.5 %[90]	10.1 %	12.7 %[91]	Nov 15, 2015	Nov 15, 2016
Status	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Target Not Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	Report Baseline Composite Error Rate for the Part D program.	3.2%	3.1%	3.6%	3.5%	3.4%
Result	3.2%	3.1%	3.7%	3.3%	Nov 15, 2015	Nov 15, 2016
Status	Target Met	Target Exceeded	Target Not Met	Target Exceeded	In Progress	In Progress

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[92]
Target		Set Baseline	31 %	36 %	42 %	TBD
Result		27 %[93]	31.8 %	41.15 %	Nov 30, 2015	N/A
Status		Baseline	Target Exceeded	Target Exceeded	Pending	Target Not In Place

[89,90] In the FY 2012 Agency Financial Report (AFR), HHS refined its error rate estimation methodology to reflect activity related to the receipt of additional documentation and the outcome of appeals decisions that routinely occur after the cut–off date for the published AFR. The error rate and target for FY 2011 has been adjusted to reflect this revised methodology.

[91] On August 29, 2014, CMS announced that, to more quickly reduce the volume of inpatient status claims currently pending in the appeals process, CMS is offering an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68 percent of the net allowable amount). The settlement is intended to ease the administrative burden for all parties. Any claims in the sample that are included in a settlement will still be considered improper for the measurement.

[92] The FY 2015 results will be available in November 2015, at which time the FY 2016 target will be determined.

[93] 27% is the FY 2012 baseline for this goal calculated based on the result of leads at the end of the first year of the Fraud Prevention System (FPS) (July 2012). The targets for 2013 and 2014 are calculated by increasing the baseline by 15% each year.

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	8.4 %[94]	7.4 %[95]	6.4 %[96]	5.6 %	6.7 %	6.4 %
Result	8.1 %	7.1 %	5.8 %	6.7 %	Nov 15, 2015	Nov 15, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target		Report national error rates in the 2012 Agency Financial Report based on 17 CHIP States	Report rolling average error rate in the 2013 Agency Financial Report based on States reported in 2012-2013	Report rolling error rate in the 2014 Agency Financial Report	6.5%	6.4%
Result		8.2%	7.1%	6.5% Target Met	Nov 15, 2015	Nov 15, 2016
Status		Target Met	Target Met	In Progress	In Progress	In Progress

Analysis of Results

ACL addresses performance efficiency at all levels of the National Aging Services Network in the provision of home and community-based services, including caregiver services. Access to and quality of these home and community-based services is foundational to the success of AoA's programs. In FY 2013, the Aging Services Network served 9,753 clients per million dollars of OAA funding exceeding the target of 8,700. Performance has largely trended upward and performance targets have been consistently achieved.

As part of its program assessment, OMHA is evaluating its customer service through an independent evaluation that captures the scope of the Level III appeal experience. This measure will assure appellants and related parties are satisfied with their Level III appeals experience based on beneficiary survey results. OMHA is specifically seeking to assess the appellants experiences that characterize the administrative law judge hearing process, including: being informed of the hearing process and applicable rules; being informed of the status of their case; feeling there was a full opportunity to be heard and present their position; believing the decision was fair, regardless of whether they agree with the outcome. In FY 2014, OMHA achieved a 3.9 level of appellant satisfaction nationwide, exceeding the 3.6 performance target level. This result indicates the vast majority of appellants were either somewhat or very satisfied with OMHA services, from initiation of cases through closure, as well as with the

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

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

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

hearing formats used to adjudicate their cases. However, appellant satisfaction scores have trended downward each year since FY 2011. If processing times are allowed to increase due to the influx of appeal receipts, it is certain that appellant's frustration with increasing processing times will grow and that their level of satisfaction with the process will decrease.

ACF continues to focus on improvements to reduce Head Start under-enrollment. Though each Head Start program is required to keep a wait list to fill vacancies as they occur, there are a number of reasons that it may be difficult to fill vacancies quickly. Low-income families are often mobile and eligible families on the waiting list may have moved out of the service area. In addition, as state pre-kindergarten programs have grown, parents may choose to send their children to those programs. The most recent data available indicate that, during the 2013-2014 program year, Head Start grantees had, on average, not enrolled 0.9 percent (0.88 percent) of the children they were funded to serve, missing the FY 2014 target of 0.6 percent. This represents approximately 8,200 children who could have been served using the Head Start funds appropriated and awarded to grantees.

ACF seeks to reduce erroneous payments in the title IV-E foster care program by estimating the national payment error rate and developing an improvement plan to strategically reduce, or eliminate where possible, improper payments. The national error rate is estimated using data collected in the most recent foster care eligibility review for each state. The FY 2014 Foster Care estimated national payment error rate is 5.5 percent. This represents an increase from the FY 2013 rate of 5.3 percent, although a drop by nearly one half from the FY 2004 baseline rate of 10.33 percent for the title IV-E foster care program. The increase in the error rate since FY 2013 is in part due to the fact that three states in the top third in terms of program size had error rate increases in the range of two to three percent this year. In particular, one state that ranks sixth in terms of program size tripled its (previously low) error rate, while two other states in the top ten in terms of program size reduced their error rates by less than one percent. Of the 15 states reviewed during the FY 2014 reporting period, nine had error rates below five percent; and six of those nine states had error rates below one percent. In contrast, three of the 15 states had error rates above 10 percent.

ACF strives to provide services to low income individuals and families through an efficient and cost effective delivery system through the Community Service Block Grant network. While states have an administrative cap of 5 percent, which limits the amount of funds that the state may retain for expenses, this ACF measure focuses on the administrative spending by sub-grantees. Historical trend data for this measure have fluctuated, with sub-grantees spending between 16 and 23 percent on administrative expenses. In FY 2013, 15.85 percent of CSBG sub-grantee funds were used for administrative costs, a slight decrease from the previous year's result of 16.07 percent and exceeding the FY 2013 target of 16 percent.

HHS employs a number of measures to track the performance of efforts to fight fraud and reduce improper payments. One of CMS's key goals is to pay claims properly the first time. The primary cause of improper payments is administrative and documentation errors, in large part due to insufficient documentation. CMS continues to develop new data analysis strategies and engage in provider and supplier education to prevent improper payments in Medicare Fee-for-Service. The Medicare Fee-for-Service improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) Program. The FY 2014 result, an error rate of 12.7 percent, was above the targeted level of 9.9 percent.

Medicare Advantage (MA) plans (Medicare Part C) are managed care plans that provide Medicare-covered services for beneficiaries who select to participate in the program. All Part C plans are paid a monthly per capita premium, and errors can occur in the transfer and interpretation of source data and

in payment calculations. CMS has implemented two key initiatives to improve payment accuracy in the Part C program: contract-level audits and new regulatory provisions that required that MA organizations must report and return overpayments that they identify and payment recover and appeal mechanism to be applied when CMS identifies erroneous payment data submitted by an MA organization. In FY 2014 results show that CMS has driven the error rate down to 9.0 percent, meeting the measure target.

The Medicare Part D Prescription Drug Program established an optional prescription drug benefit (Medicare Part D) for individuals who are entitled to or enrolled in Medicare benefits under Part A and Part B and for beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual-eligibles). The program also provides for assistance with premiums and cost sharing to full benefit dual-eligibles and other qualified low-income beneficiaries. The payment error rate for the Medicare Part D Prescription Drug Program was 3.3 percent in FY 2014, exceeding our target of 3.6 percent. The root cause of all improper payments in the Part D program reported in FY 2014 is administrative and documentation errors. CMS continues to pursue enhancements to address this issue and has national training sessions for Part D plan sponsors covering comprehensive information for Part D payment and data submission requirements.

CMS's Fraud Prevention System (FPS) uses sophisticated algorithms and computer modeling to identify providers whose behavior is aberrant and potentially fraudulent. This program seeks to increase the percentage of Medicare providers and suppliers identified as high risk that receive administrative action. CMS measures performance in this area by instances where a high risk provider had at least one administrative action (numerator) compared to the universe of high risk providers and suppliers (denominator). In FY 2014 the FPS exceeded its target, with 41.1 percent of high risk Medicare providers and suppliers receiving an administrative action. This approach reduces the burden on legitimate providers, while focusing the majority of the resources on those posing a high risk of fraud.

State Medicaid and CHIP programs, working with CMS, also have systems developed to identify, examine, track, and reduce the Medicaid and CHIP payment error rates. The Payment Error Rate Measurement (PERM) program measures improper payments in the fee-for service, managed care, and eligibility components of both Medicaid and CHIP. In FY 2013 CMS made enhancements to the rate calculation methodology to improve the accuracy of the Medicaid improper payment rate estimate. These improvements included replacing the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate and incorporating prior year state-level improper payment rate recalculations. The Medicaid Program did not meet its performance target with 6.7 percent payment error rate estimated, an increase from the previous year. CMS met its target for the CHIP performance indicator, with 6.5 percent estimate of payment errors, below the 7.1 percent reported the previous year.

Plans for the Future

ACL expects the targeted number of clients served for home and community-based services to vary between FY 2014 and FY 2016 as delayed effects of sequestration may occur. Recent performance improvements reflect the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers (ADRCs) and increased commitments and partnerships at the state and local levels have all had a positive impact on program efficiency.

Despite a growing backlog of cases, OMHA will continue to strive to meet customer expectations and maintain customer satisfaction levels.

Achieving full enrollment in Head Start programs can be difficult due to the wide variation in grantee size/type and changing community demographics; however by FY 2016, the program expects under-enrollment in Head Start programs to be 0.1 percentage point less than the FY 2015 actual result through continued program support and technical assistance. Error rates in the title IV-E foster care program have dropped. Of the 15 states reviewed during the FY 2014 reporting period, nine had error rates below five percent; and six of those nine states had error rates below one percent. In contrast, three of the 15 states had error rates above 10 percent. In light of recent performance, ACF has adjusted out-year targets and will continue to work with states to strengthen oversight of title IV-E eligibility and address payment errors in order to move toward the target of 5.3 percent for FY 2015 and 5.1 percent for FY 2016. Historical trend data for the CSBG administrative funds expended performance measure have fluctuated, with sub-grantees spending between 16 and 23 percent on administrative expenses. Given recent performance on this measure, ACF aims to meet a target level of 16 percent for fiscal years 2014 through 2016. To accomplish future targets, the ACF Office of Community Services (OCS) will continue to monitor and to provide training and technical assistance to CSBG grantees in the areas of cost effective program administration and organizational efficiency. In addition, OCS is supporting two Centers of Excellence that support organizational standards and performance management efforts. OCS plans to continue these efforts through FY 2016.

In order to protect the integrity of the Medicare Trust Fund, CMS must ensure that the correct Medicare payments are made to legitimate providers for covered, appropriate, and reasonable services for eligible beneficiaries. CMS will enhance its efforts to reduce improper payments for Medicare FFS and Medicare Parts C and D and continue to use predictive analytics to focus on areas where incidence or opportunity for improper payments and/or fraud is greatest, with the expectation that error rates will decline in FY 2015 and FY 2016 for Medicare Fee-for-Service and Part C. The target for Part D has been set at 3.5 percent for FY 2015 and 3.4 percent for FY 2016. In addition, through its efforts to use predictive techniques to reduce fraud, CMS will continue to focus its efforts to increase the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action.

CMS also plans to continue implementing effective corrective actions across states to decrease improper payments, including those associated with errors related to Medicaid and the Children's Health Insurance Program.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- CMS made significant progress using the Fraud Prevention System (FPS) to identify bad actors and take administrative action to protect the Medicare Trust Funds. In the second implementation year, which aligned with Fiscal Year 2013, CMS took administrative action against 938 providers and suppliers due to the FPS. The identified savings, certified by the OIG, associated with these prevention and detection actions due to FPS was $210.7 million, almost double the amount identified during the first year of the program. This resulted in more than a $5 to $1 return on investment, an increase from last year's $3 to $1 return.

- In 2013, CMS launched the Healthcare Fraud Prevention Partnership (HFPP) with the OIG within HHS, the U.S. Department of Justice, and the Federal Bureau of Investigation, private health insurance companies, and other health care and anti-fraud groups and associations to enhance the efficacy of CMS in identifying and preventing fraud, waste, and abuse in the Medicare and Medicaid programs.

- HHS encourages state Temporary Assistance for Needy Families (TANF) agencies to use employment data from the National Directory of New Hires to identify unreported and underreported income, thereby reducing improper assistance payments.

- In addition, ACF uses title IV-E Foster Care Eligibility Reviews to ensure program eligibility of foster care payment recipients.

- The Secretary has launched a Department-wide program integrity initiative to ensure that every program prioritizes risk management. Linking financial, programmatic, and performance data helps provide an unprecedented level of transparency and accountability and ensures program efficiency and effectiveness.

- Medicare Fee-for-Service (FFS) uses the Comprehensive Error Rate Testing (CERT) program to calculate the improper payment estimate. The factors contributing to improper FFS payments are complex and vary from year to year. Improper payment data garnered from the CERT program and other sources are used to reduce or eliminate improper payments through various corrective actions. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments for all categories of error. While some corrective actions have been implemented, others are in the early stages of implementation. CMS believes that focused corrective actions will have a larger impact over time as they become integrated into business operations. Corrective actions include final rules, policy changes and use and testing of prior authorization for certain payment types. For more information on corrective actions see the 2014 HHS AFR.

- In order to reduce the national Medicaid and Children's Health Insurance Program error rates, states are required to develop and submit corrective action plans (CAPs) to CMS. CAPs will focus on helping states comply with new system requirements, increasing provider communication and education to reduce errors related to missing or insufficient documentation and also targeting eligibility errors through the leveraging of technology and available databases to obtain eligibility verification information without client contact. CMS will also provide caseworker training and additional eligibility policy resources through a consolidated manual and web-based training. CMS has also implemented additional efforts to lower improper payments rates including provider outreach, mini-Payment Error Rate Measurement (PERM) audits, and best practice calls. For more information on corrective actions see the 2014 HHS AFR.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

Goal 4. Objective B: Enhance access to and use of data to improve HHS programs and support improvements in the health and well-being of the American people

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

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

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

The HHS Data Council coordinates health and human services data collection and includes the following HHS components: ACF, AHRQ, ACL, ASPE, CDC, CMS, FDA, HRSA, IHS, NIH, ONC, OASH, and SAMHSA. All HHS agencies support the access and use of data. Below are performance measures related to use of data to improve health outcomes and well-being. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 4.B Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	10 months	10 months	10 months	9.5 months	9.5 months	9 months
Result	10 months	10 months	10 months	9.5 months	Sep 30, 2015	Sep 30, 2016
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

Increase the combined count of webpage hits, hits to the locator, and hits to Substance Abuse and Mental Health Data Archive (SAMHDA) for SAMHSA-supported data sets (Lead Agency - SAMHSA; Measure ID - 4.4.10)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	5,585,000	6,000,300	1,792,523[97]	1,882,149[98]	2,390,402	2,390,402
Result	3,864,940	1,707,165[99]	2,298,464[100]	1,745,133[101]	Dec 31, 2015[102]	Dec 31, 2016
Status	Target Not Met but Improved	Target Not Met	Target Exceeded	Target Not Met	Pending	Pending

Increase the number of strategically relevant data sets published across the Department as part of the Health Data Initiative (Lead Agency - IOS; Measure ID - 1.2)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	122	285	288	1,200	1,800	1,980
Result	282	366	1,025	1,657	Sep 30, 2015	Sep 30, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	350,000	1,169,208	1,215,976	2,924,842	3,858,339	4,244,172
Result	1,113,531	1,829,111	2,924,842	3,507,581	Oct 31, 2015	Oct 31, 2016
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Increase the number of consumers for whom Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data is collected (Lead Agency - AHRQ; Measure ID - 1.3.23)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	143 Million	144 Million	145 Million	145 Million	146 Million	147 Million
Result	143 Million	143 Million	143 Million	Jun 30, 2015	Oct 30, 2015	Oct 30, 2016
Status	Target Met	Target Not Met	Target Not Met	Pending	Pending	Pending

Expand access to the results of scientific research (Lead Agency - IOS; Measure ID - 1.6)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target				N/A	3,250,000.0	3,500,000.0
Result				3,000,000.0	Sep 30, 2015	Sep 30, 2016
Status				Historical Actual	Pending	Pending

[97,98] Reduction in target reflects a change in the data collection methodology.

[99,100,101,102] There is no delay between fiscal year funding and the performance year.

Analysis of Results

HHS is committed to making high-quality and useful health-related data easily accessible in a timely manner. The Medical Expenditure Panel Survey (MEPS) Household Component fields questionnaires to individual household members to collect nationally representative data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. MEPS data is being used to increase the awareness of health and human service issues and generate insights into how to improve health and well-being. Through their efforts from 2006 (baseline) to 2013, AHRQ has reduced the number of months to public release of data from 12 to 10, meeting its targets. It targeted a two week reduction for FY 2014 for the point-in-time file relative to our time for data release accomplished in FY 2012 and met this goal by decreasing to 9.5 months for the number of months to public release of data from the end of data collection.

SAMHSA is tracking information usage from its publicly available resources by tracking a combined count of hits for a pool of key resources: the SAMHSA web site; the treatment locator; and the Substance Abuse and Mental Health Data Archive (SAMHDA). Since January of 2012, advancements are being made to assure the methodology of accurately counting web hits. These advancements resulted in target adjustments. The FY 2014 result did not meet the target. It is hoped believed that performance will be strong during 2015.

In addition to engaging the public, a high priority for the HHS Open Government Plan is to make HHS data more easily and broadly available through its Health Data Initiative (HDI). The mission of the HDI is to help improve health, healthcare, and the delivery of human services by harnessing the power of data and fostering a culture of innovative uses of data in a diverse array of public and private sector settings. This information can be used to increase agency accountability and responsiveness, improve public knowledge of the agency and its operations, further the core mission of the agency, create economic opportunity, or respond to need and demand as identified through public consultation. Also, researchers and analysts may use these data sets to add knowledge and understanding to existing health and human service issues. In FY 2014, HHS published 102 datasets and has federated datasets from states (454) and cities (66) into the catalog as part of the execution plan which recognizes that valuable data also resides at the local level and is a valuable resource for innovators.

CDC Vital Signs is an innovative program at the intersection of science, policy, and communications. The concept for the *CDC Vital Signs* Program was developed late in 2009 and the first issue was published on July 6, 2010. The twelve annual *CDC Vital Signs* Program topics include the five topics coinciding with the five leading causes of death in the U.S. An additional three of these twelve topics are known risk factors of these five leading causes of death, namely, obesity, tobacco use, and alcohol use. Due to the magnitude of morbidity, mortality, and financial cost associated with the indicators addressed in each issue of CDC Vital Signs, small changes in individual behavior, medical care practices, and public health policies that are expected to result from the release and use of this information have the potential to transform the nation's medical care and public health systems. CDC Vital Signs' monthly communications targets the public, health care professionals, and policymakers through fact sheets, social media, a website (http://www.cdc.gov/vitalsigns), and a linked issue of the Morbidity and Mortality Weekly Report (MMWR). Its electronic media reach grew from 250,000 potential viewings (page views, social media followers, and texting and email subscribers) in FY 2010 to over 3.5 million potential viewings in FY 2014 due to print, broadcast and cable media interest, and continued promotion to add subscribers to its social and email dissemination channels.

AHRQ has added a new measure to this report tracking Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. In FY 2011, the CAHPS program met its goal of 143 Million for whom CAHPS survey data is collected. However, for FY 2012 and FY 2013, results remained flat at the FY 2011 result.

Increased access to research publications can help to support innovative breakthroughs and accelerate the pace of scientific discovery. Developed in 2000, PubMed Central (PMC) serves as a free digital archive for biomedical and life sciences journal literature. A priority in the Open Government Plan is to increase access to the results of federally funded research. Increased access to research publications can help to support innovative breakthroughs and accelerate the pace of scientific discovery. The requirement to make peer-reviewed publications freely available stems from several sources, including the 2008 Consolidated Appropriations Act, which requires NIH-funded investigators to submit or have submitted for them into the National Library of Medicine's (NLM) PubMed Central archive of biomedical and life sciences journal literature an electronic version of their final peer-reviewed manuscript, to be made publicly available no later than 12 months after the official data of publication. In addition, Section 527 of the 2014 HHS Appropriations Act and February 22, 2013 White House policy memoranda, titled "Increasing Access to the Results of Federally Funded Scientific Research" call upon agencies with more than $100 million a year in the conduct of R&D to develop plans to make peer-reviewed publications stemming from their research freely available. NLM also works with publishers to collect and archive other articles published in more than 1,600 journals in the biomedical and life sciences. At HHS, the following agencies are developing public access plans, and will utilize PubMed Central: Food and Drug Administration, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality. It is expected that the public access requirements for agencies other than NIH will become effective at the start of FY 2016. HHS is introducing a new measure to this report that tracks the number of publications that are available to the public through PubMed Central, which includes papers submitted under public access policies as well as other publications contributed to the archive by journal publishers.

Plans for the Future

The MEPS Program continues to meet or exceeded all program assessment data timeliness goals. The accelerated data delivery schedule increases the timeliness of the data and thus maximizes the public good through the use of the most current medical care utilization and expenditure data to inform health care policy and practice. AHRQ is seeking further acceleration for the delivery of the current MEPS Household Component solicitation, with data delivery taking place in FY 2015 through FY 2018.

Given the pace of technological changes associated with automation, SAMHSA continues to carefully monitor and test the methodology used to quantify this type of measurement, expecting improvements for FY 2014 and FY 2015.

HHS expects the number of dataset published to increase in the coming years. Federation of datasets continues as HHS began federating health data from USDA (10) and continues to work with federal agencies like the VA and CFPB to harness additional health specific datasets for a comprehensive catalog of data resources. The HHS IDEA Lab (formerly the Chief Technology Officer's office) is engaged in robust outreach efforts to the HHS community and review of potential submissions. The IDEA Lab continues to educate our data communities on the content of HHS data through increased use of the

HealthData.gov blog, expanded social media presence, while benefiting from health data focused events like the well-known Health Datapalooza.

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

AHRQ believes the CAPHS survey has been hampered by excess length, which may be affecting performance improvement. The CAHPS Team and National Committee for Quality Assurance (NCQA) are responding to this issue by conducting analyses to see which items can be eliminated (without affecting reliability or validity) from the CAHPS Core Items and which items need updating. The program anticipates meeting the FY 2014 Target of 145 Million consumers for whom CAHPS survey data is collected and to increase the number of consumers each year by one million through FY 2016.

In FY 2014, the NLM's PubMed Central Database included over 3 million journal articles. HHS expects the number to grow in 2015 as the Public Access Policy is expanded to include journal articles developed through funding from CDC, FDA, AHRQ and ASPR, and as NLM continues to archive other articles contributed by journal publishers. In addition, a number of other federal agencies are considering utilizing PMC as their repository for publications.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- The Medical Expenditure Panel Survey (MEPS), first funded in 1995, is the only national source for comprehensive annual data on how Americans use and pay for medical care. The survey collects detailed information from families on access, use, expenses, insurance coverage, and quality. In an effort to release public use files at an earlier date, data processing efficiencies have been developed and instituted.

- AHRQ's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Program has not met the goal of 145 million users in FY 2013 because there was a slower uptake of the CAHPS Survey for Patient Centered Medical Homes (PCMH) than was anticipated. In addition, the Centers for Medicare and Medicaid Services (CMS) is using a newly revised CAHPS Clinician-Group Survey for Accountable Care Organizations (ACOs).

- Substance Abuse and Mental Health Data Archive (SAMHDA) serves as SAMHSA's primary repository for public access data files. SAMHDA provides free access and on-line analytic tools to the public. SAMHSA plans to promote SAMHDA to improve the amount of web traffic attracted to the site.

- In the first half of FY2014, CDC Vital Signs' total electronic media reach exceeded 1.5 million communication channels and is on target to reach its year-end goal of 2.9 million communication channels. Anticipating media saturation could slow future growth.

- HHS published 102 datasets and has federated datasets from states (454) and cities (66) into the catalog as part of the execution plan which recognizes that valuable data also resides at the local level and is a valuable resource for innovators.

It was determined that revised measures would help program managers assess the impact their work has on this overall strategy and provide more meaningful insight into objective progress and challenges. Coordination to adapt an existing measure and create a new measure to complement this objective is reflected in the measures above. AHRQ has also added a new measure to track progress. The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

Goal 4. Objective C: Invest in the HHS workforce to help meet America's health and human service needs

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

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

All HHS agencies work toward the improvement of the workforce to support the mission of the Department. The Office of the Secretary led this Objective's assessment as a part of the Strategic Review.

Objective 4.C Table of Related Performance Measures

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	80 Days	61 Days	60 Days	60 Days	Discontinued	
Result	61 Days	65 Days	68 Days	91 Days	N/A	
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met		

Analysis of Results

Within HHS, prompt turnaround for recruitment requests is necessary for hiring highly qualified candidates and is also required under several OPM directives that oblige agencies to streamline processes and decrease timelines. ASA has set goals that exceed the OPM federal targets for hiring timelines. To optimize performance, the Office of Human Resources has implemented a number of process and systems improvements to support hiring managers in their recruitment efforts. In FY 2014, the average days to hire was 91, missing the target of 60 days. This measure is a workload weighted average of the average days to hire from the Indian Health Service (114 days), National Institutes of Health (40 days), and the HHS/OHR Operating Divisions (116 days). Over the past three years, transaction reports have shown an increase in the hiring cycle time as measured from receipt of a complete job requisition package to initial job offer to a qualified candidate. Human resources managers and executives have observed in the past an inverse relationship between the number of hires and the number of days to hire. The fewer the number of hires the greater is the length of time that a

hiring manager makes a hiring decision. The budgetary uncertainties, especially in FY 2014 as highlighted by the government shutdown, only exacerbate this delay in making hiring decisions. It is also important to note that there are variables of the hiring process, outside of OHR's control, like whether or not the candidates accept the initial offer, that lengthen this time period. This measure will be discontinued starting in FY 2015, however, OHR will continue to strive for shorter hiring cycle time through strategic planning.

Plans for the Future

The Department will track the new performance measures, targeting three areas of emphasis: (1) Employee Engagement, (2) Workforce Management, and (3) Recruitment Processes. These measures provide a representative perspective of progress across the three key strategic areas identified above as improvement plans are implemented, and are described below in the *Objective Progress Update Summary*. Other initiatives in progress or planned will enhance employee engagement, the overall recruitment and hiring process, recruitment and retention in mission critical occupations (including STEMM), workforce diversity, and employee performance. The Department and OHR are committed to implementing improvements that support and enhance the workforce across HHS to help meet the Nation's health and human service needs.

Objective Progress Update Summary

The U.S. Department of Health and Human Services, in consultation with the Office of Management and Budget, has highlighted this objective as a focus area for improvement. Below is a description of the initiatives HHS plans to undertake to improve performance in this objective.

- Going forward, efforts are underway to frame optimal workforce requirements and conditions that best support employee engagement and foster organizational performance excellence. Continued attention and energy are placed on the refinement of the HHS workforce management architecture to create an agile, innovative, and results focused workforce ready to support the priorities of HHS now and in the future.

- Currently the Department is developing an improvement plan that addresses shortfalls identified in the strategic review process. This plan includes three replacement performance measures for this objective that better capture the Department's performance in key areas. These measures provide a representative perspective of progress across the three key strategic areas as improvement plans are implemented.

    - Annually the Office of Personnel Management surveys more than 74,000 HHS employees on a variety of areas affecting their workplace through the Employee Viewpoint Survey. The employee engagement index includes questions related to leadership, supervisor behaviors, and intrinsic experience. A successful agency fosters an engaged working environment to ensure each employee can reach his or her potential and contribute to the success of their agency and the entire Federal Government. HHS will track performance and set improvement targets for the HHS-wide employee engagement index.

    - HHS is committed to recruiting and keeping the best employees to meet America's health and human service needs. This metric will use the Office of Personnel Management Annual Employee Viewpoint survey of federal employees; specifically looking at the responses of HHS managers and executives to the question "My work unit

is able to recruit people with the right skills." The percentage of positive responses from HHS managers will be tracked and reported annually, setting targets for improvement.

  - HHS strives to have a workforce that is reflective of America and of the population that we serve. In addition to using hiring and retention data HHS will look at the most recent results from the Office of Personnel Management's Employee Viewpoint Survey. In particular HHS will track the percentage of employees who positively report "My supervisor is committed to a workforce representative of all segments of society," also setting targets for improvement. Using this data as well as applicant and employee churn analysis will enable HHS leadership to drive further success in this area.

- The HHS Office of Human Resources (OHR) is leading efforts to improve the recruitment, development, and management of the Department's workforce. OHR is focusing these activities in three key strategic areas: (1) Employee Engagement, (2) Workforce Management, and (3) Recruitment Processes, which are aligned to the HHS Strategic Plan, the President's Management Agenda, OMB and OPM human capital initiatives, as well as unique HHS organizational priorities. The intent of these efforts is:

  - To increase the Department's human resources infrastructure to develop the flexibility to meet the changing requirements of the health care industry and demonstrate that a focus on performance improvement is a way of life for health care professionals.

  - Develop an employee base focused on mission requirements, quality, and flexibility which will allow for changes in strategy, structure, and key processes that will enhance the effectiveness of programs.

  - Develop efficient, streamlined hiring processes, where the right person is hired for the right job, at the right time.

- Other initiatives in progress or planned will enhance employee engagement, the overall recruitment and hiring process, recruitment and retention in mission critical occupations (including science, technology, engineering, mathematics, and medical (STEMM)), workforce diversity and inclusion, and employee performance.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

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

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

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

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

Objective 4.D Table of Related Performance Measures

Increase the percent employees on telework or on Alternative Work Schedule (Lead Agency - ASA; Measure ID - 1.1)[103]

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	12.0%	14.0%	16.0%	40.0%	44.0%	TBD
Result	13.0%[104]	22.0%[105]	38.0%[106]	13.0%[107]	Dec 15, 2015	TBD
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	

[103] This measure is Department-wide.

[104] The reported value for 2011 includes employees regularly teleworking at least 4 days per pay period as well as employees on an Alternative Work Schedule (AWS) and double counts those participating in AWS and teleworking at least 4 days per pay period. The percent of employees teleworking at least 4 days per pay period during FY 2011, excluding AWS, was 0.49%. It should also be noted that data collection for this year started approximately 8 months into the FY due to the recent passing of the Telework Enhancement Act of 2010.

[105] The reported value for 2012 includes employees regularly teleworking at least 4 days per pay period as well as employees on an Alternative Work Schedule (AWS) and double counts those participating in AWS and teleworking at least 4 days per pay period. The percent of employees teleworking at least 4 days per pay period during FY 2012, excluding AWS, was 9.43%.

[106] The reported value for 2013 includes employees regularly teleworking at least 1 day per pay period as opposed to the intended 4 days per pay period explained in the measure description. The percent of employees teleworking at least 4 days per pay period during FY 2013 was 10.66%.

[107] See footnotes for FY 2013, 2012, and 2011. This value actually represents an increase in % employees regularly teleworking at least 4 days per pay period (FY 2011 =.49%, FY 2012 =9.43%, FY 2013 =10.66%).

Reduce HHS fleet emissions (Lead Agency - ASA; Measure ID - 1.2)[108]

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	12,968 MTCO2e	12,708 MTCO2e	12,454 MTCO2e	12,205 MTCO2e	11,961 MTCO2e	TBD
Result	13,404 MTCO2e[109]	13,448 MTCO2e	11,129 MTCO2e	9,749 MTCO2e[110]	Dec 15, 2015	TBD
Status	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Pending	

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

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Target	100.0%	100.0%	100.0%	100.0%	100.0%	TBD
Result	85.0%	94.0%	90.0%	99.0%	Dec 15, 2015	TBD
Status	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Pending	

Analysis of Results

In support of the HHS Sustainability Performance Plan, HHS has committed to reduce greenhouse gas emissions by technological, programmatic and behavior changes. Increasing the percentage of employees who telework or who are on an Alternate Work Schedule (AWS) reduces vehicle miles traveled, greenhouse gas emissions and other pollutants. Commuting typically causes employee stress and decreases the amount of time that employees can devote to other healthy activities including physical activity, preparing healthy meals, and developing social capital by spending time with family or community events. Widespread telework and AWS, coupled with office sharing and swing space, can reduce overall facilities costs, waste-water treatment, and energy use. When the measure was first established, it aimed to capture both employees who regularly teleworked at least 4 days per pay period as well as those who were on an AWS and therefore also saved fuel by commuting fewer days per pay period. The values for FY 2011 and 2012 were reported according to the original measure description, however, when it was discovered that some employees were both on AWS and teleworked regularly at least 4 days per pay period, it was decided that reporting for future years would exclude AWS and only capture regular teleworkers. Due to confusion surrounding the impact of this switch in reporting on the magnitude of the value for this measure, the value reported for FY 2013 included not just employees teleworking at least 4 days regularly per pay period, but all employees regularly teleworking at least 1 day per pay period. The FY 2014 value represents the correct value, percent employees regularly teleworking at least 4 days per pay period.

HHS is committed to replacing gasoline-powered vehicles with alternative fuel vehicles (AFV) in accordance with GSA acquisition guidelines and in alignment with HHS Sustainability Plan and the Presidential Order to reduce greenhouse gases. The preliminary FY 2014 data suggests great reduction in HHS fleet emissions and also that this year's goal was exceeded. The FY 2014 value is preliminary;

[108] This value excludes all fuel products used by HHS law enforcement, protective, emergency response or military tactical vehicles (if any), as well as any HHS international deployments not already excluded by the previous categories due to constraints of regulating and enforcing US standards abroad and the intent of the metric.

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

[110] Preliminary value as of January 21th, 2015. The final value is expected to be received on January 30th, 2015.

data collection for the year is not closed until January 15th, 2015 and the analysis will not be final until the fleet emission report is released January 30th.

HHS IT contracts have been revised to include power-saving configuration requirements. HHS is measuring the percentage of eligible computers, laptops, and monitors with power management, including power-saving protocols in the standard configuration for employee workstations. Consistent application of power management will decrease the electricity use of HHS facilities. The target for this measure is for 100% of HHS eligible computers, laptops, and monitors to have power management. HHS set aggressive goals to move from the 2010 level of 32% of devices with power management enabled to 100% of devices with power management by 2013 and to maintain that level continuing through 2015. In 2011, 85% of eligible devices were reported in compliance across the department, while in 2012 this increased to 94%. The 2013 department-wide Electronic Stewardship Report showed that 90% of computers, laptops, and monitors were covered by power management. The 2014 Electronic Stewardship Report showed this value increased to 99%.

Plans for the Future

HHS will continue to support initiatives toward the achievement of the goals in the Executive Order 13514 and the Sustainability Performance Plan. After discovering and correcting the data reporting issues with telework and Alternative Work Schedule participation, HHS plans to revise this measure for FY 2015 reporting, realigning its content to reflect the current reporting methodology. HHS has set aggressive goals to move from the FY 2010 level of 32 percent of devices with power management enabled to 100 percent of devices with power management and to maintain that level continuing through FY 2015. $MTCO_2e$ emission reduction targets for subsequent periods are expected to stabilize and improve going forward. HHS is replacing conventionally (petroleum based) powered vehicles with alternative fuel vehicles as possible, reducing the amount of HHS greenhouse gas emissions.

Objective Progress Update Summary

HHS demonstrated progress toward this objective as shown by the representative performance measures described in the HHS Annual Performance Plan and Report. Further evidence of progress is described below.

- HHS submitted a Strategic Sustainability Plan (SSPP 2013) in 2013. A new Climate Adaptation plan is in progress with due date of June 30 2014.
- HHS attained a score of green on its January 2014 OMB Scorecard on Sustainability and Energy for Scope 1, 2, and 3 GHG Emission Reduction Targets; Use of Renewable Energy; and Reduction in Fleet Petroleum Use. These scores mean that HHS achieved its 2013 Sustainability Plan goals in these areas.

The Department is continuing to support and execute the programs contributing to this objective, monitoring progress, performance, and program integrity while adjusting to any budgetary constraints or changes to programmatic demands.

Evaluation and Research

As part of the HHS mission to provide health and human services to the Nation, the Department is committed to continuously improving on the delivery of those services. That goal is accomplished through the evaluation of HHS programs to examine the performance of those programs in achieving their intended objectives. An important component of the HHS evaluation function is communicating the findings and recommendations of completed evaluation studies. The Department produces a Performance Improvement Report, available at http://aspe.hhs.gov/evaluation/performance/, to make available to its stakeholders and the public summaries of evaluation studies recently completed and others in progress. The Department organizes evaluations by the strategic goals and objectives of the most current HHS Strategic Plan.

Throughout this Plan, narrative sections under strategic goals and objectives describe how evaluations contributed to the strategic directions the Department has chosen to improve health and human services outcomes for the populations it serves. In addition, strategies related to conducting research and evaluations, and applying that knowledge to programs and other efforts, are included throughout the Plan.

HHS OIG FY 2014 Top Management and Performance Challenges

The HHS OIG has identified the top management and performance challenges for FY 2014. HHS management is committed to working toward resolving these challenges. The performance measures in this document track such challenges as implementing the Affordable Care Act, combating fraud and waste, enhancing quality of care, and ensuring food and medical safety. In addition, HHS employs a robust program integrity process. For further information about these challenges, please read the *HHS Fiscal Year 2014 Top Management and Performance Challenges Identified by the Office of the Inspector General* report located at http://oig.hhs.gov/reports-and-publications/top-challenges/2014/2014-tmc.pdf.

Cross-Agency Collaborations

Through its programming and other activities, HHS works closely with state, local, and U.S. territorial governments. The federal government has a unique legal and political government-to-government relationship with tribal governments and a special trust obligation to provide services for American Indians and Alaska Natives based on this association. 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.

GAO High Risk Items

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

The programs identified by GAO are:

CMS - Medicare Program
CMS - Medicaid Program

FDA - Revamping Federal Oversight of Food Safety
FDA - Protecting Public Health through Enhanced Oversight of Medical Products

To read about HHS's progress toward addressing these high-risk items, find the 2013 GAO High-Risk Series Update here: http://www.gao.gov/assets/660/652133.pdf

CMS Plan for High Risk Items

A copy of the CMS plan for addressing risk within Medicare and Medicaid programs is available at: http://www.cms.gov/apps/files/2014_CMS_GAO_High_Risk_Program_Report.pdf

FDA Plan for High Risk Items

Issue – Transforming Federal Oversight of Food Safety

According to the recent CDC study, each year, about 48 million people contract a food borne illness in the United States, about 128,000 require hospitalization, and about 3,000 die. GAO has stated that the fragmented U.S. system of oversight has caused inconsistent oversight, ineffective coordination, and inefficient use of resources.

Major GAO Concerns and FDA Actions

1. In December, 2014, GAO recommended that
    a. HHS and USDA build upon their efforts to implement GPRAMA requirements to fully address crosscutting food safety efforts.
        i. HHS agreed with the recommendation and will continue to build upon its efforts to implement GPRAMA requirements to address crosscutting food safety efforts, by expanding its strategic and performance planning documents along with working with other agencies to achieve food safety-related goals and objectives. HHS will draft revised descriptions in its strategic plan to fully address crosscutting food safety efforts and inter-agency collaborations.
        ii. Moreover, the Food Safety Modernization Act (FSMA) envisions collaborations among federal and state agencies on food safety standard setting, technical assistance, and compliance. Ongoing collaborations among the three primary Departments responsible for food safety and food defense – HHS, the United States Department of Agriculture, and the Department of Homeland Security – has strengthened the food safety system in areas of research, risk assessment, and food defense.
2. In 2014, GAO also recommended that Congress should consider
        i. directing OMB to develop a government-wide food safety performance plan and
        ii. formalizing the FSWG through statute to help ensure sustained leadership across food safety agencies over time.

Issue – Protecting Public Health through Enhanced Oversight of Medical Products

The FDA has the vital mission of protecting the public health by overseeing the safety and effectiveness of medical products—drugs, biologics, and medical devices—marketed in the United States. The agency's responsibilities begin long before a product is brought to market and continue after a product's

approval, regardless of whether it is manufactured here or abroad. In recent years, FDA has been confronted with multiple challenges. Rapid changes in science and technology, globalization, unpredictable public health crises, an increasing workload, and the continuing need to monitor the safety of thousands of marketed medical products have strained the agency's resources.

Major GAO Concerns and FDA Actions

1. Strengthen the Drug Shortage Program
    - FDA created an Intra-Agency drug shortages task force to enhance agency activities on drug shortages.
    - FDA sponsored a public workshop on September 26, 2011, to provide information for, and to gain additional insight from, professional societies, patient advocates, industry, consumer groups, health care professionals, researchers, and other interested persons about the causes and impact of drug shortages and possible strategies for preventing and mitigating drug shortages. http://www.fda.gov/drugs/newsevents/ucm265968.htm
    - FDA published a Strategic Plan for Preventing and Mitigating Drug Shortages on October 31, 2013, as required by the Food and Drug Administration Safety and Innovation Act (FDASIA) enacted July 9, 2012. This plan contains the Agency's short term and longer term plans for preventing and mitigating shortages. http://www.fda.gov/downloads/drugs/drugsafety/drugshortages/ucm372566.pdf
    - FDA published the first Annual report to congress as required by FDASIA. http://www.fda.gov/drugs/drugsafety/drugshortages/ucm384891.htm
    - The FDASIA requirement for manufacturers to notify FDA of potential supply disruptions has resulted in a sustained increased level of notifications, and allows FDA to prevent shortages in many cases. Shortages decreased from 117 new shortages in 2012 to 44 new shortages in 2013.
    - FDA has developed a new data system to enhance our ability to track drug shortages. The new data system includes strengthened internal controls, and will allow FDA to better analyze trends in drug shortages, as well as to assess its performance in mitigating and preventing shortages, through the use of some potential metrics that were included in the FDA Annual Report to Congress.

2. Conduct more inspections of foreign establishments manufacturing medical products for the U.S. market and take a risk-based approach in selecting foreign drug establishments
    - In November 2008, the agency began posting FDA employees in foreign posts in key locations overseas. FDA has opened offices in several countries where FDA presence can improve product safety and quality, and leverage resources. To date, FDA has offices in India (Mumbai and New Delhi), China (Shanghai, Guangzhou, and Beijing), Europe (Brussels, Belgium), and Latin America (San Jose, Costa Rica; Santiago, Chile; and Mexico City, Mexico), and plans for a Middle East office. FDA has investigators posted in Mumbai, Shanghai, and Guangzhou. The establishment of foreign offices has enabled FDA to enhance its relationships with foreign counterpart regulatory officials to obtain more accurate and robust information about foreign drug establishments and has facilitated FDA access to drug establishments for inspection.
    - The agency also has established a specialized foreign cadre of investigators located in FDA district offices in the United States who are dedicated to foreign inspection assignments. Now in its second year, the program has 15 investigators and has already significantly increased the number of foreign inspections.

- FDA has substantially increased its collaboration with foreign regulatory authorities. For example, FDA participates in the API Pilot Program with the European Medicines Agency (EMA) and Australia's Therapeutic Goods Administration (TGA), which calls for participants to share information, as permitted by law, about API inspections and to use this information to leverage the inspectional resources of each regulatory body.
- FDA has replaced the old drug registration and listing system, which relied on cumbersome manual entry, with the electronic drug registration and listing system (eDRLS). With eDRLS, it is mandatory for all drug establishments shipping drugs to the United States to register with FDA electronically. The implementation of eDRLS helps FDA quickly assemble information about drug establishments and since eDRLS is updated daily, FDA's import entry reviewers have near real-time access to registration information and the ability to quickly flag unregistered foreign firms and unlisted drugs when offered for importation at ports and borders.

FDA substantially has increased its inspection capacity, improved its databases, and expanded its infrastructure to increase its global presence.

Lower-Priority Program Activities

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

Changes in Performance Measures

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
ACF	4A	Revise	Increase the proportion of youth living in safe and appropriate settings after exiting ACF-funded Transitional Living Program (TLP) services.	Maintain the proportion of youth living in safe and appropriate settings after exiting ACF-funded Transitional Living Program (TLP) services.	As requested by the Office of Management and Budget (OMB), ACF has revised the language of this measure from “increase” to “maintain” to be consistent with the latest trend data.
ACF	7S	Target Change	FY 2015 Target: 5.5%	Revise FY 2015 Target from 5.5% to 5.3%.	In light of the most recent performance data, ACF proposes to adjust future targets to be in line with the latest results. ACF will continue to work with states to strengthen oversight of title IV-E eligibility and address payment errors.
AHRQ	1.3.23	Add to APP/R		Increase the number of consumers for whom Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data is collected	New measure added to representative set
AHRQ	1.3.38	Revise	1750 users of research	Increase the number of researchers for FY 2015 and FY 2016	FY 2014 data Result was greater than proposed FY 2015 and FY 2016 targets
AHRQ	1.3.60	Drop from APP/R		Drop	Per OMB’s comment that this measure is not as representative of progress in the Objective as other included measures, the measure was dropped.
ASA	2.1	Retire	Reduce the average number of days to hire	Retire and replace	ASA would like to retire this measure and replace it with better metrics of HR performance.
CMS	ACO1.1	Change CY 2013 Baseline Change CY 2015 target	CY 2013 Baseline = 4,200,000 CY 2015 Target = 6,210,000	CY 2013 Baseline = 4,002,532 CY 2015 Target = 7,090,000	We are re-baselining measures 1.1 and 1.2, placing both of these measures on the same track as ACO 1.3.
CMS	ACO1.2	Change CY 2013 Baseline Change CY 2015 target	CY 2013 Baseline = 114,995 CY 2015 Target = 191,000	CY 2013 Baseline = 102,717 CY 2015 Target = 178,000	We are re-baselining measures 1.1 and 1.2, placing both of these measures on the same track as ACO 1.3.
CMS	ACO1.3	Change CY 2013 Baseline Change CY 2015 target	CY 2013 Baseline = 28% CY 2015 Target = 35%	CY 2013 Baseline = 34% CY 2015 Target = 37%	We are re-baselining measures 1.1 and 1.2, placing both of these measures on the same track as ACO 1.3.
CMS	MCR1	Report as Contextual Indicator	FY 2015 Targets 1.1a = 90% 1.1b = 90%	Report as Contextual Indicator after FY 2015	We have consistently met or exceeded these targets for many years. We want to continue to monitor and report beneficiary satisfaction

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
					results, but would like to report the results without setting targets.
CMS	MCR20	Change FY 2015 target	1. Continue external ICD-10 outreach and communications for post-implementation 2. Review and monitor ICD-10 industry compliance level and state Medicaid program baselines 3. Continue post implementation monitoring and assessment 4. Monitor and remediate claims payment, policy, and systems issues.	1. Continue external ICD-10 outreach and communications for pre-implementation. 2. Review and monitor ICD-10 industry compliance levels 3. Continue pre-implementation monitoring and assessment. 4. Monitor, test, and remediate claims payment, policy, and systems issues.	Delay in implementation of ICD-10 from October 1, 2014 to October 1, 2015
CMS	MCR22	Retire	Review & Value Appropriately 40% of potentially misvalued codes identified in 2014 Review & Value Appropriately 20% of potentially misvalued codes identified in 2013 Review & Value Appropriately 20% of unreviewed potentially misvalued codes identified in 2012	Discontinue Goal after FY2015	GPRA target for misvalued codes has been superseded by the statutory target requirement in the Protecting Access to Medicare Act of 2014 and the Stephen Beck, Jr., ABLE Act of 2014. These Acts amend section 1848(c) of the Social Security Act to add a formal target for redistributed dollars under the physician fee schedule resulting from the misvalued code initiative.
CMS	MCR26	Change in FY 2015 targets	FY 2015 = 18.1 percent	FY 2015= 17.9 percent	OMB Recommendation based on exceeded targets in FY 2014
CMS	MCR27	Change in FY 2015 targets	MCR27.1 = 250,000 MCR27.2 = 50,000 MCR27.4 = 3,300 MCR27.6 = 3,600	MCR27.1 = 290,000 MCR27.2 = 65,000 MCR27.4 = 4,300 MCR27.6 = 3,700	OMB Recommendation based on exceeded targets in FY 2014
CMS	MSC1	Change FY 2015 target	FY 2015 Target= 6.6%	FY 2015 Target = 5.7%	We are decreasing the target due to the steady decrease in pressure ulcer prevalence.
CMS	MSC5	Change FY 2015 target; Add to APP/R	FY 2015 Target = 19%	FY 2015 Target= 17.9%	Because we are accomplishing this goal together with many partners, the targets are more ambitious.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
FDA	223205	Drop	The total number of actions taken on abbreviated new drug applications in a fiscal year. FY 2015 Target: 1,450	N/A	CDER is replacing this old Generics performance goal with a new performance goal that better reflects the new GDUFA agreement.
FDA	223215	New	N/A	Review and act on original ANDA submissions within the established time frame. FY 2015 Target: 60% within 15 months	CDER is replacing the old Generics performance goal with this new performance goal that better reflects the new GDUFA agreement.
HRSA	16.I.A.1	Revision to comparison data and target	Proportion of persons served by the Ryan White HIV/AIDS Program who are racial/ethnic minorities. Target: 5 percentage points above CDC data (using CDC national AIDS prevalence data)	Same measure. Target changed to: Within 3 percentage points of CDC data (using CDC national HIV/AIDS data)	This measure reports on Ryan White HIV/AIDS Program clients compared to CDC data on persons with HIV/AIDS. The revised target provides a tight margin either above or below CDC data and will allow the RW Program to better measure the Program's response to the HIV/AIDS epidemic.
HRSA	4.I.C.2	FY 2015 Target Change	Field strength of the NHSC through scholarship and loan repayment agreements. (Previous FY 2015 target: 15,438)	New FY 2015 target: 15,468	The FY 2015 Field Strength target was increased as a result of a change in the financing of individual NHSC programs.
HRSA	6.I.C.1	Revised wording	Numerous measures in which BHPr or Bureau of Health Professions is referenced	Numerous measures to change BHPr or Bureau of Health Professions references to Bureau of Health Workforce	Changes made to reflect the consolidation of BHPr and BCRS into the Bureau of Health Workforce
HRSA	1.I.A.3	Add to APP/R	N/A	Percentage of health centers with at least one site recognized as a patient centered medical home	New measure added to representative set
IHS	24	Revise	American Indian and Alaska Native Childhood Combined (4:3:1:3*:3:1:4) immunization rates: American Indian/Alaska Native patients aged 19 - 35 months, are immunized against preventable childhood disease. IHS-ALL (Outcome)	American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate.	The measure name was changed in HHS's FY 2015 APP/R; this title change for an IHS APP/R measure will now be consistent between the HHS APP/R and the IHS budget.
NIH	CBRR-10	Drop	By 2015, make freely available to researchers	Measure set to discontinue in FY 2015	Measure is expected to be achieved in FY 2015

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
			the results of 400 high-throughput biological assays screened against a library of 300,000 unique compounds, and the detailed information on the molecular probes that are developed through that screening process.		
NIH	SRO-5.13	Drop	By 2015 establish and evaluate a process to prioritize compounds that have not yet been adequately tested for more in-depth toxicological evaluation.	Measure set to discontinue in FY 2015	Measure is expected to be achieved in FY 2015
NIH	SRO-6.4	Drop	By 2015 identify and characterize two molecular pathways of potential clinical significance that may serve as the basis for discovering new medications for preventing and treating asthma exacerbations.	Measure set to discontinue in FY 2015	Measure is expected to be achieved in FY 2015
NIH	SRO-5.2	New	N/A	By 2018 (a) identify genetic factors that enhance or reduce the risk of development and progression of chronic obstructive pulmonary disease (COPD) and (b) validate new genetic and clinical criteria that may be added to COPD classification and contribute to better and/or earlier diagnosis or prognosis of the disease.	NIH is adding new measures to replace those that have ended or will be ending in FY 2015
NIH	SRO-5.5	New	N/A	By 2018 complete pre-commercial development of a point-of-care technology targeted for use in primary care setting.	NIH is adding new measures to replace those that have ended or will be ending in FY 2015
NIH	SRO-8.2	New	N/A	By 2017 identify circuits within the brain that mediate reward for (1) drugs, (2) non-drug rewards such as food or palatable substances, and (3) aversion to drug effects,	NIH is adding new measures to replace those that have ended or will be ending in FY 2015

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
				and (4) determine the degree of overlap between these circuits.	
NIH	SRO-3.9	FY 2014 Target	Design a clinical trial testing an agent for a disorder of the immune system in children (e.g. Still's disease).	Design a clinical study testing an agent for a disorder of the immune system in children (e.g., Still's disease).	Minor revisions to improve clarity of language in target description and improve alignment of FY 2014 and 2015 performance targets.
NIH	SRO-3.9	FY 2015 Target	Complete a clinical pilot study in patients with a pediatric cohort of patients with a disorder of the immune system in children.	Complete a clinical pilot study in a cohort of pediatric patients with a disorder of the immune system.	Minor revisions to improve clarity of language in target description and improve alignment of FY 2014 and 2015 performance targets.
IOS	1.1	Retire	Increase the number of identified opportunities for public engagement and collaboration among agencies	Retire	Measure being replaced with new, improved measure
IOS	1.2	Move and Revise	Increase the number of high-value data sets and tools that are published by HHS	Migrate to Objective 4B; revise wording to "Increase the number of strategically relevant data sets published across the department as part of the Health Data Initiative."	This measure is more applicable to 4B, which involves access and use of data sets, therefore recommendation is to move it to that objective.
IOS	1.3	Retire	Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice	Retire	Measure being replaced with new, improved measure
IOS	1.4	New; Add to APP/R	N/A	Add "Increase the number of opportunities for the public to co-create solutions through open innovation."	Refinement of public engagement goal using challenge data as a measure
IOS	1.5	New; Add to APP/R	N/A	Add "Increase the number of innovation solutions developed across the Department."	Refinement of goal to look at IDEA Lab programming and its impact across the Department
IOS	1.6	New; Add to APP/R	N/A	Add "Expand access to the results of scientific research funded by HHS."	New measure added to representative set to reflect Open Data goals.
SAMHSA	2.3.21	Retire	Decrease underage drinking as measured by an increase in the percent of SPF SIG states that show a decrease in 30-day use of alcohol for individuals 12-20 years old.	Discontinue measure	Measure is being discontinued. Program eliminated. No data to report after FY 2015. Grantees are transitioning to a different program

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
SAMHSA	2.3.56	Revise FY 2016 Target	Increase the number of program participants exposed to substance abuse prevention education services	FY 2016 target in FY 2015 President's Budget was 3,000. New target proposed is 2,580.	Fewer grants will be awarded after FY 2014 which results in fewer participants recruited.
SAMHSA	2.3.56	Data source will change for 2015 and beyond.	Increase the number of program participants exposed to substance abuse prevention education services	The data source will change from the DCAR contract to the PEP-C contract. This will be part of Phase One of the Consolidated/common data platform (CDP) transition.	SAMHSA is changing some of its contracts and is creating a new CDP. The same measure will be transferred to a different data source and stored in a different database. Reliability and validity will be monitored.
SAMHSA	2.3.61	Target Changes for FY 2016	Target in the FY 2015 President's Budget is 824,501 for FY 2016	Increase the number of calls answered by the suicide hotline	FY 2016 target is increased in the FY 2016 President's Budget submission (compared with the FY 2015 President's Budget) based on the actual result and to set more ambitious targets. Was increased from 824,501 to 1,308,825.
SAMHSA	3.2.37	Target Changes for FY 2016	Target in the FY 2015 President's Budget is 5,911 for FY 2016	Increase the number of individuals referred to mental health or related services	The FY 2016 target in the FY 2015 President's Budget was 5,911. It was increased to 8,850 in the FY 2016 President's Budget.
SAMHSA	3.2.30	Retire	Decrease the percentage of middle and high school students who report current substance abuse	Discontinue measure	This measure is being replaced by 3.2.50 in the Rep Set as this more accurately captures how the data is used to drive performance by the program. FY 2014 data is not available.
SAMHSA	3.2.50	New Measure but same as 3.2.30 with different source.	New.	Decrease the percentage of middle and high school students who report current alcohol use.	This replaces 3.2.30 in the Annual Performance Plan and Report.
SAMHSA	3.4.20	Target changes for 2016	FY 2016 target was 4,360 in the FY 2015 President's Budget.	The FY 2016 target was changed from what was reported in the FY 2015 President's Budget. It is 2,290 in the FY 2016 President's Budget.	The online training was fully implemented. Previous training consisted of train the trainer learning sessions. Using the current standardized online system, the numbers are lower and expected to stay lower. The revised targets meet realistic expectations for the program.

Data Sources and Validation

Administration for Children and Families (ACF)

Measure ID	Data Source	Data Validation
1.1LT and 1A; 1.1LT and 1B (ACF)	State *LIHEAP Household Report* and Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey	ACF obtains weighted national estimated numbers of LIHEAP income eligible (low income) households from the Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey. Specialized tabulations are developed to select those ASEC households which would be eligible under the federal LIHEAP maximum cutoff of the greater of 150 percent of HHS' Poverty Guidelines or 60 percent of HHS' state median incomes estimates. [1] The weighted estimates include data on the number of those households having at least one member who is 60 years or older and the number of those households having at least one member who is five years or younger. The estimates are subject to sampling variability. The Census Bureau validates ASEC data. ACF aggregates data from the states' annual *LIHEAP Household Report* to obtain a national count of LIHEAP households that receive heating assistance. The count includes data on the number of households having at least one member who is 60 years or older and the number of those households having at least one member who is five years or younger. The aggregation and editing of state-reported LIHEAP recipiency data for the previous fiscal year are typically completed in November of the following fiscal year. Consequently, the data are not available in time to modify ACF interventions prior to the current fiscal year (i.e. there is at least a one-year data lag). There is some electronic data validation now that ACF is using a web-based system for grantees to submit and validate their data for the *LIHEAP Household Report.* ACF also cross checks the data against LIHEAP benefit data obtained from the states' submission of the annual *LIHEAP Grantee Survey* on sources and uses of LIHEAP funds. [1] Congress raised the federal LIHEAP maximum income cutoff to 75 percent of state median income for both FY 2009 and FY 2010. Most states did not elect to use 75 percent of state median income (SMI). With the enactment of P.L. 112-10 on April 15, 2011, grantees could only qualify those LIHEAP applicants that were income eligible up to the 60 percent of SMI threshold. The use of 75 percent of SMI was no longer allowable.

Measure ID	Data Source	Data Validation
2B (ACF)	Biennial CCDF Report of State Plans	The CCDF State Plan preprint requires states to provide information about their progress in implementing the program components related to quality rating and improvement systems (QRIS). CCDF State Plans are submitted on a biennial basis. In order to collect data on years when CCDF State Plans are not submitted, updates are provided by states and territories using the same questions as included in the CCDF State Plan to ensure data consistency.
3.6LT and 3B (ACF)	Program Information Report (PIR)	Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The Office of Head Start also engages in significant monitoring of Head Start grantees through monitoring reviews of Head Start and Early Head Start grantees, which examine and track Head Start Program Performance Standards compliance at least every three years for each program. Teams of ACF Regional Office and Central Office staff, along with trained reviewers, conduct more than 500 on-site reviews each year. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.
3A (ACF)	Classroom Assessment Scoring System (CLASS: Pre-K)	CLASS: Pre-K is a valid and reliable tool that uses observations to rate the interactions between adults and children in the classroom. Reviewers, who have achieved the standard of reliability, assess classroom quality by rating multiple dimensions of teacher-child interaction on a seven point scale (with scores of one to two being in the low range; three to five in the mid-range; and six to seven in the high range of quality). ACF will implement ongoing training for CLASS: Pre-K reviewers to ensure their continued reliability. Periodic double-coding of reviewers will also be used, which is a process of using two reviewers during observations to ensure they continue to be reliable in their scoring.
3F (ACF)	Program Information Report (PIR)	The PIR is a survey of all grantees that provides comprehensive data on Head Start, Early Head Start, and Migrant Head Start programs nationwide. Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.

Measure ID	Data Source	Data Validation
4.1LT and 4A (ACF)	The Runaway and Homeless Youth Management Information System (RHYMIS)	RHYMIS incorporates numerous business rules and edit checks, provides a hot-line/help desk and undergoes continuous improvement and upgrading. Extensive cleanup and validation of data take place after each semi-annual transfer of data from grantee systems into the national database. Historically, the reporting response rate of grantees has exceeded 97 percent every year.
7D (ACF)	State Annual Reports	States are required to submit an Annual Report addressing each of the CBCAP performance measures outlined in Title II of CAPTA. One section of the report must "provide evaluation data on the outcomes of funded programs and activities." The 2006 CBCAP Program Instruction adds a requirement that the states must also report on the OMB performance measures reporting requirements and national outcomes for the CBCAP program. States were required to report on this new efficiency measure starting in December 2006. The three percent annual increase represents an ambitious target since this is the first time that the program has required programs to target their funding towards evidence-based and evidence-informed programs, and it will take time for states to adjust their funding priorities to meet these new requirements.
7P1 (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). States' Statewide Automated Child Welfare Information Systems (SACWIS) are undergoing reviews to determine the status of their operation and the system's capability of reporting accurate AFCARS data. To speed improvement in these data, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.

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

Measure ID	Data Source	Data Validation
7S (ACF)	Regulatory Title IV-E Foster Care Eligibility Reviews	Data validation occurs on multiple levels. Information collected during the onsite portion of the review is subject to quality assurance procedures to assure the accuracy of the findings of substantial compliance and reports are carefully examined by the Children's Bureau Central and Regional Office staff for accuracy and completeness before a state report is finalized. Through the error rate contract, data is systematically monitored and extensively checked to make sure the latest available review data on each state is incorporated and updated to reflect rulings by the Departmental Appeals Board and payment adjustments from state quarterly fiscal reports. This ensures the annual program error rate estimates accurately represent each state's fiscal reporting and performance for specified periods. The Children's Bureau also has a database (maintained by the contractor) that tracks all key milestones for the state eligibility reviews.
12B (ACF)	CSBG Information System (CSBG/IS) survey administered by the National Association for State Community Services Programs (NASCSP)	The Office of Community Services (OCS) and NASCSP have worked to ensure that the survey captures the required information. The CSBG Block Grant allows states to have different program years; this can create a substantial time lag in preparing annual reports. States and local agencies are working toward improving their data collection and reporting technology. In order to improve the timeliness and accuracy of these reports, NASCSP and OCS are providing states training, and better survey tools and reporting processes.
14D (ACF)	Family Violence Prevention and Services Program Performance Progress Report Form	Submission of this report is a program requirement. The outcome measures and the means of data collection were developed with extensive input from researchers and the domestic violence field. The forms, instructions, and several types of training have been given to states, tribes, and domestic violence coalitions.
16.1LT and 16C (ACF)	Matching Grant Progress Report forms	Data are validated with methods similar to those used with Performance Reports. Data are validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages, and retentions.
18.1LT and 18A (ACF)	Performance Report (Form ORR-6)	Data are validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages, and retentions.

Measure ID	Data Source	Data Validation
20C (ACF)	Office of Child Support Enforcement (OCSE) Form 157	States currently maintain information on the necessary data elements for the above performance measures. All states were required to have a comprehensive, statewide, automated Child Support Enforcement system in place by October 1, 1997. Fifty-three states and territories were Family Support Act-certified and Personal Responsibility and Work Opportunity Reconciliation Act-certified (PRWORA) as of July 2007. Certification requires states to meet automation systems provisions of the specific act. Continuing implementation of these systems, in conjunction with cleanup of case data, will improve the accuracy and consistency of reporting. As part of OCSE's audit of performance data, OCSE Auditors review each state's and territory's ability to produce valid data. Data reliability audits are conducted annually. Self-evaluation by states and OCSE audits provide an on-going review of the validity of data and the ability of automated systems to produce accurate data. Each year OCSE Auditors review the data that states report for the previous fiscal year. The OCSE Office of Audit has completed the FY 2012 data reliability audits. Since FY 2001, the reliability standard has been 95 percent.
22.2LT and 22B (ACF)	National Directory of New Hires (NDNH)	Beginning with performance in FY 2001, the above employment measures – job entry, job retention, and earnings gain – are based solely on performance data obtained from the NDNH. Data are updated by states, and data validity is ensured with normal auditing functions for submitted data. Prior to use of the NDNH, states had flexibility in the data source(s) they used to obtain wage information on current and former TANF recipients under high performance bonus (HPB) specifications for performance years FY 1998 through FY 2000. ACF moved to this single source national database (NDNH) to ensure equal access to wage data and uniform application of the performance specifications.

Administration for Community Living (ACL)

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

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

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

Measure ID	Data Source	Data Validation
2.10 (ACL)	State Program Report and National Survey of Older Americans Act Participants.	This is a composite measure that utilizes data from multiple sources. One source is the State Program Report. Another source is the National Survey. State Program Report data is annually submitted by States. The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by ACL's Administration on Aging (AoA) and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data. The National Survey draws a sample of Area Agencies on Aging to obtain a random sample of clients receiving selected Older Americans Act (OAA) services. Trained staff administers telephone surveys. Results are analyzed and compared to client population to assure representative sample.
3.1 (ACL)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by ACL's Administration on Aging (AoA) and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.
3.5 (ACL)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by ACL's Administration on Aging (AoA) and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.

Agency for Healthcare Research and Quality (AHRQ)

Measure ID	Data Source	Data Validation
1.3.16 (AHRQ)	MEPS website - MEPSnet/IC interactive tool.	Data published on website A number of steps are taken from the time of sample selection up to data release to ensure the reliability and accuracy of MEPS data including: Quality control checks are applied to the MEPS sample frame when it is received from NCHS as well as to the subsample selected for MEPS. - Following interviewer training, performance is monitored through interview observations and validation interviews. - A variety of materials and strategies are employed to stimulate and maintain respondent cooperation. - All manual coding and data entry tasks are monitored for quality by verification at 100 percent until an error rate of less than 2 percent is achieved for coding work or less than 1 percent for data entry. - All specifications developed to guide the editing, variable construction and file creation are monitored through data runs that are used to verify that processes are conducted correctly and to identify data anomalies. - Analytic weights are developed in a manner that reduces nonresponse bias and improves national representativeness of survey estimates. - The precision of survey estimates are reviewed to insure they are achieving precision specifications for the survey. - Prior to data release, survey estimates on health care utilization, expenditures, insurance coverage, priority conditions and income are compared to previous year MEPS data and other studies. Significant changes in values of constructed variables are investigated to determine whether differences are attributable to data collection or variable construction problems that require correction. Expenditure data obtained from the MEPS medical provider survey are used to improve the accuracy of household reported data.

Measure ID	Data Source	Data Validation
1.3.21 (AHRQ)	MEPS website	Data published on website A number of steps are taken from the time of sample selection up to data release to ensure the reliability and accuracy of MEPS data including: - Quality control checks are applied to the MEPS sample frame when it is received from NCHS as well as to the subsample selected for MEPS. - Following interviewer training, performance is monitored through interview observations and validation interviews. - A variety of materials and strategies are employed to stimulate and maintain respondent cooperation. All manual coding and data entry tasks are monitored for quality by verification at 100 percent until an error rate of less than 2 percent is achieved for coding work or less than 1 percent for data entry. - All specifications developed to guide the editing, variable construction and file creation are monitored through data runs that are used to verify that processes are conducted correctly and to identify data anomalies. - Analytic weights are developed in a manner that reduces nonresponse bias and improves national representativeness of survey estimates. The precision of survey estimates are reviewed to insure they are achieving precision specifications for the survey. - Prior to data release, survey estimates on health care utilization, expenditures, insurance coverage, priority conditions and income are compared to previous year MEPS data and other studies. Significant changes in values of constructed variables are investigated to determine whether differences are attributable to data collection or variable construction problems that require correction. Expenditure data obtained from the MEPS medical provider survey are used to improve the accuracy of household reported data.
1.3.23 (AHRQ)	CAHPS database National CAHPS Benchmarking Database	Prior to placing survey and related reporting products in the public domain, a rigorous development, testing, and vetting process with stakeholders is followed. Survey results are analyzed to assess internal consistency, construct validity, and power to discriminate among measured providers.

Measure ID	Data Source	Data Validation
1.3.38 (AHRQ)	Surveys/case studies	The Hospital Survey on Patient Safety Culture (HSOPS) is a survey which measures organization patient safety climate. AHRQ staff - from the Patient Safety Portfolio and the Office of Communications and Knowledge Transfer (OCKT) – in collaboration with Westat, the HSOPS support contractor, have developed methods and conducted validation studies of HSOPs using a multi-modal approach. First, we have compared HSOPs to the AHRQ Patient Safety Indicators (PSIs), which are based on individual hospital administrative data and are indicators of harm. Next, AHRQ compared HSOPS to HCAHPS, which characterizes the patient's experience with care. In addition, we have compared HSOPS to CMS pay-for-performance-measures. Finally, AHRQ has conducted multiple case studies of the utilization and implementation of HSOPS by individual hospitals and hospital systems.

Assistant Secretary for Administration (ASA)

Measure ID	Data Source	Data Validation
1.1 (ASA)	Manual data calls for telework information through the use of spreadsheets.	Office of Human Resources Telework Liaisons
1.2 (ASA)	HHS data for fleet statistics comes from analysis and output via a resource called the Federal Automotive Statistical Tool (FAST). The input for the HHS data comes from an internal HHS data resource called the HHS Motor Vehicle Management Information System (MVMIS). Per the intent of the metric, HHS's measure reflects actual fleet performance values when excluding all fuel products used by HHS law enforcement, protective, emergency response or military tactical vehicles (if any).	Both the FAST and MVMIS have internal validation processes
1.3 (ASA)	OCIO HHS Electronic Stewardship data.	OpDiv electronic stewardship workgroup
2.1 (ASA)	HHS personnel records	

Assistant Secretary for Preparedness and Response (ASPR)

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

Centers for Disease Control and Prevention (CDC)

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

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

Measure ID	Data Source	Data Validation
2.1.8 (CDC)	National HIV surveillance system	CDC evaluates surveillance programs to determine the quality of data. HIV data are reported from all 50 states, DC, and the U.S. dependent areas. The period of time between a diagnosis of HIV and the arrival of a case report at CDC is called the "reporting delay." Data on diagnoses of HIV from the National HIV Surveillance System will be available in November. Transitioning to updated data processing has caused data delays. Once this transition is complete the data availability will improve
2.2.4 (CDC)	DHAP Legal Assessment Project	The Legal Assessment Project (LAP) is a legal research and policy analysis project led by CDC's Division of HIV/AIDS Prevention, Office of the Director. Using standard legal research methods, the LAP researches state statutes, regulations, and policies that affect states' ability to conduct effective HIV prevention.
2.8.1 (CDC)	The National TB Surveillance System	TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.
3.3.2a (CDC)	Emerging Infections Program / Active Bacterial Core Surveillance/Emerging Infections Program Surveillance for Invasive MRSA Infections	Surveillance Site personnel trained in methodology, updates annually; laboratory audits performed by Site staff
3.3.3 (CDC)	National Healthcare Safety Network (NHSN)	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
3.3.4 (CDC)	National Healthcare Safety Network (NHSN)	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
4.6.3 (CDC)	National Health Interview Survey, NCHS	NCHS validates the data

Measure ID	Data Source	Data Validation
4.6.5 (CDC)	Youth Risk Behavior Surveillance System (YRBSS), which monitors priority health-risk behaviors and is conducted every other year (odd years). Beginning in FY 2011, the National Youth Tobacco Survey (NYTS) was added as an additional data source but removed in 2014 when the variance of the data reported in the years between YRBSS data reporting became too great as compared with YRBSS.	Validity and reliability studies of YRBSS attest to the quality of the data. CDC conducts quality control and logical edit checks on each record
4.11.9 (CDC)	National Health Interview Survey (NHIS), CDC, NCHS	Data are reported from a national surveillance system and follow predetermined quality control standards.
8.B.1.3a (CDC)	Tracking spreadsheets from the ELC-ELR monitoring project	Data is validated by the Meaningful Use program by collaborating with the various programs (ELR, ISS, SS) to determine the number of awardees that meet the requirements of the EHR-MU standards.
8.B.2.2 (CDC)	Electronic media reach of CDC Vital Signs is measured by CDC.gov web traffic and actual followers and subscribers of CDC's social media, e-mail updates and texting service The data source for this measure is Omniture® web analytics, which is a software product that provides consolidated and accurate statistics about interactions with CDC.gov and social media outlets as individuals seek and access information about *CDC Vital Signs.*	Monthly review of Omniture data by CDC Office of the Associate Director for Communication (OADC) and Vital Signs staff.
8.B.2.5 (CDC)	The data source for this measure is Omniture® web analytics, which is a software product that provides consolidated and accurate statistics about interactions with CDC.gov	Ongoing review of Omniture reports by Community Guide staff.
8.B.4.2 (CDC)	Infectious Diseases (EID) Laboratory Fellowships, CDC/Council of State and Territorial Epidemiologists' (CSTE) Applied Epidemiology Fellowship, Post-EIS Practicum (now known as the Health Systems Integration Program), PHPS Residency, and Applied Public Health Informatics Fellowship were added to the measure in FY 2011. The PHPS Residency pilot program ended in FY 2012. The Informatics Training in Place Program was added in FY 2014. Trainees funded by other federal agencies are excluded.	Staff reviews and validates data through the fellowship programs' personnel systems.

Measure ID	Data Source	Data Validation
10.A.1.5 (CDC)	Annual Program Results (APRs)	Data are validated through routine site monitoring and data quality assurance activities. These activities are performed routinely at sites providing direct service delivery and sites that receive technical assistance for service delivery improvement for this performance measure. Data validation includes routine procedures for assessing and maintaining data completeness and accuracy throughout the data lifecycle as well as systematic procedures for assessing that the reported data are validated. Final aggregated numbers for results and future targets are reviewed by an expert team representing both programmatic technical area experts at headquarters and country technical team members with expert knowledge of country program context, historical performance, and current performance capacity.
10.F.1a (CDC)	FETP Annual Program Reports	Reports from Countries are submitted to CDC annually. These reports are confirmed by program directors in each Country.
10.F.1b (CDC)	FETP Annual Program Reports	Reports from Countries are submitted to CDC annually. These reports are confirmed by program directors in each Country.
13.5.3 (CDC)	Self-reported data from 62 PHEP grantees.	Quality assurance reviews with follow-up with grantees

Centers for Medicare and Medicaid Services (CMS)

Measure ID	Data Source	Data Validation
ACO1.1 (CMS)	Master Data Management System	CMS contractors perform assignment and reconciliation tasks; the data are cleaned and reviewed for quality assurance and validation processes
ACO1.2 (CMS)	Medicare Provider Enrollment, Chain, and Ownership System (PECOS)	CMS contractors perform assignment and reconciliation tasks; the data are cleaned and reviewed for quality assurance and validation processes
ACO1.3 (CMS)	Central Repository of Alignment Files (CCRAF); Central Repository of Alignment Files and Payment (CCRAFP)	CMS contractors perform assignment and reconciliation tasks; the data are cleaned and reviewed for quality assurance and validation processes

Measure ID	Data Source	Data Validation
CHIP 3.3 (CMS)	Statistical Enrollment Data System	Each State must assure that the information is accurate and correct when the information is submitted to SEDS by certifying that the information shown on the CHIP forms is correct and in accordance with the State's child health plan as approved by the Secretary. CMS staff populates the data into various SEDS reports and verifies each of the enrollment measures. Each form has the following seven measures that are reported by service delivery system: 1: Unduplicated Number Ever Enrolled During the Quarter. 2: Unduplicated Number of New Enrollees in the Quarter. 3: Unduplicated Number of Disenrollees in the Quarter. 4: Number of Member-Months of Enrollment in the Quarter. 5: Average Number of Months of Enrollment (item 4 divided by item 1). 6: Number Enrolled At Quarter's End (point in time). 7: Unduplicated Number Ever Enrolled in the Year" (4th Quarter Only). CMS compares these enrollment measures to past quarters and trends over the life of each program to ensure that there are not any anomalies in the data, and if apparent errors are detected, CMS corresponds with the State staff who are responsible for reporting enrollment statistics. If there are major increases or decreases, CMS investigates the causes of the changes in enrollment patterns.
MCD6 (CMS)	Developmental. The core set of measures required under CHIPRA was published in December 2009. CMS will initially use the automated web-based system - CHIP Annual Reporting Template System (CARTS) for the reporting of quality measures developed by the new program. This is the same system that was used for the CHIP Quality GPRA goal that was discontinued after FY 2010 (MCD2).	Developmental. CMS will monitor performance measurement data related to the core set of measures through CARTS.
MCD8 (CMS)	Developmental. For FY 2011 and FY 2012, the data source will be the links to the Federal Register. The link to the recommended core set is: http://federalregister.gov/a/2010-32978. The link to the published core set is http://federalregister.gov/a/2011-33756. In February, 2013, CMS provided States with technical specifications for reporting information on the adult quality core measures set and technical assistance to increase the feasibility of reporting. Information voluntarily reported to CMS by early 2014, will serve as the data source for assessing States' progress in reporting standardized adult quality measurement data to CMS.	Developmental. For FY 2011 and FY 2012, the data validation will be the link to the core set in the Federal Register. The link to the recommended core set is: http://federalregister.gov/a/2010-32978. The link to the published core set is http://federalregister.gov/a/2011-33756

Measure ID	Data Source	Data Validation
MCR1.1a (CMS)	The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in all Medicare Advantage plans and in the original Medicare fee-for-service plan.	The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 4.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.
MCR1.1b (CMS)	The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in the original Medicare fee-for-service plan and in all Medicare Advantage plans.	The Medicare CAHPS are administered according to the standardized protocols as delineated in the Medicare Advantage and Prescription Drug Plan CAHPS Survey Quality Assurance Protocols & technical Specifications available at www.ma_pdpcahps.org. This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully analyzed and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.
MCR23 (CMS)	The Prescription Drug Event (PDE) data	CMS has a rigorous data quality program for ensuring the accuracy and reliability of the PDE data. The first phase in this process is on-line PDE editing. The purpose of on-line editing is to apply format rules, check for legal values, compare data in individual fields to other known information (such as beneficiary, plan, or drug characteristics) and evaluate logical consistency between multiple fields reported on the same PDE. On-line editing also enforces business order logic which ensures only one PDE is active for each prescription drug event. The second phase of our data quality program occurs after PDE data has passed all initial on-line edits and is saved in our data repository. We conduct a variety of routine and ad hoc data analysis of saved PDEs to ensure data quality and payment accuracy.

Measure ID	Data Source	Data Validation
MCR26 (CMS)	Medicare claims data. The data used to calculate the performance measures are administrative claims data submitted by hospitals. Administrative claims data is a validated data source and is the data source for public reporting of hospital readmission rates on the Hospital Compare website (www.hospitalcompare.hhs.gov). As stated on the Hospital Compare website, research conducted when the measures were being developed demonstrated that the administrative claims-based model performs well in predicting readmissions compared with models based on chart reviews.	The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. CMS uses national administrative inpatient hospital claims data to calculate the readmission rate measure. The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. Inpatient hospital claims information is assumed to be accurate and reliable as presented in the database.
MCR28.2 (CMS)	The CDC National Healthcare Safety Network	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
MIP1 (CMS)	Comprehensive Error Rate Testing (CERT) Program.	The CERT program is monitored for compliance by CMS through monthly reports from the contractors. In addition, the OIG periodically conducts reviews of CERT and its contractors.
MIP5 (CMS)	The Part C Error Rate estimate measures errors in clinical diagnostic data submitted to CMS by plans. The diagnostic data is used to determine risk adjusted payments made to plans.	Data used to determine the Part C program payment error rate is validated by several contractors. The Part C program payment error estimate is based on data obtained from a rigorous Risk Adjustment Data Validation process in which medical records are reviewed by independent coding entities in the process of confirming that medical record documentation supports risk adjustment diagnosis data for payment.

Measure ID	Data Source	Data Validation
MIP6 (CMS)	The components of payment error measurement in the Part D program are: A rate(s) that measures payment errors related to low income subsidy (LIS) payments for beneficiaries dually-eligible for Medicare and Medicaid and non-duals also eligible for LIS status. A rate that measures payment errors from errors in Prescription Drug Event (PDE) records. A PDE record represents a prescription filled by a beneficiary that was covered by the plan. A rate that measures payment errors resulting from incorrect assignment of Medicaid status to beneficiaries who are not dually eligible for Medicare and Medicaid. A rate that measures payment errors from errors in Direct and Indirect Remuneration (DIR) amounts reported by Part D sponsors to CMS. DIR is defined as price concessions (offered to purchasers by drug manufacturers, pharmacies, or other sources) that serve to decrease the costs incurred by the Part D sponsor for prescription drugs.	For the Part D component payment error rates, the data to validate payments comes from multiple internal and external sources, including CMS' enrollment and payment files. Data are validated by several contractors. Data for the LIS payment error measure come from CMS' internal payment and enrollment files for all Part D plan beneficiaries. Data for the PDE error measure come from CMS' PDE Data Validation process, which validates PDE data through contractor review of supporting documentation submitted to CMS by a national sample of Part D plans. The data element for incorrect Medicaid status is the PERM eligibility error rate, which is validated by the Medicaid program for the entire Medicaid population and is used by the Part D program as a proxy for incorrect Medicaid status. From the population of Part D beneficiaries who are eligible for Medicare and Medicaid, we randomly assign a subset, equal to the PERM rate, to be ineligible for Medicaid, resulting in payment error. Data for the DIR error measure come from audit findings for a national sample of Part D plans; the audits are conducted by contractors as part of the Financial Audit process conducted by CMS' Office of Financial Management (OFM).
MIP8 (CMS)	Our predictive analytics work, using FPS, will focus on activities in the areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk-based approach increases contractors' efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud	FPS captures the link between each individual ASR and each subsequent administrative action. The FPS Dashboard and supporting systems will enable a seamless reporting of all data necessary to develop the baseline and to measure performance against any future targets.
MIP9.1 (CMS)	As part of a national contracting strategy, adjudicated claims data and medical policies are gathered from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS and our contractors are working with the 17 States to ensure that the Medicaid and CHIP universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews. In addition, the OIG conducts annual reviews of the PERM program and its contractors.
MIP9.2 (CMS)	As part of a national contracting strategy, adjudicated claims data and medical policies are gathered from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS and our contractors are working with the 17 States to ensure that the Medicaid and CHIP universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews.

Measure ID	Data Source	Data Validation
MSC1 (CMS)	CMS reports the prevalence of pressure ulcers in long-stay nursing home residents with quality measures (QMs) derived from the Minimum Data Set (MDS). For this goal, we report the prevalence of pressure ulcers measured in the last three months of the fiscal year. The numerator consists of high-risk residents with a pressure ulcer, stages 2-4, on the most recent assessment. The denominator is all high-risk residents. Beginning with the FY 2012 reporting period, the data source is changing from MDS version 2.0 to MDS version 3.0. The new pressure ulcer measure excludes less serious Stage 1 pressure ulcers.	The MDS, version 3.0, is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self-reported by the nursing home. MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner
MSC5 (CMS)	CMS reports the percentage of long-stay nursing home residents that received an antipsychotic medication with a quality measure (QM) derived from the Minimum Data Set (MDS).	The MDS is the source of the data used to calculate this measure. The MDS is considered part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home.

Food and Drug Administration (FDA)

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

Measure ID	Data Source	Data Validation
214305 (FDA)	Field Data Systems	These maximum capacities are extrapolated to estimate for times of emergency with the laboratory operating under abnormal conditions that are variable and uncertain. FDA and FERN work to maximize capabilities by continually improving methods and training along with increasing automated functionality and available cache of supplies. Through using these laboratories, with known instrumentation and methods, after examining the sample throughput during emergencies, and after consultation with the laboratories and FDA subject matter experts, the listed sample totals are the estimates reached. The surge capacity estimates provided in the performance measures for these laboratories have been examined under the stress of emergencies and outbreaks such as the melamine contamination, Deepwater Horizon oil spill, and the Japan nuclear event.
214306 (FDA)	BioPlex and ibis Biosensor systems	CFSAN scientists have developed the means to evaluate and adapt commercially available instruments to develop and validate more rapid, accurate, and transportable tests to stop the spread of foodborne illness and cases of chemical contamination. Using one such system, known as Bioplex, CFSAN scientists are using the device to rapidly serotype pathogens such Salmonella. The Bioplex system can serotype 48 different samples in 3 to 4 hours, which vastly improves response time in foodborne illness outbreaks. CFSAN scientists also are using the ibis Biosensor system to speed the identification of Salmonella, E. coli, and other pathogens, toxins, and chemical contaminants.
223205; 223215 (FDA)	Review performance monitoring is being done in terms of cohorts, e.g., FY 2009 cohort includes applications received from October 1, 2008, through September 30, 2009. CDER uses the Document Archiving, Reporting, and Regulatory Tracking System (DARRTS). FDA has a quality control process in place to ensure the reliability of the performance data in DARRTS.	The Document Archiving, Reporting, and Regulatory Tracking System (DARRTS) is CDER's enterprise-wide system for supporting premarket and postmarket regulatory activities. DARRTS is the core database upon which most mission-critical applications are dependent. The type of information tracked in DARRTS includes status, type of document, review assignments, status for all assigned reviewers, and other pertinent comments. CDER has in place a quality control process for ensuring the reliability of the performance data in DARRTS. Document room task leaders conduct one hundred percent daily quality control of all incoming data done by their IND and NDA technicians. Senior task leaders then conduct a random quality control check of the entered data in DARRTS. The task leader then validates that all data entered into DARRTS are correct and crosschecks the information with the original document.
234101 (FDA)	CBER's Office of Vaccines Research and Review; and CBER's Emerging and Pandemic Threat Preparedness Office	The data are validated by the appropriate CBER offices and officials.

Measure ID	Data Source	Data Validation
243201 (FDA)	Submission Tracking and Reporting System (STARS).	STARS tracks submissions, reflects the Center's target submission processing times and monitors submissions during the developmental or investigational stages and the resulting application for marketing of the product.
262401 (FDA)	NCTR Project Management System; peer-review through FDA/NCTR Science Advisory Board (SAB) and the NTP Scientific Board of Counselors; presentations at national and international scientific meetings; use of the predictive and knowledge-based systems by the FDA reviewers and other government regulators; and manuscripts prepared for publication in peer-reviewed journals.	NCTR provides peer-reviewed research that supports FDA's regulatory function. To accomplish this mission, it is incumbent upon NCTR to solicit feedback from its stakeholders and partners, which include FDA product centers, other government agencies, industry, and academia. The NCTR SAB —composed of non-government scientists from industry, academia, and consumer organizations, and subject matter experts representing all of the FDA product centers—is guided by a charter that requires an intensive review of each of the Center's scientific programs at least once every five years to ensure high quality programs and overall applicability to FDA's regulatory needs. Scientific and monetary collaborations include Interagency Agreements with other government agencies, Cooperative Research and Development Agreements that facilitate technology transfer with industry, and informal agreements with academic institutions. NCTR also uses an in-house strategy to ensure the high quality of its research and the accuracy of data collected. Research protocols are often developed collaboratively by principal investigators and scientists at FDA product centers and are developed according to a standardized process outlined in the "NCTR Protocol Handbook." NCTR's Project Management System tracks all planned and actual expenditures on each research project. The Quality Assurance Staff monitors experiments that fall within the Good Laboratory Practices (GLP) guidelines. NCTR's annual report of research accomplishments, goals, and publications is published and available on FDA.gov. Research findings are published in peer-reviewed journals and presented at national and international scientific conferences.
280005 (FDA)	CTP's Tobacco Inspection Management System (TIMS) is a database that contains the tobacco retail inspection data submitted by state and territorial inspectors commissioned by FDA.	CTP/OCE has in place a process for ensuring the quality of the data in TIMS. OCE staff conduct random quality control checks of inspection data submitted for tobacco retail inspections where no violations were found. OCE staff conduct quality control checks for all tobacco retail inspections where potential violations were found.

Health Resources and Services Administration (HRSA)

Measure ID	Data Source	Data Validation
1.I.A.1 (HRSA)	HRSA Bureau of Primary Health Care's Uniform Data System	Validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norm.

Measure ID	Data Source	Data Validation
1.I.A.3 (HRSA)	HRSA/Bureau of Primary Health Care contractors that perform PCMH surveys.	Data validated by Health Center program staff.
1.II.B.1 (HRSA)	Uniform Data System	Validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norm.
4.I.C.2 (HRSA)	HRSA Bureau of Clinician Recruitment Service's Management Information Support System (BMISS)	BMISS is internally managed with support from the NIH which provides: Data Management Services, Data Requests and Dissemination, Analytics, Data Governance and Quality, Project Planning and Requirements Development, Training, and Process Improvement.
6.I.C.2 (HRSA)	Annual grantee data submitted through the Bureau of Health Profession's Performance Management System.	Data are entered through a web-based system that incorporates extensive validation checks. Once approved by the project officer (1st level of review), data are cleaned, validated, and analyzed by scientists within BHPr's Office of Performance Measurement (2nd level of review). Inconsistencies in data reported identified throughout the 2nd level of review are flagged and sent to the project officer for follow-up and correction.
10.I.A.1 (HRSA)	Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC).	Data are validated by CDC.
16.E (HRSA)	ADAP Quarterly Report data provided by State ADAPs.	Web-based data checked through a series of internal consistency/validity checks. Also HIV/AIDS program staff review submitted Quarterly reports, and provide technical assistance on data-related issues.
16.I.A.1 (HRSA)	HRSA HIV/AIDS Bureau's Ryan White HIV/AIDS Program Services Report	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all Ryan White HIV/AIDS Program Services Report (RSR) submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.
24.II.A.2 (HRSA)	Data are captured within the National Marrow Donor Program's computerized system, containing information pertaining to registered volunteer adult donors willing to donate blood stem cells to patients in need. Monthly reports generated from the computerized system to indicate the number of registered donors (broken down by self-reported race and ethnicity).	Validated by project officers analyzing comprehensive monthly reports broken down by recruitment organization. To decrease the likelihood of data entry errors, the program contractor utilizes value protected screens and optical scanning forms.
29.IV.A.3 (HRSA)	Reported by grantees through the Program's Performance Improvement Measurement System	Validated by project officers

Measure ID	Data Source	Data Validation
36.II.B.1 (HRSA)	Family Planning Annual Report (FPAR). The FPAR consists of 14 tables in which grantees report data on user demographic characteristics, user social and economic characteristics, primary contraceptive use, utilization of family planning and related health services, utilization of health personnel, and the composition of project revenues. For this measure, FPAR Table 11: "Unduplicated number of Users Tested for Chlamydia by Age and Gender," is the data source.	The responsibility for the collection and tabulation of annual service data from Title X grantees rests with the Office of Population Affairs (OPA), which is responsible for the administration of the program. Reports are submitted annually on a calendar year basis (January 1 - December 31) to the regional offices. Grantee reports are tabulated and an annual report is prepared summarizing the regional and national data. The annual report describes the methodology used both in collection and tabulation of grantee reports, as well as the definitions provided by OPA to the grantees for use in completing data requests. Also included in the report are lengthy notes that provide detailed information regarding any discrepancies between the OPA requested data and what individual grantees were able to provide. Data inconsistencies are first identified by the Regional Office and then submitted back to the grantee for correction. Additionally, discrepancies found by the contractor compiling the FPAR data submits these to the Office of Family Planning (OFP) FPAR data coordinator who works with the Regional Office to make corrections. All data inconsistencies and their resolution are noted in an appendix to the report. These are included for two reasons: (1) to explain how adjustments were made to the data, and how discrepancies affect the analysis, and (2) to identify the problems grantees have in collecting and reporting data, with the goal of improving the process.

Indian Health Service (IHS)

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

Measure ID	Data Source	Data Validation
TOHP-SP (IHS)	Routine IHS Tribal consultation documentation for HHS consultation report and IHS Director's Activities database	Routine IHS Tribal consultation documentation for HHS consultation report and IHS Director's Activities database

Immediate Office of the Secretary (IOS)

Measure ID	Data Source	Data Validation
1.1 (IOS)	The data sources are: 1) the number of HHS federal advisory committees (per data released from the HHS Office of the White House Liaison; 2) all challenges and competitions that are made available to member of the public at http://challenge.gov/HHS and the number of HHS API-enabled databases (see http://www.hhs.gov/digitalstrategy/).	Collection is based on annual data reported by the HHS Office of the White House Liaison, the HHS Open Innovation Manager, and the Digital Communications Division.
1.2 (IOS)	Quarterly reports on data via Data.Gov submissions and HHS data calls	Datasets available at www.healthdata.gov and also tracked by the Director of the Health Data Initiative
1.3 (IOS)	HHS Innovation Council and HHS IDEA Lab administrative records.	Many of the collaborations and resulting projects are listed on the HHS IDEA Lab website at http://www.hhs.gov/idealab/
1.4 (IOS)	The Open Innovation Manager's Database	The HHS Open Innovation Manager tracks all challenges issued by HHS
1.5 (IOS)	Data are collected and maintained by HHS IDEA Lab staff	Descriptions of innovative solutions are available on the HHS IDEA Lab website at http://www.hhs.gov/idealab/
1.6 (IOS)	NLM PubMed Central Database	The validation is based on quarterly database queries. A listing of available articles and participating journals is available at http://www.ncbi.nlm.nih.gov/pmc/

National Institutes of Health (NIH)

Measure ID	Data Source	Data Validation
CBRR-1.1, CBRR-1.2 (NIH)	Doctorate Records File and the NIH IMPAC II database	Analyses of career outcomes for predoctoral and postdoctoral NRSA participants, compared to individuals that did not receive NRSA support," using the Doctorate Records File and the NIH IMPAC II administrative database. Contact: Jennifer Sutton Program Policy and Evaluation Officer Office of Extramural Programs (301) 435-2686

Measure ID	Data Source	Data Validation
CBRR-10 (NIH)	Publications, databases, administrative records, and/or public documents.	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Further information on Probe Reports from the NIH Molecular Libraries Program can be found here: http://www.ncbi.nlm.nih.gov/books/NBK47352/ Further information on the Molecular Libraries Program can be found here**:** http://commonfund.nih.gov/molecularlibraries/ Further information on the S1P1 compound in clinical development can be found here: http://ir.receptos.com/releases.cfm Macrophage models of Gaucher disease for evaluating disease pathogenesis and candidate drugs. Aflaki E, Stubblefield BK, Maniwang E, Lopez G, Moaven N, Goldin E, Marugan J, Patnaik S, Dutra A, Southall N, Zheng W, Tayebi N, Sidransky E.Sci Transl Med. 2014 Jun 11; 6(240):240ra73. doi: 10.1126/scitranslmed.3008659. http://stm.sciencemag.org/content/6/240/240ra73.full.html Cytokine storm plays a direct role in the morbidity and mortality from influenza virus infection and is chemically treatable with a single sphingosine-1-phosphate agonist molecule. Oldstone MB, **Rosen H**.; Curr Top Microbiol Immunol. 2014;378:129-47. doi: 10.1007/978-3-319-05879-5_6. Review., PMID: 24728596 http://www.ncbi.nlm.nih.gov/pubmed/24728596

Measure ID	Data Source	Data Validation
SRO-3.9 (NIH)	Publication, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. For additional information contact: NIAMS SPPB (Reaya Reuss, 301-496-8271, reussa@mail.nih.gov) Liu Y, Ramot Y, Torrelo A, Paller AS, Si N, Babay S, Kim PW, Sheikh A, Lee C-CR, Chen Y, Vera A, Zhang X, Goldbach-Mansky R, Zlotogorski A. (2012). Mutations in PSMB8 Cause CANDLE Syndrome with Evidence of Genetic and Phenotypic Heterogeneity. Arthritis Rheum. March; 64(3): 895-907. (PMID: 21953331) Brehm A, Liu Y, Sheikh A, Omoyinmi E, Biancotto A, Zhou Q, Montealegre G, Reinhardt A, de Jesus AA, Pelletier M, Tsai WL, Remmers EF, Kardava L, Hill S, Kim H, Lachmann HL, Megarbane A, Chae JJ, Brady J, Castillo RD, Brown D, Vera Casano A, Ling G, Plass N, Chapelle D, Huang Y, Stone D, Chen Y, Lee C-CR, Kastner DL, Torrelo T, Zlotogorski A, Moir S, Gadina M, McCoy P, Rother, Hildebrand PW, Brogan P, Aksentijevich I, Krüger E, Goldbach-Mansky R. Diverse proteasome subunit mutations link proteasome dysfunction and type interferon induction in PRAAS/CANDLE (Manuscript in preparation). Montealegre Sanchez G, de Jesus AA, Reinhardt A, Brogan P, Berkun Y, Brown D, Chira P, Gao L, Chapelle D, Plass N, Kim H, Davis M, Liu Y, Huang Y, Lee C-C, Hadigan C, Heller T, Zlotogorski A, O'Shea JJ, Hill S, Rother K, Gadina M, Goldbach-Mansky R. (2013). Chronic Atypical Neutrophilic Dermatosis with Lipodystrophy and Elevated Temperatures (CANDLE): Clinical Characterization and Initial Response to Janus Kinase Inhibition with Baricitinib. (ACR oral presentation) (Abstract) Kim H, Brooks S, Liu Y, de Jesus AA, Montealegre Sanchez G, Chappelle D, Plass N, Huang Y, Goldbach-Mansky R. Validation of a Novel IFN-Regulated Gene Score As Biomarker in Chronic Atypical Neutrophilic Dermatosis with Lipodystrophy and Elevated temperature (CANDLE) Patients on Baricitinib, a Janus Kinase 1 /2 Inhibitor, a Proof of Concept (ACR abstract and oral presentation) (Abstract)

Measure ID	Data Source	Data Validation
SRO-5.2 (NIH)	Publications, databases, administrative records, and/or public documents.	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Risk loci for chronic obstructive pulmonary disease: a genome-wide association study and meta-analysis. Cho M, et al., The Lancet Respiratory Medicine 2(3); 214-225, March 2014. NHLBI contact: Dr. Lisa Postow lisa.postow@nih.gov
SRO-5.5 (NIH)	Publications, databases, administrative records, and/or public documents.	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. For additional information contact: NIBIB OSPC (Christine Cooper, 301-594-8923, cooperca2@mail.nih.gov)

Measure ID	Data Source	Data Validation
SRO-5.13 (NIH)	Publications, databases, administrative records, and/or public documents. http://www.epa.gov/ncct/Tox21/	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. 1) Attene-Ramos MS, Miller N, Huang R, Michael S, Itkin M, Kavlock RJ, Austin CP, Shinn P, Simeonov A, Tice RR, Xia M. The Tox21 robotic platform for assessment of environmental chemicals - from vision to reality. Drug Discovery Today 2013; 18:716-723.Myers SL, Yang CZ, Bittner GD, Witt KL, Tice RR, Baird DD. Estrogenic and anti-estrogenic activity of off-the-shelf hair and skin care products. Journal of Exposure Science and Environmental Epidemiology 2014; 1–7. 2) Attene-Ramos MS, Huang R, Michael S, Witt KL, Richard A, Tice RR, Simeonov A, Austin CP, Xia M. Profiling of the Tox21 chemical collection for mitochondrial function to identify compounds that acutely decrease mitochondrial membrane potential. Environ Health Perspect 2014; DOI:10.1289/ehp.1408642. 3) Huang R, Sakamuru S, Martin MT, Reif DM, Judson RS, Houck KA, Casey W, Hsieh J-H, Shockley K, Ceger P, Fostel J, Witt KL, Tong W, Rotroff DM, Zhao T, Shinn P, Simeonov A, Dix DJ, Austin CP, Kavlock RJ, Tice RR, Xia M. Profiling of the Tox21 10K compound library for agonists and antagonists of the estrogen receptor alpha signaling pathway. Sci. Rep. 2014; 4:5664; DOI:10.1038/srep05664.

Measure ID	Data Source	Data Validation
SRO-6.4 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Progress Reports for the following grant numbers: HL109146, HL109152, HL109164, HL109168, HL109172, HL109250, HL109257, and HL109086 Phenotype of asthmatics with increased airway S-nitrosoglutathione reductase activity Nadzeya V et al., ERJ Express. Published on October 30, 2014 as doi: 10.1183/09031936.00042414 Regional Ventilation Changes in Severe Asthma after Bronchial Thermoplasty with 3He MR Imaging and CT, Thomen R et al., RSNA Radiology, DOI: http://dx.doi.org/10.1148/radiol.14140080 Improved CT-based estimate of pulmonary gas trapping accounting for scanner and lung-volume variations in a multicenter asthmatic study. Choi S et al., J Appl Physiol 117: 593-603, Aug 2014, doi:10.1152/japplphysiol.00280.2014

Measure ID	Data Source	Data Validation
SRO-8.2 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Smith, RJ, Lobo, MK, Spencer, S, Kalivas, PW, Cocaine-induced adaptations in D1 and D2 accumbens projection neurons (a dichotomy not necessarily synonymous with direct and indirect pathways). Curr Opinion Neurobiol, 2013, 10:546-552. Stamatakis, AM, Jennings, JH, Ung, RL, Glair, GA, Weinberg, RJ, Neve, RL, Boyce, F, Mattis, J, Ramakrishnan, C, Deisseroth, K, Stuber, GD. A unique population of ventral tegmental area neurons inhibits the lateral habenula to promote reward. Neuron, 2013, 80:1039-1053. Stamatakis, AM, Sparta, DR, Jennings, JH, McElligott, ZA, Decot, H, Stuber, GH. Amygdala and bed nucleus of the stria terminalis circuitry: Implications for addiction-related behaviors. Neuropharmacology 2014, 76 PtB:320-328. Stuber, GD, Britt, JP, Bonci, A. Optogenetic modulation of neural circuits that underlie reward seeking. Biol. Psychiat., 2012, 71:1061-1067. Britt, JP, Bonci, A. Optogenetic interrogations of the neural circuits underlying addiction. Curr. Opinion Neurobiol, 2013; 23:539-545. Ferguson, SM,. Phillips, PEM, Roth, BL, Wess, J, Neumaier, JF. Direct-pathway striatal neurons regulate the retention of decision-making strategies. J. Neurosci., 2013, 33:11668-11676 Barrot, M, Sesack, SR, Georges, F, Pistis, M, Hong, S, Jhou, TC. Braking dopamine systems: a new GABA master structure for mesolimbic and nigrostriatal functions. J. Neurosci., 2012, 32:14094-14101. Jhou, TC, Good, CH, Rowley, CS, Xu, SP, Wang, H, Burnham, NW, Hoffman, AF, Lupica, CR, Ikemoto, S. Cocaine drives aversive conditioning via delayed activation of dopamine-responsive habenular and midbrain pathways. J. Neurosci., 2013, 33:7501-7512. Jennings, JH, Sparta, DR, Stamatitakis, AM, Ung, RL, Pleil, KE, Kash, TL, Stuber, GD. Distinct extended amygdala circuits for divergent motivational states. Nature, 2013, 496:224-230.

Measure ID	Data Source	Data Validation
SRO-8.7 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Isaac C. Rhew, Eric C. Brown, J. David Hawkins, and John S. Briney. Sustained Effects of the Communities That Care System on Prevention Service System Transformation. American Journal of Public Health: March 2013, Vol. 103, No. 3, pp. 529-535. Greenberg MT, Feinberg ME, Johnson LE, Perkins DF, Welsh JA, Spoth RL. Factors That Predict Financial Sustainability of Community Coalitions: Five Years of Findings from the PROSPER Partnership Project. Prevention Science; 2014 Apr 6. [Epub ahead of print] Mercer, SH.; McIntosh, K; Strickland-Cohen, MK; Horner, RH. Measurement invariance of an instrument assessing sustainability of school-based universal behavior practices. School Psychology Quarterly, Vol 29(2), Jun 2014, 125-137. Szonja Vamos, MS, Miriam Mumbi, RN, Ryan Cook, BA, Ndashi Chitalu, MD, Stephen Marshall Weiss, PhD, MPH, and Deborah Lynne Jones, PhD. Translation and sustainability of an HIV prevention intervention in Lusaka, Zambia. Transl Behav Med. Jun 2014; 4(2): 141–148. Published online Sep 11, 2013.

Office of the Assistant Secretary for Health (OASH)

Measure ID	Data Source	Data Validation
1.5 (OASH)	Commerce and Census	

Office of Medicare Hearings and Appeals (OMHA)

Measure ID	Data Source	Data Validation
1.1.5 (OMHA)	Appellate Climate Survey	The most recent version of the survey was administered by a third party contractor using a stratified random sample of appellants whose cases were closed within fiscal year 2014. The survey was designed to collect appellant: demographic information, overall satisfaction, satisfaction with hearing format, satisfaction with other aspects (e.g., scheduling, clarity of case processing documents, interaction with the ALJ team after the scheduling and prior to the hearing, and use of the OMHA website) and possible predictors of satisfaction (e.g., case fully heard and considered, ALJ behavior, etc.).

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

Measure ID	Data Source	Data Validation
1.A.2, 1.B.4 (ONC)	Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey, Electronic Medical Record Supplement	The NAMCS is nationally representative of office-based physicians. Historically, the response rate is approximately 68%. Beginning with survey year 2010, the survey allows ONC to evaluate trends in electronic health record adoption by region, provider specialty, and state. Estimates for FYs 2008-11 for this measure derive from the mail supplement to the NAMCS.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Measure ID	Data Source	Data Validation
2.3.21 (SAMHSA)	National Survey on Drug Use and Health State estimates	Performance results are based on state-level estimates obtained via the National Survey on Drug Use and Health (NSDUH). State estimates are entered by each SPF SIG grantee into the Prevention Management and Reporting Tool (PMRTS). Validation and verification checks are run on the data as they are being entered. Automated programs identify typical data errors such as missing data and outliers. Additionally, the data management team analyzes data to calculate annual performance results. Data are carefully cleaned using the pre-established Uniform Coding Conventions. Data abnormalities are communicated to the GPOs and grantees via cleaning sheets for explanation or correction. The data management team responsible for this data assures that required fields are complete and that all edits are made. The SPFSIG cross site evaluation team performs analyses and generates reports annually and on an ad hoc basis as needed. Information about methodology for the NSDUH is available at http://www.samhsa.gov/data/Methodological_Reports.aspx The final year of data (2014 data to be reported at the end of 2015) will come from a different data source.

Measure ID	Data Source	Data Validation
2.3.56 (SAMHSA)	Data are collected through dosage forms and/ participant level instruments using standardized items. These data are collected and provided by grantees online through an electronic system called the Performance Management Reporting and Training system (PMRTS). All grantees receive training in using the system and are provided technical assistance in data to be collected. These data are then cleaned and analyzed by an analytic contract. In FY2012, The Data Collection Analysis and Reporting (DCAR) contract was awarded and serves the data collection, cleaning, analysis, and reporting functions. The data to be reported in August 2015 will come from a different contract. It will come from the Pep C contract.	FY2013 data have been carefully collected, cleaned, analyzed, and reported by SAMHSA's Data Collection Analysis and Reporting contract (DCAR). After data were entered into the PMRTS, the system uses automated programs to do the initial data cleaning (identifies outliers, missing data, etc.) the Data Management Team the reviews the data for completeness and accuracy. Information on any data problems identified is transmitted through the use of "cleaning sheets" to the Government Project Officer (GPO) and the grantee to resolve. The Data Management Team then makes any required edits to the files, following the extensive and detailed Uniform Coding Conventions. The edited files are then sent to SAMHSA staff and the Data Analysis Team for analysis and reporting.
2.3.61 (SAMHSA)	The number of calls answered is reported in the National Suicide Prevention LifeLine Monthly Report	Specialists in information technology at the National Suicide Prevention LifeLine evaluation center validate phone records received from Sprint to determine the number of calls received and answered at 1-800-273-TALK.
3.2.02a (SAMHSA)	TRAC on-line data reporting and collection system. This measure is part for the phase one transition into the CDP.	All TRAC data are automatically checked as they are input into the TRAC system. Validation and verification checks are run as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the TRAC database.
3.2.16 (SAMHSA)	TRAC through 2014 with transition to the Consolidated Data Platform (CDP) in early 2015.	All data are automatically checked as they are input to TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.2.26 (SAMHSA)	TRAC on-line data reporting and collection system. This measure is part of the phase 1 transition into the Consolidated Data Platform (CDP). Phase 1 for the CDP begins in early 2015.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.2.30 (SAMHSA)	Data on children's outcomes were reported in the grantees' ED524 Bi-Annual Report submitted to their GPO every six months. The methods for collecting these measures varied by grantee, but were generally student self-report for the violence and substance use measures and school records for attendance and mental health services.	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things.
3.2.37 (SAMHSA)	This measure will be in phase one of the CDP transition.	

Measure ID	Data Source	Data Validation
3.2.50 (SAMHSA)	Until SAMSHA implements the Consolidated Data Platform (CDP) during 2015 and 2016, the data will be collected and tabulated by hand on an ED524 form and then submitted to SAMHSA on an annual basis.	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators review the data; provide range checks, and otherwise assess concurrent validity by comparing data and measures.
3.4.02 (SAMHSA)	Data are collected through standard instruments and submitted through the TRAC on-line data reporting and collection system. This measure is included in phase one of SAMHSA's CDP transition.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.4.15 (SAMHSA)	TRAC on-line data reporting and collection system. In 2015, TRAC is being discontinued but this measure is not part of phase one in the CDP. This data is from the block grants. It is not included in phase one of the CDP.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.4.20 (SAMHSA)	Data are submitted annually to SAMHSA by States, which obtain the information from local human service agencies that provide services.	SAMHSA's CMHS has developed additional error checks to screen data and contacts States and local providers concerning accuracy when data is reported outside expected ranges. CMHS has also issued guidance to all States and localities on data collection and monitors compliance with data collection through increased site visits to local PATH-funded agencies.
3.4.21 (SAMHSA)	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation). This measure is not part of the CDP phase one transition.	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews.
3.4.24, 3.4.25 (SAMHSA)	Services Accountability Improvement System. This data is included in Phase 1 of the Consolidated Data Platform (CDP) and will be stored in this system starting in 2015.	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
4.4.10 (SAMHSA)	Data is collected from the contractors who manage the Treatment Locator and SAMHDA websites via standard tracking software measuring unique hits	These numbers are provided to the COTRs via email at the end of each month and on January second of the next year. Validation checks are reviewed at that time. Data are maintained by the COTRs for each project.